

Army Regulation 600-85

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Personnel—General

**Alcohol and Drug  
Abuse Prevention  
and Control  
Program**

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Headquarters  
Department of the Army  
Washington, DC  
3 November 1986

# SUMMARY of CHANGE

AR 600-85

Alcohol and Drug Abuse  
Prevention and Control Program

This revision updates the Army's Alcohol and Drug Abuse Prevention and Control Program. It defines Army policy on alcohol and other drug abuse, and assigns responsibilities for implementing the program. The following are the major changes in this revision:

- o A Clinical Internship and Certification Program has been instituted (chap 4).
- o The Civilian Urinalysis Program is implemented (chap 5).
- o The Limited Use policy has been updated (chap 6).
- o New DA Forms 4465, 4466, and 3711-R, with instructions for use with DAMIS are included (chap 7).
- o Procedures for Reserve Component urinalysis testing of aviation personnel are listed (chap 9).
- o Updated procedures for biochemical testing to include field screening and use of alcohol breath measuring devices (chap 10).
- o A Quality Assurance Program for the ADAPCP in accord with DOD Instruction 1010.6 is added (app G).

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Department of the Army  
Washington, DC

2 September 1988

AR 600-85

Interim Change

No. 102

Expires 2 September 1989

Immediate Action  
INTERIM CHANGE

Personnel--General

Alcohol and Drug Abuse Prevention and Control Program

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Justification. This interim change includes policy changes for Army Reserve and Army National Guard personnel concerning alcohol and drug prevention and control. It also contains authority for the Army Reserve and Army National Guard to test their personnel for the abuse of legal or use of illegal drugs. These changes have been made so that Army Reserve and Army National Guard commanders can control abuse of legal drugs and illegal drug use within their organizations.

Expiration. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600-85, 3 November 1986, I01 expiration date is extended to 1 September 1989.
2. Post this change per DA Pam 310-13.
3. File this interim change in front of the publication.

(DAPE-MPH-A)

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CARL E. VUONO  
General, United States Army  
Chief of Staff

Official:



MILTON H. HAMILTON  
Administrative Assistant to the  
Secretary of the Army

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Headquarters  
Department of the Army  
Washington, DC  
1 September 1987

# Immediate Action INTERIM CHANGE

AR 600-85  
Interim Change  
No. 101  
Expires 1 September 1988

## Personnel--General

### Alcohol and Drug Abuse Prevention and Control Program

---

Justification. This interim change includes policy changes for Army Reserve and Army National Guard personnel concerning alcohol and drug prevention and control. It also contains authority for the Army Reserve and Army National Guard to test their personnel for the abuse of legal or use of illegal drugs. These changes have been made so that Army Reserve and Army National Guard commanders can control abuse of legal drugs and illegal drug use within their organizations.

Expiration. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600-85, 3 November 1986, is changed as follows:

Page 1. In the Summary paragraph, change "Interim Changes 2 through 11" in the last sentence to "Interim Changes 102 through 111."

Page 1. The applicability paragraph is superseded as follows:

#### Applicability.

a. This regulation applies to all Regular Army personnel on active duty. This regulation with the exception of chapter 9, also applies to members of the Army National Guard of the United States (ARNGUS) and the U.S. Army Reserve (USAR) who are serving on--

(1) Active duty (AD), other than for training, for 30 days or more, including AD in an AGR status under Title 10, United States Code.

(2) Initial active duty training (IADT).

(3) Special tours of active duty training (special ADT) for 30 days or more.

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(4) 45 days' involuntary active duty training (45 days' ADT).

b. The provisions of chapter 9 apply to members of the ARNG and USAR when performing military duty other than that specified in a above, to include performing Inactive Duty Training (IDT) in either a State or Federal status.

Pages 37-38. Chapter 9 is superseded as follows:

### Chapter 9 Army National Guard and Army Reserve

#### 9-1. Purpose

This chapter implements the provisions of the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) in the Reserve Components (RC).

#### 9-2. Applicability

The chapter applies to all RC soldiers while performing military duty except extended AD, IADT, SADT for 30 days or more, or 45 days' involuntary ADT. (See the APPLICABILITY provisions of this regulation).

#### 9-3. Background

This chapter implements the ADAPCP in the RC during periods of military duty in which other provisions of this regulation do not apply. The outcome for the RC under this chapter is expected to be the same as for the Active Component: providing soldiers the opportunity to free themselves from the harmful effects of alcohol and other drug abuse. The ADAPCP is a comprehensive program designed to improve Army readiness through the prevention of alcohol and drug abuse and, as appropriate, facilitate the return to effective duty of rehabilitated soldiers who have the potential for future service. The RC ADAPCP will be operated with input from the National Guard Bureau (NGB), the Office of the Chief, Army Reserve (OCAR), and MACOM headquarters as a command program. Commands will have the widest possible latitude to use this program to improve and maintain unit readiness. This chapter will address matters specific to the RC ADAPCP rather than reiterate the guidance elsewhere in this regulation. The intent is for the RC ADAPCP to parallel as closely as possible the Active Component (AC) ADAPCP while taking into consideration differences in mission, and in regulatory and operational requirements and capabilities, between the RC and AC.

#### 9-4. Introduction

The provisions of chapter 1 apply to the Reserve Components under this chapter except as specified below:

a. Use will be made of the AC ADAPCP through local coordination, as resources permit.

b. In addition to available AC ADAPCP resources, the RC will refer soldiers to community-based rehabilitative and counseling services at no cost to the Government. Although a soldier may always self-refer to a drug or alcohol treatment center, the RC will not itself provide rehabilitation for alcohol or other drug abuse. AC ADAPCP when available through local coordination can be used. This does not relieve commanders of their responsibility to the soldiers under their command in the areas of ADAPCP prevention, education, abuser identification, referral to community counseling and rehabilitation centers, and subsequent return to duty if warranted.

c. The Alcohol and Drug Control Officer (ADCO) function will be added at the State Area Command (STARC) and Major U.S. Army Reserve Command (MUSARC) level in the RC in order to coordinate the RC ADAPCP. The STARC/MUSARC ADCO will perform coordinating functions as specified for installation level ADCOs in paragraph 1-23.

d. RC TOE and TDA units will carry out the applicable ADAPCP functions specified in chapter 1.

e. RC commanders may not be able to take disciplinary actions under the Uniform Code of Military Justice (UCMJ) referred to in paragraphs 1-9 and 1-10 due to jurisdictional limitations. If administrative sanctions are considered insufficient, RC commanders should consult with their supporting judge advocate.

#### 9-5. Prevention and control

The provisions of chapter 2 apply to the Reserve Components under this chapter. The Alcohol and Drug Intervention Council (ADIC) (see para 2-7) will be instituted at the STARC and MUSARC level when appropriate.

#### 9-6. Identification, referral, and screening

The provisions of chapter 3 apply to the Reserve Components under this chapter except as specified below:

- a. Community-based referral, counseling, and rehabilitation services (State certified) will be used in lieu of ADAPCP screening in the RC unless AC resources are available.
- b. Personnel separation procedures are contained in appropriate NG and USAR regulations.
- c. Commanders will use DA Form 4856 (General Counseling) to refer soldiers to community-based counseling and rehabilitative services. Upon receipt of the counseling form, it is the responsibility of the soldier to seek counseling and/or rehabilitation. Failure to seek Army-approved counseling and treatment or to complete rehabilitation may result in consideration for separation under, for example, AR 135-175 or AR 135-178. Examples of statements to be entered on General Counseling Forms are at paragraph 9-13.
- d. The commander or his or her designee will work with the treatment program of the soldier's choice, except that neither methadone maintenance nor mandatory disulfiram (Antabuse) treatment will satisfy the requirements of this chapter.
- e. Enrollment in the community-based (civilian) equivalent of Track I (awareness education), Track II (outpatient counseling), or Track III (inpatient rehabilitation) is the responsibility of the individual soldier in consultation with the command ADCO.

#### 9-7. Rehabilitation

The provisions of chapter 4 apply to the Reserve Components under this chapter except as specified below:

- a. The goal of the RC ADAPCP rehabilitation and treatment program is the earliest possible return of a rehabilitated soldier to full effective duty.
- b. The RC commander must be innovative and empathetic when working with the individual soldier and the rehabilitative process. This is especially true because RC soldiers will normally be treated by no/low cost, nonmilitary programs such as Alcoholics Anonymous (AA) or the Veterans Administration (VA). The commander has a need to know how treatment of a soldier is progressing; therefore, as long as not prohibited by State or local law, the soldier will sign a release statement to allow the commander to obtain such information in order to effectively assist community-based rehabilitation personnel in the treatment of the soldier (see para 9-13). Failure of the soldier to sign such a release may result in discharge under appropriate USAR or NG regulations.

c. When an RC soldier under this chapter is detoxified at Army expense, an appropriate line of duty determination will be made.

d. Appropriate RC personnel regulations apply for separation actions.

e. Section V, ADAPCP clinical certification and internship, does not apply to the RC ADAPCP under this chapter

#### 9-8. ADAPCP civilian counseling services

The provisions of chapter 5, as implemented by MACOM headquarters, OCAR, and NGB, apply to the Reserve Components under this chapter.

#### 9-9. Legal aspects of the ADAPCP

The provisions of chapter 6 apply to the Reserve Components under this chapter unless explicitly prohibited by regulation or State law. In addition, exceptions may be authorized by MACOM headquarters or the NGB after coordination with HQDA (DAPE-HRD-A).

#### 9-10. Management information system

a. During periods covered by this chapter, Reserve Components are exempt from the reporting requirements in this regulation. However, each STARC and MUSARC will submit a DA Form 3711-R (Alcohol and Drug Abuse Prevention and Control Program Transmittal Summary (RCS, CSGPA-1291)) through command channels, to USADAOA. Appropriate MACOM headquarters will consolidate these reports.

b. STARC and MUSARC ADCOs need not maintain individual case files on personnel referred to community-based programs except as needed for statistical information.

#### 9-11. Evaluation

The provisions of chapter 8 do not apply to the Reserve Components under this chapter. Technical support and program evaluation to the RC will be furnished through coordinating installation ADAPCPs.

#### 9-12. Biochemical testing

The provisions of chapter 10 apply to the Reserve Components under this chapter except as specified as follows:

a. STARC and MUSARC commanders will be responsible for the functions listed in paragraphs 1-4c and d.

b. Unit commanders will be responsible for the functions listed in paragraph 10-4e.

c. Due to the geographical separation of RC units and personnel from the ADCO, urine specimens will be shipped directly from the unit to the appropriate forensic toxicology drug testing laboratory. Specimens will be collected and shipped using proper chain of custody procedures as outlined in appendix E.

d. STARC and MUSARC ADCOs will be responsible for managing urinalysis quotas within their commands. RC urinalysis quotas will be allocated by the appropriate MACOM. First priority for quotas will go toward satisfying the annual requirement for testing aviation, PRP, and MP personnel.

#### 9-13. Sample remarks for DA Form 4856 (General Counseling)

Sample remarks for each section of the DA Form 4856 are listed below:

a. Section 8. Date and Circumstances: Simply describe the Who, What, When, Where, and How of the specific incident(s). The commander may include comments on the soldier's duty performance (both generally and specifically) and comments regarding the soldier's attitude toward the Army, the unit, the job, supervisors, peers, and subordinates.

b. Section 9. Date and Summary of Counseling:  
"On date, I advised Soldier's name of his/her rights under Article 31, UCMJ (or the applicable State code) and the limited use policy IAW AR 600-85. Based on (urinalysis, blood alcohol level, direct observation, alcohol breath measuring device, job performance, etc.), I suspect him/her of being an (alcohol) (drug) abuser. Substance abuse is incompatible with the maintenance of high standards of performance, military discipline, and readiness, and poses a substantial threat to the health and welfare of this unit. This counseling is imposed as an administrative measure and is not to be construed as punishment. You are to seek evaluation, treatment, and rehabilitation at a State certified substance abuse treatment center of your choice and at your own expense. Your treatment under this chapter will not include either methadone maintenance or mandatory disulfiram (Antabuse) treatment; therapeutic use of disulfiram (Antabuse) will be permitted on a voluntary basis. I will work closely with the counselor of your choice (employed at no expense to the Army) to assist you in your attempts to return to full, productive duty as soon as possible; however, continued abuse may result in your discharge from the (ARNG) (USAR). Sign

the release below and have your counselor fill out block 17 of DA Form 4856 and return it to the unit first sergeant within 30 days. Your failure to sign the release, seek counseling, and complete Army-approved treatment may result in discharge IAW (AR 135-175, for USAR officers) (AR 135-178, for USAR enlisted soldiers) (appropriate NG regulations). Substance abuse is serious. It makes you unfit for duty in this command. The impact on your personal and family life is equally serious."

c. Section 17. Interview Results and Recommendation: Statement Authorizing Release of Information (the soldier should sign the following statement). "Pursuant to chapter 3, AR 340-21 (Army Privacy Program), I hereby consent to release of information by the Army concerning my alcohol/drug abuse to the State-certified, Army-approved substance abuse counseling and treatment center of my choice. I further consent, under applicable State and Federal law, to the release of information concerning my treatment and rehabilitation by the substance counseling and treatment center to my commander."

2. Post this change per DA Pam 310-13.

3. File this interim change in front of the publication.

(DAPE-HRD-A)

By Order of the Secretary of the Army:

CARL E. VUONO  
General, United States Army  
Chief of Staff

Official:

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

Distribution:

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Effective 3 December 1986

Personnel—General

Alcohol and Drug Abuse Prevention and Control Program

This UPDATE printing publishes a revision which is effective 3 December 1986. Because the structure of the entire text has been reorganized, no attempt has been made to highlight changes from the earlier regulation dated 1 December 1981.

By Order of the Secretary of the Army:

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

Official:

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

**Summary.** This revision updates the Army's Alcohol and Drug Abuse Prevention and Control Program, defining Army policy on alcohol and other drug abuse, and assigning responsibilities for implementing the program. It also changes policies and procedures of the program as directed by DOD Directive 1010.1, DOD Instruction 1010.3, and DOD Instruction 1010.6. This revision institutes the Civilian Urinalysis Program, updates biochemical testing, and adds sections on clinical certification and quality assurance. Interim Changes 2 through 11 of AR 600-85 have been consolidated into this revision reflecting changes in the Limited Use Policy and changes in management information reporting.

**Applicability.** This regulation applies to all Active Army personnel. This regulation also applies to members of the Army National Guard (ARNG) and the U.S. Army Reserve (USAR) who are serving on—

- (1) Active duty (AD).
- (2) Initial active duty training (IADT)

(3) Special tours of active duty training (special ADT).

(4) 45 days involuntary active duty training (45 days' ADT).

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

**Impact on New Manning System.** This regulation does not contain information that affects the New Manning System.

**Internal control systems.** This regulation is not subject to the requirements of AR 11-2. It does not contain internal control provisions.

**Supplementation.** Supplementation of this regulation and establishment of forms other than DA forms are prohibited without prior approval of the Deputy Chief of Staff for Personnel HQDA (DAPE-HRL-A), WASH DC 20310-0300.

**Interim changes.** Interim changes are not official unless they are authenticated by The

Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

**Suggested improvements.** 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) directly to HQDA (DAPE-HRL-A), WASH DC 20310-0300.

**Distribution.** Distribution of this issue has been made in accordance with DA Form 12-9A-R requirements for 600-series publications. The number of copies distributed to a given subscriber is the number of copies requested in block 382 of the subscriber's DA Form 12-9A-R. DA Pam 600-85 distribution is A for Active Army, ARNG, and USAR.

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\*This regulation supersedes AR 600-85, 1 December 1981

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## **Glossary**

**RESERVED**

## Chapter 1 General

### Section I Introduction

#### 1-1. Purpose

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

#### 1-2. References

Required and related references and prescribed and referenced forms are listed in appendix A.

#### 1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

#### 1-4. Responsibilities

a. The Deputy Chief of Staff for Personnel (DCSPER) is the proponent for the Army Alcohol and Drug Abuse Prevention and Control Program and has General Staff responsibility for plans, policy, programs, budget formulation, and behavioral research pertaining to alcohol and other drug abuse in the Army.

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

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

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

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

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

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

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

e. The Director, U.S. Army Drug and Alcohol Operations Activity (USADAOA) is assigned to ODCSPER and reports through the Alcohol and Drug Policy Office. (See AR 10-78.) The Director provides

technical assistance and training development in support of the ADAPCP.

f. Major Army command (MACOM) commanders will—

(1) Provide program management and operational supervision of the ADAPCP. MACOMs will also monitor major elements of prevention, education, identification, rehabilitation, and evaluation within their command.

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

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

(4) Designate a full-time alcohol and drug control officer (ADCO), civilian program administrator (CPA), educational coordinator (EDCO), and adequate staffing at MACOM level to manage effectively and provide assistance to the ADAPCP within the command.

(a) Ensure there are full-time ADCOs, civilian program coordinators (CPCs), EDCOs and adequate additional staffing authorized and assigned at installation level to provide an effective program.

(b) Ensure that all appointed personnel are of sufficient grade or rank and appropriate military occupational specialty (MOS) for the ADAPCP and to comply with this regulation.

g. Special responsibilities of specific MACOM commanders:

(1) Commander, U.S. Army Criminal Investigation Command (USACIDC) will—

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

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

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

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

(2) Commanding General, U.S. Army Health Services Command (HSC) and Commanders, 7th Medical Command, 18th Medical Command, and U.S. MEDDAC (Japan) will—

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

(b) Develop and provide relevant insertive technical training for counselors and clinical directors assigned to HSC or medical command (MEDCOM) supported Community Counseling Centers (CCCs).

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Ensure that the installation safety officer maintains coordination with the ADCO and provides data on the incidence of

alcohol and drug involvement in accidents or other safety mishaps.

i. U.S. Army Medical Center (MEDCEN)/medical department activity (MEDDAC) Commander will—

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

(2) Appoint, in writing, a physician as the clinical program consultant. This medical officer will be responsible for providing, coordinating, and supervising consultative and other medical support for the ADAPCP.

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

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

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

(6) Ensure client records are maintained and disposed of in accord with applicable regulations.

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

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

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

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

### 1-5. Eligibility and Jurisdiction

a. The provisions of chapter 9 apply to members of the ARNG and USAR when not on Active Duty (AD) or any type of active duty for training (ADT).

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

(1) U.S. citizen civilian employees of the Army. This includes nonappropriated fund (NAF) employees.

(2) Retired military personnel.

(3) Other DOD personnel who may be deemed eligible on a case-by-case basis.

(4) Foreign nationals where Status of Forces Agreements or other treaty arrangements provide for medical services.

(5) Family members of eligible personnel.

c. Chapter 5 details the aspects of ADAPCP for civilian employees and family members. Policies and guidance described in other than chapter 5 are applicable to all civilian clients including retired personnel.

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

### 1-6. Program authority

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

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

(1) The program would be a command program.

(2) The program would be decentralized.

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

### 1-7. Concept

a. The ADAPCP is a manpower conservation program comprised of the following functional areas:

(1) Prevention.

(2) Education.

(3) Identification.

(4) Rehabilitation.

(5) Treatment.

(6) Program evaluation.

(7) Research.

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

### 1-8. Objectives

The objectives of the ADAPCP are the following:

a. Prevent alcohol and other drug abuse.

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

c. Restore both military and civilian employee alcohol and other drug abusers as early as possible.

d. Provide for program evaluation and research.

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

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

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

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

### 1-9. General policy

a. Alcohol and drug abuse are incompatible with military service. Soldiers identified as alcohol and drug abusers who, in the opinion of their commanders warrant retention, will be afforded the opportunity for rehabilitation. Those soldiers identified as alcohol abusers who do not warrant retention will be considered for separation from the military by their unit commander. Consideration and processing for separation of soldiers identified as drug abusers will be in accordance with paragraph 1-10 and applicable administrative regulations.

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

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

d. Rehabilitation or treatment of alcohol or drug abusers will not be the sole basis for

denial of continued service, permanent security clearances, job security, or career advancement.

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

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

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

h. An active and aggressive urinalysis program serves as a valuable tool and an effective deterrent against drug abuse. Installation, community, and activity commanders will ensure that a drug testing program is maintained in accord with DOD Directive 1010.1, particularly in high risk areas or situations, and in all oversea areas. Because of the sensitive nature of the duties performed by personnel with aviation, military police specialties, and personnel who are members of the Nuclear or Chemical Personnel Reliability Program, all personnel in these categories will be tested a minimum of once a year.

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

j. Commanders may be prohibited by the Limited Use Policy from taking some types of administrative and disciplinary actions against soldiers who are enrolled in the ADAPCP. However, a soldier cannot request enrollment in the ADAPCP to avoid a pending or threatened disciplinary or administrative action. For further guidance see Limited Use Policy in chapter 6 of this regulation.

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

l. Implementation of an ADAPCP capability is required for installations, communities and activities within the DA. Such capability is required to deliver standardized treatment and rehabilitation services and to conduct local program prevention

activities in education, training, law enforcement, and community action. Although in-house ADAPCP capability and broad objectives of the ADAPCP are being achieved, continued emphasis and support by the chain of command, to the lowest level, are necessary.

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

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

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

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

p. Enrollment of civilian employees and family members is voluntary. However, supervisors may utilize referral for screening services as an alternative to disciplinary action. Disciplinary or administrative action may be suspended in such cases for a period of 90 days. Employees will be offered assistance for alcohol or drug abuse related problems. They may refuse such assistance and accept the consequences for continued substandard performance. Civilian employees have the option of participating in either the installation rehabilitation program or of being referred to an approved program in the civilian community. Exceptions are oversea commands where they will always utilize the services of the local ADAPCP.

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

r. DA has established a drug abuse testing program for certain civilian employees in critical jobs. (See para 5-14b.)

#### 1-10. Alcohol

a. The use of alcohol is legal and socially acceptable, but it should not become the purpose or focus of any military social activity. Abuse or excessive use of alcohol will not be condoned or accepted as part of any military tradition, ceremony, or event. It is Army policy to encourage soldiers and civilian employees to examine their personal use of alcohol; if necessary, they should seek assistance without fear of damage to their careers. Commanders are responsible for informing personnel of inappropriate performance or social conduct associated with problem drinking. Peers are encouraged to provide positive support by calling attention

to problem drinking and influencing their peers to volunteer for assistance. Command leadership will promote responsible attitudes by those who drink and acceptance of those who do not drink. Commanders will ensure that subordinates are educated about alcoholism and its early signs and symptoms. It is the responsibility of each individual, military and civilian, to conform to Army standards of conduct and performance of duty. Publicity that glamorizes or encourages alcohol abuse is prohibited.

b. Military personnel on duty will not have a blood alcohol level of .05 percent or above. The percentage will be based on milligrams of alcohol per 100 milliliters of blood (.05 is equivalent to 50 milligrams of alcohol per 100 milliliters of blood). Any violation of this provision provides a basis for disciplinary action under the Uniform Code of Military Justice (UCMJ) and a basis for administrative action, to include the characterization of discharge. Disciplinary or administrative action must be consistent with the Limited Use Policy. Nothing in this regulation will be interpreted to mean that impairment does not exist if the blood alcohol level is less than .05 percent. To be in violation of this provision, a soldier must have known or should reasonably have known prior to becoming impaired that he or she had duties to perform.

#### 1-11. Other drugs

a. Any soldier involved with the illicit trafficking, distributing, or selling of drugs will be considered for disciplinary action under the UCMJ and/or for separation for misconduct.

b. Soldiers identified as illegal drug abusers may be considered for disciplinary actions under the UCMJ in addition to separation actions.

c. Officers, warrant officers, and noncommissioned officers (E5-E9) who are identified as drug abusers will be processed in accord with AR 635-100 and AR 635-200. These individuals have violated the special trust and confidence the Army has placed in them.

d. Any soldier who has been identified in two separate instances occurring since 1 July 1983 as users of illegal drugs will be processed for separation from the service.

e. Soldiers diagnosed as physically dependent (other than alcohol), will not generally possess the potential for future service and will be processed for separation. These soldiers will be detoxified, given medical treatment, and afforded the opportunity for rehabilitative treatment through the Veterans Administration, or a civilian program. (See para 4-14.)

f. Soldiers identified as nondependent drug abusers, who in the opinion of their commander warrant retention, should be enrolled in the ADAPCP, when enrollment is recommended as a result of the ADAPCP screening.

#### 1-12. Prevention

The Commander will—

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

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

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

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

### 1-13. Education

Commanders will ensure that information on alcohol and other drug abuse and prevention aspects of the ADAPCP are provided to all soldiers civilian employees, and their family members. Commanders will ensure that leaders at all levels are knowledgeable about ADAPCP policies, procedures, and prevention strategies. Alcohol and drug education doctrine is developed by the U.S. Army Training and Doctrine Command (TRADOC) with input from the major Army commands, in coordination with HQDA.

### 1-14. Personnel in sensitive positions

See AR 604-5 and AR 690-1.

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

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

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

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

e. The foregoing comments apply only to disclosure within the Armed Forces of ADAPCP records pertaining to members of the Armed Forces. Disclosure of ADAPCP information pertaining to civilian employees, however, is subject to the further restrictions of Public Laws 92-255 and 93-282 and title 42 CFR. Without a court order, disclosure even within the Armed Forces of such records requires the written consent of the individual and then is permissible only for purposes expressly authorized by the cited laws and regulations:

### 1-15. Aviation personnel

a. Alcohol and other drug abuse by aviation personnel is of special concern because of its impact on aviation safety. AR 40-501 establishes medical fitness standards for aviation personnel. These include rated aviators and flight surgeons, air traffic controllers, aviation maintenance personnel, and other personnel from career management fields 28, 67, and 93.

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

c. Aviation personnel identified as nondependent abusers who are otherwise considered fit do not necessarily have to be restricted from flying duties, except for any period of time spent in a residential treatment program. This would be provided their abuse of alcohol has not interfered with their performance of duty. In such cases, commanders, flight surgeons, and the ADAPCP clinical director must closely coordinate with each other and provide appropriate recommendations to commanders. After careful consideration of the advice of the clinical director and a medical recommendation from the flight surgeon, commanders will determine appropriate action regarding aviation service or flying status in accord with AR 40-501 and AR 600-107.

d. Aviation personnel who use illegal drugs, whether or not determined by aviation medical authorities to be medically fit, are subject to suspension from flying duties, in addition to appropriate disciplinary and administrative actions. Cases indicating the nonhabitual use of marijuana or the casual or experimental use of other dangerous drugs, may be recommended for waiver by competent medical authority. The waiver may be provided if there is no history of repeated drug use, if there is evidence of abstinence from current drug abuse, and if the individual is otherwise qualified. Nonprescription use of any narcotic or dangerous

drug within a 1-year period is disqualifying for flight status. Aviators may be suspended for nonmedical reasons per AR 600-107. The commander, ADAPCP clinical director, and flight surgeon should coordinate with one another as to the proper course of action on a case-by-case basis using guidelines in the regulations cited above. Individuals considered medically unfit who are rehabilitated must obtain a waiver as outlined in AR 40-501.

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

### 1-16. Personnel reliability program

See AR 50-5 and AR 50-6.

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

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

(a) Nondependent abuse.

(b) No diagnosis apparent.

(c) Personnel enrolled in the ADAPCP without a medical evaluation.

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

(a) Medically diagnosed dependence on alcohol or other drugs.

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

b. An individual or the commander of an individual who successfully completes rehabilitation as evidenced on a DA Form 4466 (Client Progress Report), may request requalification in accord with AR 50-5 or AR 50-6.

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

### 1-17. Reenlistment during enrollment in the ADAPCP

a. Individuals currently enrolled in the ADAPCP are not allowed to reenlist in the Army; however, soldiers who need additional service to complete their enrollment in the ADAPCP may be extended for the

number of months necessary to permit completion. (See AR 601-280.)

b. A waiver for reenlistment is no longer required if the individual successfully completes the rehabilitation program as indicated on DA Form 4466.

## Section II Organizational Functions

### 1-18. General

An Alcohol and Drug Program Office will be established at MACOM and installation levels for the purpose of operating the Army's ADAPCP. The Alcohol and Drug Program Office will be organized to attain the objectives of the ADAPCP and to respond to the needs of commanders and supervisors. Effective and efficient use of manpower and dollar resources are essential.

### 1-19. Manpower and staffing policies

The guidance for determining manpower requirements of ADAPCP activities in TDA organizations is in DA Pam 570-551, DA Pam 570-533, DA Pam 570-557, and DA Pam 570-566. The staffing guides are generally applicable to activities in the continental United States (CONUS); however, they may be applied to oversea organizations when similar conditions exist. AR 570-4 prescribes policy and DA Pam 570-4 lists procedures for determining manpower requirements.

### 1-20. Functions by type of organization

a. The functions of MACOMS in the ADAPCP (fig 1-1) are as follows:

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

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

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

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

b. The functions of the installation and communities in the ADAPCP (fig 1-2) are as follows:

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

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

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

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

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

(6) Provide commanders and supervisors with ADAPCP consultation to assist in the implementation, prevention, and educational functions of the Army's program.

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

c. The functions of TOE and TDA units in the ADAPCP are as follows:

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

(2) Battalion and separate company commanders are responsible for implementing ADAPCP related prevention and education initiatives. Battalion commanders are responsible for monitoring the implementation of ADAPCP initiatives by their subordinate companies, batteries, and troops. They are also responsible for assigning the function of ADCO to an officer as a collateral duty during mobilization and combat. During peacetime, this function is provided at the installation or community level.

(3) Company level unit commanders will implement ADAPCP initiatives. These initiatives include appointment of a unit alcohol and drug coordinator (UADC), and identification of personnel needing referral to the ADAPCP. They also include urinalysis testing and monitoring of personnel who are ADAPCP clients.

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

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

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

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

## Section III ADAPCP Staff Organization and Management

### 1-21. General

a. This section prescribes policies, procedures, and responsibilities for military and civilian personnel serving on ADAPCP staffs.

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

### 1-22. MACOM level

a. Each MACOM will implement and operate an ADAPCP in accordance with the provisions of this regulation.

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

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

### 1-23. Installation level

a. Army installations and activities will implement and operate an ADAPCP in accordance with the provisions of this regulation. Consultation and technical supervision of ADAPCP professional and paraprofessional counselors will be provided by the MEDCEN/MEDDAC commander.

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

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

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

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

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

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

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

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

(f) Provide periodic program evaluation to the commander.

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

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

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

(2) The CPC will—

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

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

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

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

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

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

(3) The EDCO will—

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

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

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

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

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

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

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

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

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

(c) Ensure that the highest ethical standards are maintained by the ADAPCP clinical staff in terms of the client, the quality of client case notes, and personal conduct of ADAPCP staff members.

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

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

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

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

(5) ADAPCP rehabilitation counselors will—

(a) Conduct the initial ADAPCP screening of individuals and provide results to commanders and physicians. They will request medical evaluations if indicated, required, or requested.

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

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

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

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

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

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

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

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

(j) Participate in inservice training programs.

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

### 1-24. Tenant units

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

b. Battalions and separate companies will appoint a noncommissioned officer (NCO)

as the unit alcohol and drug coordinator (UADC). This individual must be thoroughly familiar with the ADAPCP and other services available in the community to assist alcohol and other drug abusers. The UADC will assist commanders and subordinate units in all aspects of the ADAPCP by performing the following functions:

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

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

(3) Coordinate the urinalysis testing program.

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

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

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

### 1-25. Selection of ADAPCP personnel.

Consistent with military necessity, commanders will select ADAPCP personnel in accordance with the following guidance:

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

b. ADAPCP enlisted counseling personnel should be E5 or above and MOS qualified.

c. Recovering alcoholics and drug abusers selected as counselors, clinical directors or any staff member who has regular contact with ADAPCP enrollees will have been alcohol or drug free for a minimum of 2 years (due to the sensitive nature of the ADAPCP and in order to maintain credibility with commanders and clients). Additionally, any ADAPCP staff who is identified as

an alcohol or drug abuser, to include recovering clinical personnel (MOS immaterial) who experience a relapse, will not be allowed to resume their duties in the program until they are alcohol or drug free for a minimum of 2 years. During this time, the individual will be given appropriate consideration for reassignment to a position for which they can qualify. These individuals, once they are drug free for 2 years, should be given every consideration for filling ADAPCP positions as they become open after they can prove that no further abuse/use has occurred.

d. Civilian personnel will meet the qualification requirements established in the OPM X-118 Qualification Standards. Exceptions are those positions designated excepted service. Qualification standards for excepted service positions will be developed in accordance with the Federal Personnel Manual (FPM) and Civilian Personnel Regulation 302.2. All recruitment actions will be reviewed by the ADCO. Clinical directors also will have program management experience and specialized training in alcohol and other drug abuse rehabilitation and treatment and must meet local requirements for credentialing. If otherwise qualified according to the GS-180 or GS-185 series, or standardized job description, other GS-series may be qualified for clinical director positions. All civilians employed in the ADAPCP will sign the DA form 5019-R (Condition of Employment for Certain Civilian Positions Identified as Critical under the Drug Abuse Testing Program) which authorizes them to be directed to submit to urinalysis. DA Form 5019-R is located at the back of this regulation. This form will be locally reproduced on 8½- by 11-inch paper. Due to the sensitive nature of the ADAPCP and special skills involved for providing rehabilitation services in the military environment, civilian personnel considered as fully qualified will be interviewed and approved by ADCO, clinical director, and clinical consultant prior to final selection. The ADCO makes the final decision to hire all ADAPCP civilian personnel.

e. Award of additional skill identifier.

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

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

### 1-26. Training for the ADAPCP staff

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

a. Enlisted military personnel will receive the necessary training to sustain skill proficiency for their skill qualification tests (SQTs).

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

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

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

## Chapter 2 Prevention and Control

### Section I Introduction

#### 2-1. General

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

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

#### 2-2. Responsibilities for prevention.

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

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

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

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

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

## Section II Alcohol and Other Drug Abuse Control Actions

### 2-3. Objectives

a. Reduce the abuse of alcohol and the availability and abuse of other drugs within the military community.

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

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

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

e. Encourage cooperation between military and adjacent civilian communities for the prevention and control of alcohol and other drug abuse.

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

### 2-4. Commander actions

a. Commanders will publicize the fact that the abuse of alcohol or other drugs will not be condoned within the unit.

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

### 2-5. Deglamorization of alcohol

a. Military and civilian personnel will not promote any official function or unofficial function which glamorizes the abuse of alcohol through drinking contests, games, or initiations or the awarding of alcoholic beverages as prizes for contests. Soldiers violating this prohibition may be subject to disciplinary action under the provisions of Article 92, UCMJ, or administrative action, as appropriate. Civilian personnel may be subject to administrative sanctions under applicable regulations.

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

c. See AR 230-1 for club policies on the deglamorization of alcohol.

### 2-6. Alternatives to substance abuse

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

### 2-7. Community involvement

a. Councils.

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

member of the council. As with a separate ADIC, minutes concerning alcohol and other drug issues discussed will be recorded and approved by the commander.

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

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

(b) Provost Marshal.

(c) Staff chaplain.

(d) MEDCEN/MEDDAC commander.

(e) Staff Judge Advocate.

(f) Public affairs officer.

(g) Major unit commanders.

(h) Moral support officer.

(i) Post education officer.

(j) ADCO.

(k) Army Community Services (ACS) officer.

(l) Dependent schools officer.

(m) CPO.

(n) CPC.

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

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

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

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

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

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

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

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

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

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

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

(9) Public affairs officers who serve the military community.

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

(11) Other human service personnel, groups, and private organizations who have access to various groups of people within the military community such as wives clubs, rod and gun clubs, parent-teacher associations.

### 2-8. Youth and family involvement

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

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

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

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

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

## Section III Prevention Education

### 2-9. General

This section prescribes policy for alcohol and other drug abuse prevention education programs.

### 2-10. The objectives of prevention education.

These objectives are as follows:

a. Inform all members of the Army about policy and operations of ADAPCP

and the extent of alcohol and drug abuse problems.

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

c. Provide commanders and supervisors with the information and skills they need to conduct effective alcohol and other drug abuse prevention, control, and rehabilitation activities within their units.

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

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

## 2-11. Policy

a. Commanders at all levels will provide education and training on ADAPCP policy and on effective measures to alleviate problems associated with alcohol and drug abuse. This will be provided in accord with paragraph 2-12f of this regulation and in compliance with DOD Instruction 1010.5.

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

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

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

(2) Education for cadet, officer, and warrant officer candidates will, in addition to (1) above, emphasize the duties and responsibilities of junior leaders in the alcohol and drug abuse prevention effort. This will include their responsibilities in creating and maintaining military discipline and enforcement of the law. The causes, symptoms, and

prevalence of abuse, intervention, and referral techniques, and post-treatment responsibilities of junior leaders will also be addressed. Education will be completed before commissioning or within 90 days after entry on active duty.

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

(a) The ADAPCP and Army Policy to include the ADAPCP as a service organization supporting leaders in fulfilling their leadership roles and an overview of benefits derived from the ADAPCP.

(b) Roles and responsibilities of leaders to include responsibilities for prevention, deterrence and detection; early identification, intervention, and referral techniques.

(c) The impact of alcohol and drug abuse to include law enforcement and performance aspects.

(d) Strategies for preventing alcohol and drug abuse, to include a discussion of ways to eliminate the stigmatizing effects of alcohol and drug abuse on clients.

## 2-12. Responsibilities for education and training

a. *Deputy Chief of Staff for Personnel (DCSPER)*. 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)* 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, U.S. Army Health Services Command (CG, HSC)*. In addition to responsibilities contained in paragraph 2-11 and in e, f, and g below, the Commanding General, HSC will—

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

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

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

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

(2) Conduct ongoing U.S. Army Alcohol and Drug Abuse Team Training and U.S. Army Drug and Alcohol Rehabilitation Training (USADART) in support of the ADAPCP.

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

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

(5) Provide continuing education and training for assigned health care professional and paraprofessional personnel in those areas of alcohol and drug abuse relevant to their duties. Areas of particular focus will be identification, intervention, treatment, and referral.

e. *Major Army commanders*. Major Army 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 ensure that alcohol and other drug training and educational programs are managed effectively. Ensure that programs comply with HQDA goals, objectives, and guidelines. (See app C.)

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

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

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

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

(4) Conduct the following education and training:

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

1. *Soldiers (private through specialist 4)*. Education will be conducted within 60 days after each PCS and will emphasize the legal consequences of abuse, under both the UCMJ and the local laws. Emphasis will be on the availability of an ADAPCP at the installation to include location, referral procedures, and types of treatment available. Emphasis will also be on alternatives to abuse available at the local installation and neighboring communities.

2. *Leaders (NCOs and warrant officers)*. Education will be conducted within 60 days after PCS and will emphasize the command-unique elements of the alcohol and drug abuse problem and local military and civilian resources. Emphasis will also be on the availability of an ADAPCP to include location, leaders' responsibilities in the identification and referral process, their opportunities for continuing education and training, and their responsibilities for the maintenance of military discipline and the enforcement of the UCMJ.

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

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

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

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

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

1. *Family members OCONUS*. Education will be provided on a voluntary basis and will emphasize the local alcohol and drug abuse situation, local alcohol and drug

abuse laws, counseling, treatment, rehabilitation opportunities and procedures, and alternatives to substance abuse available at the local installation and neighboring community.

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

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

### 2-13. Alcohol and other drug awareness education

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

b. *On those installations where alcohol or other drug safety action (traffic) programs are not available, the alcohol or other drug awareness education should be designed to include traffic safety subjects. Coordination with the Provost Marshal Office (PMO), Safety Office, and local law enforcement agencies and courts must be made to ascertain teaching requirements and to obtain expert technical assistance and avoid duplication of effort.*

## Section IV Law Enforcement and Drug Suppression

### 2-14. Objectives

Law enforcement objectives are as follows:

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

### 2-15. Procedures

a. Commanders at MACOM and installation level will—

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

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

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

(a) TB MED 291.

(b) AR 40-2.

(c) AR 40-61.

(d) AR 190-50.

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

b. Installation commanders will—

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

(2) Ensure that all offenses involving illegal possession, use, sale, or trafficking in drugs or drug paraphernalia are reported to the military police for investigation or referral to U.S. Army Criminal Investigative Command (USACIDC).

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

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

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

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

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

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

disturbances, child or spouse abuse.) All alcohol and driving related incidents will be a mandatory referral for evaluation and education per AR 190-5.

### 2-16. Law enforcement relationship to the ADAPCP

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

b. 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, for rehabilitation purposes, of military police, CID, or other investigative personnel who have an actual alcohol or other drug abuse problem. Their law enforcement status must be made known to the ADCO at the time of their enrollment. These measures are for the protection of the law enforcement client as well as the ADAPCP.

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

## Chapter 3 Identification, Referral, Screening, and Evaluation

### Section I Methods of Identification

#### 3-1. General

a. Identification is accomplished through a variety of methods. They are as follows:

- (1) Voluntary (self) identification.
- (2) Command identification.
- (3) Biochemical identification.
- (4) Medical identification.
- (5) Investigation/apprehension.

b. Commanders will identify soldiers as drug abusers based upon evidence provided by these methods.

#### 3-2. 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 soldiers and Army civilians to volunteer for assistance and will avoid actions that would discourage these individuals from seeking help. Normally, soldiers 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 soldier initially seeks help from an activity or individual other than his or her unit commander, the individual contacted will immediately notify the soldier's unit commander and installation ADCO.

b. The requirement that the individual contacted must notify the soldier's unit commander and installation ADCO is not in conflict with a chaplain's right of privileged communication. The situation in which the soldier is seeking assistance is addressed in a above, but the situation in which the soldier merely reveals to a chaplain that he or she is abusing or has abused alcohol or other drugs is not addressed. In the latter instance, it is expected that the chaplain would inform the soldier that—

(1) Professional alcohol and drug treatment and rehabilitation counseling is available through the ADAPCP.

(2) The Army requires that the soldier's unit commander become involved in the rehabilitation process.

(3) The chaplain cannot assist the soldier's entry into the ADAPCP without going through the member's unit commander.

c. Identifications resulting from a soldier seeking emergency treatment for an actual or possible alcohol or other drug overdose are considered to be a variation of volunteering. For reporting purposes, such cases will be classified as volunteer (self) identifications.

d. A limited use policy which restricts the consequences of the soldier's involvement in the ADAPCP is described in chapter 6, section II of this regulation. These provisions are unchanged by the mandatory separation processing of drug abusers, and such separation processing must comply with the provisions of limited use and AR 635-100 and AR 635-200.

e. A soldier or family member may seek assistance from other agencies for problems in which the abuse of alcohol or other drugs is a factor. Every effort will be made to ensure that these agencies, military or civil human services, such as ACS and chaplains, are aware of the ADAPCP services and procedures for referral, if appropriate. Such cases will be classified as volunteer (self) identification.

f. For Army civilian volunteers, see chapter 5.

### 3-3. Command Identification

This is identification which occurs when a commander observes, suspects, or otherwise becomes aware of an individual whose job performance, social conduct, interpersonal relations, physical fitness, or health appears to be adversely affected because of abuse of alcohol or other drugs (apparent or suspected). When abusers or suspected abusers are identified, they will be interviewed by their unit commander or designated representative. If appropriate, they will be referred to the ADAPCP for an initial screening interview.

### 3-4. Biochemical Identification

Biochemical identification can be accomplished by either urinalysis or alcohol breath testing methods. Commanders should be alert to positive urine tests for drugs that are seldom or never used for military outpatients, for example, cocaine, amphetamines, THC, or PCP. Biochemical testing is discussed in detail in chapter 10.

### 3-5. Medical Identification

Apparent alcohol or other drug abuse may be noted by a physician during routine or emergency medical treatment. In such instances, the physician will refer the individual to the ADAPCP, utilizing the SF 513 (Medical Record-Consultation Sheet). The ADCO will immediately notify the client's unit commander of the physician's referral. In the case of an Army civilian or family member, the CPC will contact the patient in an attempt to schedule an interview.

### 3-6. Investigation/apprehension

A soldier's alcohol or other drug abuse may be identified through military or civilian law enforcement investigation or apprehension. Upon notification of apprehension of a soldier for apparent alcohol or other drug abuse, the commander will refer the individual to the ADAPCP for an initial screening interview. Referral for screening or enrollment does not interfere with or preclude pending legal or administrative actions in any way.

## Section II Referral and Screening

### 3-7. Responsibilities of commanders for referral

a. When individuals are identified, voluntarily or involuntarily, as possible alcohol or other drug abusers, their unit commander or designated representative, will—

(1) Advise them of their rights under Article 31, UCMJ. Use of DA Form 3881 (Rights Warning Procedure/Waiver Certificate) is strongly recommended.

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

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

(4) Give them the opportunity to provide additional evidence, including information on drug sources, if they desire. (However, such disclosure is strictly voluntary and will

not be made a requirement for or any part of treatment or rehabilitation).

(5) Collect any illegal drugs or drug paraphernalia that the soldier voluntarily relinquishes and turn them over to the local Provost Marshal according to AR 190-22.

b. The commander will refer all individuals who are suspected or identified as drug and/or alcohol abusers, including those identified through urinalysis and blood alcohol tests. All individuals with urine, positives will be referred to the ADAPCP for initial screening. Medical evaluation by a physician is required unless the urine positive is for THC alone. (para 3-5). Soldiers with blood alcohol levels of .05 percent or above while on duty will be referred to the ADAPCP for screening and evaluation. Soldiers who are referred by the commander for an initial screening interview, regardless of the means of identification, will be referred with DA Form 2496 (Disposition Form), (overprinted), Subject: ADAPCP Military Client Referral and Screening Record. (See fig. B-1.) The referral and screening record will be signed by the commander. The initial screening interview will be accomplished by the ADAPCP staff at the earliest opportunity (not to exceed 4 working days), with emergency referrals receiving priority.

c. A limited use policy that restricts the consequences of the soldier's involvement in the ADAPCP is described in chapter 6, section II, of this regulation. These provisions are unchanged by the mandatory separation processing of drug abusers. Such separation processing must comply with the provisions in chapter 6 and AR 635-100 and AR 635-200.

d. If, after the initial ADAPCP screening, a commander believes that a soldier would not respond favorably to rehabilitation or, based on the soldier's overall record, does not have the potential for future service, the soldier will be considered, and, if required by paragraph 1-10 or if otherwise appropriate, be processed for separation, (other than chap 9) in accord with AR 635-100, and/or AR 635-200.

### 3-8. Self-referrals

The ADAPCP staff will conduct an initial screening interview with all eligible personnel that self-refer to the ADAPCP for assistance. During the initial interview, the counselor will advise the soldier of the commander's role in the rehabilitation process and provide information about the ADAPCP. The commander will be a part of the rehabilitation program and will be directly involved in the decision of whether rehabilitation is required. The commander will also provide recommendations for the appropriate rehabilitation track and establish standards of behavior and goals for evaluation of the soldier's progress in rehabilitation and in the unit. Army civilians will sign a consent form if they wish their supervisor involved. The ADAPCP staff will contact the commander and coordinate the soldier's referral, if ADAPCP services

are required. After coordination with the soldier's commander, the referral is processed in the same manner as any other command referral; however, the type of referral will be annotated on the ADAPCP Military Client Referral and Screening Record as a self-referral.

### 3-9. Other referrals

In addition to medical referral (para 3-5) or referrals from law enforcement agencies (para 3-6), agencies of various types may be a source of identification and means of referral of soldiers suspected of alcohol or other drug abuse. These referrals will be enrolled following the initial screening interview only after notification and concurrence of the commander. Referrals from sources other than command; medical, investigation/apprehension, will be handled in the same manner as a self-referral.

## Section III Screening, Evaluation, and Recommendations

### 3-10. Screening

An initial screening interview will be conducted with all individuals who are either referred for screening or who voluntarily seek treatment in the program. This interview will be conducted by a member of the ADAPCP staff, skilled in alcohol or other drug abuse counseling techniques. The initial screening interview will take place within 4 duty days after referral. The ADAPCP counselor will inform the soldier of the applicability of the limited use policy to the disclosure of information concerning past drug use, or possession of drugs incidental to personal use. If referral for medical evaluation is required, DA Form 4465 (ADAPCP Client Intake Record (CIR)) (fig B-2) and the ADAPCP Military Client Referral and Screening Record will be provided to the evaluating physician for review prior to medical evaluation. Any other comments or recommendations made to the physician conducting the medical evaluation will be recorded on a SF 600 (Health Record—Chronological Record of Medical Care) and accompany the Client Intake Record and the ADAPCP Referral and Screening Record. Upon completion of medical evaluation, all forms will be returned to the ADAPCP for inclusion in the ADAPCP client case file.

### 3-11. Medical evaluation

a. Medical evaluation of illegal drug abusers is required following ADAPCP screening except for individuals with a positive test for cannabinoids (THC) or otherwise suspected as a cannabis abuser when there is no reason to believe, after ADAPCP screening, that the soldier is cannabis dependent. A medical evaluation also is required in cases of suspected alcohol dependency, and in all cases prior to entry into in-patient treatment.

b. The commander, supervisor, clinical director, counselor, or soldier may request a

medical evaluation by a physician at any time to determine the extent of alcohol or other drug abuse by a soldier.

c. Medical evaluations determine whether serious medical illness is indicated because of alcohol or other drug abuse. Medical evaluations will be conducted by physicians using table B-3 of this regulation as general guidance and TB MED 290

### 3-12. Rehabilitation team

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

a. Unit counseling by the commander or the commander's designated representative.

b. Other action (for example, referral to another agency).

c. No ADAPCP services required at the present time.

d. Enrollment in one of the following:

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

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

(3) **Track III, Rehabilitation**. Residential medical treatment with nonresidential followup. Enrollment in this track is limited to those clients who have been evaluated by a physician as requiring residential treatment. Generally, residential care will be reserved for those individuals with longstanding problems of abuse, but for whom prognosis for recovery is favorable with proper treatment. Enrollment in this track is for 360 days, with the time starting on the date of the commander's formal enrollment of the individual in Track III.

## Chapter 4 Rehabilitation

### Section I Introduction

#### 4-1. General

a. Rehabilitation of alcohol and other drug abusers is a command responsibility. All commanders must have a working

knowledge of the various program elements within the ADAPCP. They will ensure that all community resources are used in assisting individuals during rehabilitation. Commanders must also ensure that individuals are assisted in coping with the environment in which they are expected to function. The commander's attitude and direct involvement with the rehabilitation process will influence the entire effort; therefore, command support and the support of the first-line supervisor, whether civilian or military, must be positive and clearly visible.

b. Rehabilitation begins when an individual is identified as being involved with alcohol and other drug abuse, or illegal use. Initial efforts should begin with counseling by the commander or supervisor in the case of civilian employees, with counseling by the supervisor for job performance problems. In some instances, special expertise is needed to bring about the desired changes in an individual's performance or conduct. In these instances the commander or supervisor will refer the individual to the ADAPCP for screening and professional assistance.

#### 4-2. Objectives

The objectives of the rehabilitation program are—

a. *For military personnel.*

(1) Restore the individuals identified as alcohol or other drug abusers to effective duty.

(2) Identify individuals who cannot be rehabilitated within the scope of this regulation.

b. *For civilian employees.* Restore civilian employees with job performance problems related to alcohol or drug abuse to effective performance. (See chap. 5.)

c. *For military and civilian family members.* Resolve alcohol and drug abuse problems in the family with the ultimate goal of enabling the soldier or employee to perform more effectively.

#### 4-3. Coordination

The program for alcohol and other drug abuse rehabilitation is comprised of a variety of operating elements. It is essential that careful coordination and open communication between these elements be maintained to insure the smooth transition of the individual through the rehabilitation process. These elements are—

a. Prevention and education.

b. Identification and referral.

c. Screening, medical evaluation, and command consultation.

d. Rehabilitation treatment and followup.

#### 4-4. Concept

In the interest of determining the best rehabilitation program for the client, the responsible ADAPCP staff member will always employ the "rehabilitation team" concept. A record of the rehabilitation team's meetings, discussions, and decisions, will be maintained in the client's ADAPCP case

file. No other record of the proceedings will be maintained. In the case of civilian clients, this concept will only be used if the client has given consent to involve the supervisor by signing DA Form 5017-R (Civilian Employee-Consent Statement). DA Form 5017-R is located at the back of this regulation. DA Form 5017-R will be reproduced locally on 8½ by 11-inch paper.

## Section II Rehabilitation and Treatment

### 4-5. General

a. After the initial screening interview has been completed, the rehabilitation team will meet to make a determination of what rehabilitation approach will best meet the needs of the individual and achieve his or her earliest possible return to full effective duty. Frequency and length of counseling sessions will be determined by the rehabilitation team if enrollment is required. The rehabilitation team will ensure the compatibility of the therapeutic plan with the mission requirements of the individual's unit or organization.

b. Rehabilitation tracks. The Army's rehabilitation program is divided into three tracks. This provides more flexibility for the commander and more appropriate client case management. These tracks are based upon the degree of severity of involvement with substance abuse. (See figs 4-1 through 4-5.) Any one or all of the following tracks can be a part of an individual's rehabilitation plan.

(1) *Track I.* Provides alcohol and other drug awareness education and individual or group counseling or assessment as required. The education and discussion effort should be designed to focus the client's attention on the adverse effects and consequences of alcohol or other drug abuse. It should also emphasize the Army policy regarding alcohol and drug abuse. The benefits of the educational focus may be enhanced by brief individual or group assessments. Participation in this track will normally not exceed 30 days. The client will be transferred to one of the other tracks or referred to another agency or resource for other counseling services if more intensive rehabilitation is required. Track one does not require a medical evaluation; although the client, the commander, the clinical director, or ADAPCP counselor may request one at any time during the rehabilitative process. In any event, an ADAPCP screening is required prior to Track I enrollment. Clients enrolled in Track I are counted as regular ADAPCP cases. The overall management and design of Track I educational services as well as other installation or community prevention efforts are the responsibility of the EDCO and the CPC. However, clinical personnel (that is, the clinical director, psychologists, social workers, and other counselor personnel) will provide instruction in Track I which is technical or clinical in nature. Such personnel will also provide any clinical assessment

of clients that may be required. Case load or work unit credit will be provided for Track I clients to the same extent as they are provided for the rehabilitation efforts and credits of Track II and III clients.

(2) *Track II.* This track provides individual, group, or family counseling on a non-residential or outpatient basis. In addition to a more-intensified counseling effort, the education sessions of Track I are available, as necessary. Enrollment in this track will be for a minimum of 30 days and will not exceed 360 days. There is no set time in Track II other than the minimum 30 days. Track II does not require a medical evaluation; however, one may be requested at any time during the rehabilitation process. The client may be transferred to Track III or referred to another agency or resource for additional counseling or treatment services if required.

(3) *Track III.* Provides an intensive residential rehabilitation treatment program of 6 to 8 weeks duration with mandatory non-residential followup period for a total treatment program of 1 year. Initial treatment in Track III is provided under medical supervision in a residential treatment facility setting. This track is designed for individuals who cannot respond favorably to outpatient treatment or have a longstanding history of abuse that they have become dependent upon alcohol or other drugs. The decision to enter a client into Track III is made by a physician in consultation with the other rehabilitation team members. The residential phase of treatment is the direct responsibility of the MEDDAC/MEDCEN commander; however, Track III remains an integral part of the ADAPCP and operates in accord with the provisions of this regulation and applicable medical regulations. All client accountability and reporting is done by the servicing ADAPCP of the client. Servicing ADAPCP staff members are required to remain in contact with and monitor progress of clients that are referred from their ADAPCP to an RTF. When a client is referred directly to an RTF (without responsible ADAPCP's knowledge), it is the responsibility of the gaining RTF to ensure that the client's servicing ADAPCP has been notified and that all administrative information is provided for the client's enrollment in the ADAPCP. Normally, all referrals to the RTF will be made through the installation ADAPCP clinical director. A medical evaluation is required prior to placement in Track III and again before release from the residential phase of Track III.

### 4-6. Residential treatment

a. *Policy.* RTFs for alcohol and other drug abuse patients will be established as an integral part of both the health care delivery system and the ADAPCP. Nonmedical treatment facilities, "Half-way Houses" or other nonmedical treatment residential facilities programs outside MEDDAC operational supervision are not authorized and will not be provided ADAPCP resources.

RTFs will be operated by the respective medical commander, ordinarily as a separate and independent clinical service under the supervision of the MEDDAC/MEDCEN Chief of Professional Services, and in coordination with other aspects of the ADAPCP as provided by the provisions of this regulation. RTFs will not be located with psychiatric wards. All RTFs will provide for female as well as male patients.

#### b. Responsibilities.

(1) TSG will establish health care standards and guidance for residential treatment; TSG and Commanding General, HSC have approving authority for requests to establish RTFs.

(2) OCONUS MACOMs having MEDDAC/MEDCEN as subordinate command elements will recommend approval or disapproval for requests arising within their commands. When requests for RTFs are approved by TSG and HSC, in coordination with ODCSPER, MACOMs will revise the mission statement of the supervisory MEDDAC/MEDCEN to reflect the added requirement to operate the RTF.

(3) MEDDAC/MEDCEN commanders will determine requirements for an RTF. If a valid requirement exists, a request to establish a residential treatment program will be forwarded concurrently through command channels to HQDA (DASG-PS), WASH DC 20310, and Commanding General, HSC, Fort Sam Houston, TX 78234. The request will include a description of the proposed facility and staffing plan as well as identify the sources of the proposed RTF resources. When appropriate, comments from installation and major unit commanders whose personnel would be eligible to participate in the proposed program should be obtained and forwarded with the request. Commanders in the forwarding chain will recommend approval or disapproval.

c. *Staffing.* ODCSPER, HQDA and designated MACOMs will develop and publish staffing guides for an RTF.

d. *Eligibility for admissions and charges for care.* AR 40-3 describes eligibility and priorities for admissions to Army medical treatment facilities and states policy governing charges for care. Rates of charges for care in Army MTFs are contained in AR 40-330.

e. *Admission and discharge of patients.* The admission and discharge of patients to and from RTFs will be coordinated with the ADAPCP clinical director that services the client's unit or geographical area. As a part of admission to an RTF, the client will be enrolled in the servicing ADAPCP, be referred by his commander, the clinical director, and a physician. Additionally, an agreement should be sought with family members to accompany and participate in a part of the rehabilitation process; when appropriate. All administrative and legal matters should be resolved prior to admission; when possible. Upon admission, the RTF staff will maintain and report client data as required to the ADAPCP. The client will

return to duty with his referring (former) unit and to the servicing ADAPCP for followup services or administrative action, as required.

f. *Treatment.* Each RTF will follow the multidisciplinary treatment approach. Group therapy will be the primary treatment modality for patients and family members. Pharmacotherapy, Alcoholics Anonymous (AA), Alanon family groups, individual counseling, education, physical training, recreational therapy and other modalities may be employed if necessary. Generally, there will be a 2-week initial evaluation period during which patients will be screened and discharged if the evaluation indicates that the patient will not benefit from residential treatment. RTFs will be operated in a strictly military environment. The length of treatment will be 6 to 8 weeks. Treatment may be extended for some patients with advanced alcoholism or other drug dependency or conversely may be terminated earlier for patients who would not respond to further treatment. Followup services will be coordinated by the RTF with the patient's commander and servicing ADAPCP, subsequent to patient's return to duty.

#### 4-7. Transfer of clients to RTFs

a. The orderly administrative transfer of ADAPCP clients from nonresidential rehabilitation (Track I or Track II) to a residential treatment in Track III is essential. Coordination between the physician, local ADAPCP, and the RTF admitting physician and RTF staff is necessary to ensure that initial and followup treatment is effective. The local ADAPCP will—

(1) Provide any treatment summaries requested by the RTF that may be helpful to the residential treatment staff.

(2) Provide followup care for each client released from an RTF and ensure that all previous records on the client are in order.

b. The RTF will—

(1) Provide recommendations for followup care and an assessment of progress during residential treatment to the local ADAPCP by the most expeditious means possible.

(2) Provide all information necessary to the local ADAPCP for completion of Client Progress Reports (CPRs) that become due during residential treatment. Client Intake Records (CIRs) and CFRs will be maintained at and by the local ADAPCP on each Track III client in the client's ADAPCP case file.

#### 4-8. Rehabilitation progress

a. With the exception of the 6 to 8 weeks, plus followup of Track III clients, the length of time a service member is enrolled in the ADAPCP will be determined by the commander in consultation with the rehabilitation team. The commander, as a member of the rehabilitation team, is responsible for determining progress by evaluating the following:

(1) Duty performance and conduct (that is work efficiency, relationships with coworkers).

(2) Nonduty performance and conduct (that is unit and personal responsibilities).

(3) Abstinence from alcohol and/or other drug abuse.

(4) Personal motivation to overcome alcohol or other drug abuse problems and to be rehabilitated.

b. Discussion of this criteria will provide the commander with an overall impression of the client's progress in the ADAPCP. When the commander determines that duty performance and progress is unsatisfactory and cannot justify further rehabilitation efforts in a military environment, discharge from military service will be effected. ADAPCP services will continue to be provided until the client is separated.

#### 4-9. Type and frequency of counseling

The type and frequency of counseling used in rehabilitation will vary depending upon the individual case and will be determined by the rehabilitation team.

a. If relapse occurs during rehabilitation, the rehabilitation team will determine what course of action should be taken on a case-by-case basis and will adjust the frequency of appointments for counseling as required.

b. ADAPCP services will be available for all eligible former ADAPCP clients. Re-enrollment will occur on a case-by-case basis after the meeting of the rehabilitation team. Re-enrollment in the ADAPCP requires the submission of a new CIR and will be treated as a new case for administrative reporting.

#### 4-10. Appointments

Appointments for counseling will be scheduled for clients so as not to interfere with the client's job or duty requirements; in so far as possible. Counselors may schedule appointments during duty and non-duty hours, as required. In the event that counselors have clients engaged in field exercises or training, they will consult with the commander and arrange to provide counseling sessions at the duty site, when appropriate.

#### 4-11. Return to the unit

One of the most critical and difficult aspects of the rehabilitation process is the reinvolvement of the soldier in his or her role and responsibilities in the unit. Human attitudes toward the alcohol or other drug abuser undergoing rehabilitation will range from *compassionate understanding to open hostility*. If rehabilitation is to succeed, the service member must be afforded a realistic opportunity to demonstrate that he or she is motivated to remain alcohol or drug free and can once more function effectively.

a. The immediate unit commander and other key unit personnel must ensure that the soldier is—

(1) Assigned duties commensurate with his or her abilities, experience, and MOS.

(2) Required to comply with the same standards of performance and behavior that

are expected of other members of the unit of equal grade and length of service.

(3) Provide positive support and not subjected to embarrassment or ridicule (for example, derogatory reference to his prior alcohol or other drug abuse or his participation in the ADAPCP) by other members of his unit.

(4) Encouraged to participate fully in followup, as prescribed.

b. Frequent consultation between the immediate unit commander and the ADAPCP staff is critical during this phase of the rehabilitation process.

#### 4-12. Rehabilitation modalities

No single rehabilitation modality will prove effective for all individuals. Installation rehabilitation programs must offer a wide variety of rehabilitation modalities structured to meet both individual needs and the requirements for effective duty performance. Rehabilitation modalities used by the ADAPCP staff will be structured within the scope of the Army's rehabilitation objective of individualized, short term treatment with rapid restoration to full effective duty. The ADCO in coordination with the clinical director, will ensure that—

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

b. Paraprofessional counselors are experienced and trained in the alcohol and drug abuse rehabilitation field.

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

#### 4-13. Alcoholics Anonymous

AA is a bona fide treatment modality as well as an organization. It will be used extensively in Track III and as an adjunct to Tracks I and II. Installations will facilitate formation of AA, Alanon and Alateen chapters, and activities on-post and provide assistance to these groups to the greatest extent possible. AA, Alanon, and Alateen do not fall into the category of "outside organizations" and under no circumstances will chapters be required to provide the names of members. Commanders and ADAPCP staff members should become familiar with AA, Alanon and Alateen as referral sources.

#### 4-14. Referral to Veterans Administration medical facilities

a. Alcohol or drug dependent soldiers may be transferred to the VA only under the following conditions:

(1) When within 30 days of separation.

(2) On the soldier's written request for transfer and additional treatment.

b. The request will specify the length of treatment to which the soldier agrees. No active duty service member will be transferred to the VA through medical channels without completing separation processing. (See app D and AR 634-200.)

#### 4-15. Unacceptable rehabilitation modalities

Certain rehabilitation modalities are not adaptable to the Army's rehabilitation model and will not be used in Army alcohol/drug rehabilitation programs. Some of these are as follows:

a. *Methadone maintenance.* This modality will not be used in Army rehabilitation programs, except as described in paragraph 4-21. The policy is intended to assist the individual in overcoming drug dependency, not to substitute one drug for another. Military personnel will not be entered into civilian methadone maintenance programs. The ADCO and the clinical consultant should establish liaison with representatives of local civilian programs using methadone maintenance and inform them of the Army policy regarding the use of the drug in treatment.

b. *Mandatory disulfiram (Antabuse) programs.* While the use of Antabuse is medically recognized as being of chemotherapeutic value in the treatment of alcoholism, it will not be a mandatory requirement of any Army rehabilitation program. It will not be used to the exclusion of other accepted rehabilitation/treatment modalities. This policy is not to discourage the use of Antabuse when appropriate and prescribed by a physician. The intent of this policy is to ensure that rehabilitation program personnel consider Antabuse on an individual case basis rather than as a therapeutic requisite.

#### 4-16. Standards

a. The standard for providing clinical services in the ADAPCP is based on the Consolidated Manual for Adult Psychiatric, Alcoholism and Drug Abuse Facilities, published by the Joint Commission on Accreditation of Hospitals, as modified by HSC and the OCONUS MEDCOMs.

b. In accord with DOD Instruction 1010.6, a standardized quality assurance plan, in the best interests of the soldier and the Army, will be developed by the AMEDD and Command parts of the program.

### Section III Detoxification

#### 4-17. General

Detoxification involves withdrawing alcohol or other drugs from an individual, treating the physical symptoms resulting from that withdrawal, and initiating rehabilitation. Not every alcohol or other drug abuser need be hospitalized during detoxification. The decision as to whether hospitalization is required is a medical one and will be made only by a physician. Requirements to submit to medical care will be in accordance with the provisions of section IV of AR 600-20, and AR 40-3.

#### 4-18. Methods of referral for detoxification

An individual will normally be admitted for detoxification to a MTF by one of the following methods:

a. Referral by the individual's commander or the ADAPCP staff to a physician for evaluation.

b. Referral from the emergency room, outpatient clinic, or other hospital wards or clinics by a physician who suspects an individual may need evaluation or detoxification. The ADCO and the individual's unit commander will be notified by the MTF if the referral is independent of or without the knowledge of the commander and the ADAPCP staff.

c. Civilian employees in CONUS will be referred to civilian community hospitals. Civilian employees in oversea areas will be referred to the MTF if eligible for Army medical Services.

#### 4-19. Responsibilities

a. The MEDCEN/MEDDAC commander will—

(1) Provide adequate personnel and facilities to evaluate and manage patients admitted or referred for detoxification.

(2) Notify the ADCO and the appropriate unit commander of all individuals referred for alcohol and other drug abuse or related conditions. (Examples would be alcohol or other drug-related diseases or injuries, or emergency treatment of overdose cases.)

(3) Ensure coordination with the ADAPCP so that a structured rehabilitation regimen for individuals undergoing detoxification can be implemented when discharged from the MTF and referred to the ADAPCP.

b. The unit commander will maintain contact with the individual undergoing detoxification and will participate, when appropriate, in the detoxification effort.

#### 4-20. Medical processing

a. The attending physician will determine the time necessary for detoxification. Usually 3 to 7 days of inpatient care will be sufficient for most alcohol or other drug dependent individuals; however, longer periods may be necessary.

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

#### 4-21. Use of methadone

Methadone may be used only to ease extreme and otherwise uncontrollable discomfort of rapid withdrawal from opiate dependency. Methadone will not be used for maintenance therapy. (See para 4-15a.)

#### 4-22. Line of duty determination

During detoxification a line of duty determination is not required. An exception to this would be if an individual is determined by a physician to be totally and physically incapacitated for a period of more than 24 consecutive hours. In such cases, the

determination will be "Not in Line of Duty; Due to Own Misconduct" only for the period of actual incapacitation. (See AR 600-33.)

#### 4-23. Action after detoxification

The commander may enroll the individual in the ADAPCP before, during, or after detoxification. After the detoxification has been completed, the enrolled individual will continue in the track of rehabilitation deemed appropriate by the rehabilitation team in coordination with the attending physician.

### Section IV Personnel Actions During Rehabilitation

#### 4-24. Effect of enrollment

Enrollment in the ADAPCP need not interfere with normal command administrative actions. (See chap 5 for civilian personnel.)

a. The granting of leave during the rehabilitation period will be determined by the commander in consultation with the rehabilitation team. This is necessary to permit the coordination of counseling activities.

b. The commander may temporarily relieve the soldier from duties requiring special mental or physical alertness. For temporary personnel actions relating to civilian employees see chapter 5 of this regulation. The commander may also temporarily deny a soldier access to classified information. Ordinarily, security clearances will not be revoked until, in the judgment of the commander and the CCF—

(1) The soldier has failed to respond to rehabilitation treatment.

(2) The soldier is determined to be otherwise unreliable or untrustworthy to the extent that access to classified information or special duty requirements would not be consistent with national security.

c. During rehabilitation, the individual facts of the client's situation must be reviewed to decide upon appropriate personnel actions. The ADAPCP staff should not interfere with any pending, favorable actions.

#### 4-25. Disposition of personnel

a. Personnel identified as alcohol or other drug abusers during leave, TDY, or PCS status who require detoxification, will be admitted to the nearest military MTF. Upon completion of detoxification, the soldier will be returned to his or her unit for rehabilitation.

b. In all cases of identification as an abuser, the immediate commander of the individual's unit will be notified of the circumstances that led to the curtailment of the soldier's leave or other status. This includes compassionate leave, temporary assignment, or TDY.

#### 4-26. Separation actions

The ADAPCP is a manpower conservation program; designed to assist commanders in

retaining soldiers with potential for continued military service. However, when a commander, in consultation with the ADAPCP staff, determines that further rehabilitative measures are not practical and that separation will be based upon alcohol or other drug abuse, the following procedures are suggested:

a. Commissioned officers and warrant officers identified as illegally abusing drugs will be processed for separation in accord with AR 635-100.

b. Enlisted soldiers (E5-E9) identified as illegally abusing drugs will be processed for separation in accord with AR 635-200.

c. Soldiers who are identified as second time illegal drug abusers will be processed for separation in accord with AR 635-100 or AR 635-200.

d. Soldiers diagnosed as being drug dependent by a physician will be detoxified and processed for separation in accord with AR 635-100 or AR 635-200. These individuals will be referred to the Veterans Administration—

(1) Within 30 days of separation.

(2) When requested by the soldier in writing.

e. Discharge for alcohol or other drug abuse rehabilitation failure. AR 635-100 and 635-200 provide procedures for the discharge of soldiers for alcohol and other drug rehabilitation failure. The discharge is based on alcohol or other drug abuse such as the illegal, wrongful, or improper use of any controlled substance, alcohol, or other drug when—

(1) The member is enrolled in the ADAPCP.

(2) The commander determines that further rehabilitation efforts are not practical, rendering the soldier a rehabilitation failure. This determination will be made in consultation with the rehabilitation team. (See AR 635-200, chap 9, for enlisted, and AR 635-100, chap 5, for officers.)

f. When not precluded by the limited use policy, offenses of alcohol or other drug abuse may properly be the basis for discharge proceedings under chapter 14 of AR 635-200. However, the evidence aspect of the limited use policy is applicable to discharge under paragraph 14-12 or other separation provisions. Members processed for separation under other provisions of that regulation, who also are or become subject to separation under this chapter and whose proceedings on other grounds ultimately result in their retention in the service, will be considered for separation under this chapter.

g. When the commander determines that a soldier who has never been enrolled in the ADAPCP lacks the potential for further useful service, the soldier will be screened per this regulation. If found nondependent, the soldier will not be rehabilitated but will be considered for separation under other appropriate provisions of AR 600-200.

h. Separations for alcohol abuse rehabilitation failure will be reported separately

**Table 4-1**  
**ADAPCP Clinical Internship Program**

Activity	Time
(1) Clinical supervision	90 hours/year
(2) In-service training	45 hours/year
(3) USADART/equivalent	N/A.
(4) Three prepared (by intern) in-service presentations	N/A.
(5) Clinical practice hours (total)	1200 hours/year
(a) Screening	130 hours/year
(b) Rehabilitation planning	130 hours/year
(c) Group intervention (counseling)	335 hours/year
(d) Individual intervention (counseling)	215 hours/year
(e) Crisis intervention	85 hours/year
(f) Termination	85 hours/year
(g) Clinical documentation	90 hours/year
(h) Command consultation	130 hours/year
(6) Case presentations	1 week (40 minutes)
(7) Supervision meeting with clinical consultant	1 hour/quarter

from separations for drug abuse rehabilitation failure. If separation is based on both, the primary basis will be used for reporting purposes.

**Section V**  
**ADAPCP Clinical Internship,**  
**Certification, and Credentialing**

**4-27. ADAPCP Clinical Internship Program**

a. From the effective date of this revision of AR 600-85 and in accordance with revised DOD Instruction 1010.6, all individuals hired into ADAPCP counseling positions will be required to complete a 1-year clinical internship. During that year, the counselor will complete all requirements for certification with the exception of the certification examination, which may be taken only after the successful completion of the internship.

b. In addition to meeting certification requirements, the intern will complete a structured clinical training program. This program is to be accomplished under the direct supervision of the clinical director or clinical supervisor. The program for the internship, as outlined in tables 4-1 and 4-2, takes into account leave time, holidays, time for administrative, and other program activities and time if necessary, to complete USADART courses or their approved equivalents. The local clinical director/supervisor may include additional requirements and training, based on local needs or clinical issues. Finally, it is important to keep in mind that this program is designed to guarantee that a counselor has the basic background and skills necessary to function competently in the ADAPCP.

c. The clinical director/supervisor should utilize other activities, departments, and/or resources to assist the counselor in accomplishing the internship. This is especially

true for inservice training and clinical practice hours. Possible support activities include—

- (1) MTF emergency room.
- (2) Hotlines (on or off installation).
- (3) Community mental health activity.
- (4) Chaplain's office.
- (5) Staff duty officer (SDO) or charge of quarters (CQ) calls or incidents.
- (6) ACS.
- (7) Education classes with practica.

d. Deviations/substitutions which may be necessary because of unique characteristics of a given installation are allowed. However, reasons for deviations must be documented, along with details of the substituted experiences. Substituted experiences must be commensurate with those activities they are replacing.

e. In accordance with DOD Instruction 1010.6 and Army medical regulations, clinical directors will be credentialed through the supporting medical treatment facility credentialing committee. Certification is also required and will contribute to credentialing requirements from the effective date of this regulation.

f. The clinical director or clinical supervisor will ensure that the counselor has the opportunity to complete all aspects of the clinical certification internship. A file will be maintained by the clinical director/supervisor to include documentation of completion or failure to complete all components of the internship. This file will be the basis for the supervisor's recommendation for the counselor to—

- (1) Take the certification examination.
- (2) Be considered for certification.
- (3) Be continued in Government employment (if in the first year of service).

**Table 4-2**  
**Clinical Practice Hours**

**Practice area:** Screening  
**Major competency areas:**  
a. Conduct intake interviews.

- b. Develop initial assessment, to include problem and initial plan.
- c. Identify referrals when necessary.

**Practice area:** Rehabilitation planning

**Major competency areas:**

- a. Identify client's primary and secondary problems.
- b. Determine rehabilitation process.
- c. Establish treatment goals.
- d. Make complete case presentation to rehabilitation staff.
- e. Identify need for treatment plan revisions, and implement.

**Practice area:** Group counseling

**Major competency areas:**

- a. Plan a group format.
- b. Conduct group sessions.
- c. Monitor group members progress.
- d. Assess group members progress.
- e. Maintain case files.
- f. Write client progress notes
- g. Monitor rehabilitation plan.

**Practice area:** Individual counseling

**Major competency areas:**

- a. Develop an individual counseling treatment plan.
- b. Conduct individual counseling sessions.
- c. Monitor client progress.
- d. Assess client progress.
- e. Maintain case files.
- f. Write client progress notes.
- g. Monitor rehabilitation plan.

**Practice area:** Crisis intervention

**Major competency areas:**

- a. Determine nature and extent of crisis.
- b. Establish intervention priorities.
- c. Determine strategy.
- d. Identify necessary resources.
- e. Determine danger potential and move to ensure safety of all involved.
- f. Respond effectively to crisis.

**Practice area:** Termination

**Major competency areas:**

- a. Prepare client for program release.
- b. Plan and participate in rehabilitation team meeting to discuss termination.
- c. Document termination actions and plans in case file.
- d. Close out case file.

**Practice area:** Clinical documentation

**Major competency areas:**

- a. Prepare written clinical case notes
- b. Document pertinent case data and counselor activities.
- c. Prepare progress forms and other DA required reports.

**Practice area:** Command consultation

**Major competency areas:**

- a. Plan initial rehabilitation team meeting.
- b. Establish treatment plan with commander and client.
- c. Review treatment progress with commander.
- d. Plan treatment termination with client and commander.

#### 4-28. ADAPCP Clinical Certification

a. The ADAPCP Clinical Certification Program pertains to the objective assessment of key attitudes, knowledge, and skills that have been identified as critical to providing the highest quality service in a given professional field. In compliance with DOD

Instruction 1010.6, this program is now mandatory and a condition of continuing employment. Certification will be granted to individuals currently employed in the ADAPCP who meet the following criteria:

(1) *Work experience.* Six months experience as a full-time counselor in the ADAPCP. The 6 months can be concurrent with the first 6 months of internship.

(2) *Training experience.* Successful completion of the U.S. Army Drug and Alcohol Rehabilitation Training individual and group courses. Equivalent training may be accepted at the discretion of the Certification Review Board.

(3) *Education.* High school diploma or equivalency.

(4) *Professional reference.* An acceptable assessment of counseling competence by ADAPCP clinical supervisor or consultant.

(5) *Examination.* To be certified, individuals must pass the ADAPCP Clinical Certification Examination. The examination is designed to test both clinical knowledge and familiarity with ADAPCP policies and regulations.

(6) *ADAPCP clinical internship.* The successful completion of supervised 1-year internship is required for the final evaluation and assessment of a counselor's competency for certification (DODI 1010.6). The certificate will be awarded upon successful completion of the internship and passing the certification examination.

(7) *Substance abuse history.* Individuals with a history of alcoholism or drug abuse must be able to demonstrate to their supervisor that they have been alcohol or other drug free and have had no incidence caused by alcohol or drug abuse within the 2 years prior to employment. Furthermore, they must remain drug free as a condition of continuing employment and Army certified status.

b. Candidates for clinical certification must become certified within 3 years. An individual may take the examination a maximum of three times. As of the effective date of the revision of AR 600-85, certification is a condition of continuing employment in the ADAPCP.

c. To maintain certified status, clinical directors and counselors must provide proof of completing a minimum of 15 hours per year of continuing education which has been approved by the Certification Review Board.

d. Clinical Certification Program application packets may be obtained from the Academy of Health Sciences Certification Program Director. The application packets will contain a detailed description of the Clinical Certification Program, selected sample examination questions, and suggested study materials.

e. For additional details on the application procedures, potential candidates for certification should contact the program managers at: Commandant, Academy of Health Sciences, ATTN: Behavioral Sciences Division (Clinical Certification), Fort Sam Houston, Texas 78234-6100.

#### 4-29. Quality assurance

a. In accord with DOD Instruction 1010.6, AR 600-85, and applicable medical regulations, periodic reviews of all clinical elements of the ADAPCP will be carried by out by ODCSPER, as program proponent, and OTSG and HSC, which have clinical supervision responsibilities.

b. In accordance with DOD Instruction 1010.6 and Army medical regulations, professional clinical directors must be fully qualified, trained and credentialed, by the servicing medical treatment facility credentialing committee, in the rehabilitation/treatment modalities which they employ. Certification as well as credentialing are required from the effective date of these regulations.

c. Clinical supervisors (supervising counseling) and paraprofessional counselors must be experienced and specifically trained in the alcohol and drug abuse rehabilitation field and must become certified as described in paragraph 4-28 as a condition of employment or continuing employment.

d. Adequate professional supervision and consultation will be available at all times for professional and paraprofessional counselors.

e. Clinical directors will assess the skills and training needs of each clinical staff member and develop individual development plans (IDPs). These IDPs will identify the skill needs of each member and will outline the steps planned to enhance the identified skills.

f. With the exception of licensed medical personnel, AR 600-85 establishes standardized criteria for the selection and certification of personnel who serve in clinical roles as alcohol and drug abuse counselors. (See para 1-25.)

(1) The requirement for certification of ADAPCP alcohol and drug abuse counselors will include sufficient knowledge and skills relating to the core tasks required for rehabilitative personnel followed by a structured didactical course pertaining to substance abuse. A supervised 1-year internship will be the minimum prerequisite for the final evaluation and assessment of a newly hired counselor's competency for certification.

(2) In accord with AR 600-85, staff members, such as civilian or education coordinators, do not have clinical responsibility for treatment or followup and are not required to be certified. Civilian or military paraprofessional personnel who have clinical responsibilities (by job description) for treatment, consultation and followup will receive certification through the Army Clinical Certification Program. Substance abuse counselors who do not meet Army standards will obtain the training and supervision necessary to meet these standards within 2 years, following the publication of this revision of AR 600-85 and in accord with DOD Instruction 1010.6.

(3) Licensed health care providers (physicians, psychologists, clinical social workers, and psychiatric nurses) working in managerial, or supervisory roles over drug

and alcohol abuse personnel will have additional training in chemical dependency, but are not included in the ADAPCP Clinical Certification Program.

## Chapter 5 ADAPCP Civilian Counseling Services

### 5-1. General

This chapter addresses various aspects of ADAPCP policies and special administrative procedures for civilians and family members which differ from those for military service members. In the private sector there are a variety of titles applied to counseling services for employees, including "Employee Assistance Program and Employee Counseling Service Program." In DA, ADAPCP services for civilian employees and military and civilian counseling services (CCS) and will be identified as a part of the ADAPCP and not as a separate program.

a. In 1973, the DA merged the civilian personnel office (CPO) sponsored alcoholism program with the previously established military ADAPCP. As a result, the Army has one ADAPCP, with the Deputy Chief of Staff for Personnel having overall responsibility. The OPM has issued Federal Personnel Manual chapter 792, subchapter 5, "Alcoholism and Drug Abuse Programs" and subchapter 6, "Employee Counseling Service Program" and FPM Supplement 793-2, Alcohol and Drug Abuse Programs as general guidance for all Federal agencies in implementing programs to assist civilian employees with alcohol and drug abuse and other problems. The Army program follows the mandates of Public Laws 91-616 and 92-285 and "utilizes existing services and facilities insofar as possible" for civilian as well as military personnel and their family members. The FPM guidance has been incorporated into the Army program insofar as organizational structure, funding, and manpower constraints permit. However, there remains a very clear and distinct delineation between ADAPCP counseling and assistance and Management Employee Relations (MER) functions of the Civilian personnel office and other agencies which assist civilians in various ways.

b. The ADAPCP is responsible for implementing only the alcohol and drug counseling program aspects of the Employee Counseling Service Program as described in FPM chapter 792. The CPC is assigned to the ADAPCP to ensure that the special needs of civilian employees with alcohol and other drug problems are met. The CPC also acts as a liaison between the ADAPCP and the CPO. There are specific considerations involving civilian clients for example, confidentiality, separate case record files, and applicable civilian personnel regulations) that differ from the military. In compliance with the intent of FPM chapter 792, provisions

are made for civilian client's alcohol and drug problems within the ADAPCP. These are designed to augment CPO responsibilities for counseling and assistance in other employee problem areas. Under no circumstances will the CCS of the ADAPCP be identified as a separate counseling service or employee assistance program. Under no circumstances will civilian employee alcohol and other drug problem management be placed under the CPO, regardless of the name applied to the services provided. The Army structure is different from other Federal agencies and other military services structures within DOD. The civilian aspects of the ADAPCP, as outlined in this regulation, not only meet OPM guidance but meet the letter and intent of all the Public Laws pertaining to alcohol and other drug abuse and have been reviewed by the Government Accounting Office (GAO).

c. It is recognized that the philosophy of FPM chapter 792, subchapter 6 (Employee Counseling Services Program (ECSP)) may encourage early identification and referral of alcohol and drug abuse problems and eliminate the need for supervisors to determine the nature of an employee's problem before making a referral. Therefore, the ECSP described in FPM chapter 792 may be integrated into the ADAPCP with the following provisions:

(1) The name will remain ADAPCP CCS.

(2) The CCS should function as a screening service for all employees whose job performance appears to be affected by a personal problem. If the personal problem involved has as its basis alcohol or other drug abuse, the ADAPCP will provide counseling or referral services designed to resolve the problem and restore the employee to effective job performance. If the personal problem is unrelated to alcohol or other drug abuse, the employee will be referred to the appropriate installation or community resource and ADAPCP involvement with that client will end. If the employee has signed a civilian Employee consent Statement, the supervisor will be notified of the referral and advised that ADAPCP involvement has ended.

(3) Policy statement will make it clear that the CCS exists to enhance earlier identification of alcohol and other drug abuse and that it functions only as a screening and referral service for other problems.

(4) Integration of the ECSP into the CCS will not take priority over ADAPCP functions such as the extension of services to family members.

(5) Proposals to integrate the ECSP into the ADAPCP must have the concurrence of the servicing civilian personnel office.

(6) employees referred to other resources who are not enrolled in the ADAPCP will be entered in the ADAPCP log.

d. In accordance with paragraph 1-2, all military family members and U.S. citizen employees and family members, to include NAF employees, under the jurisdiction of

the Secretary of the Army are eligible for ADAPCP civilian counseling services. It should be noted that temporary employees or civilians are not eligible for ADAPCP services. Other DOD employees who are entitled to care in the Army medical treatment facility may also be offered ADAPCP services. In special instances, foreign national employees are provided Army medical services through special treaty arrangements and are eligible for ADAPCP services on a space available basis.

### 5-2. Objectives

a. The CCS for civilian employees will be implemented as a counseling service that is responsive only to alcohol and drug abuse problems and serves as a screening and referral service for other civilian employee problems. The civilian aspects of the ADAPCP are based upon the assumption that alcohol and other drug abuse and related problems have an adverse effect on the job performance and retainability of any Army civilian. It is extremely important to treat the "whole person." Therefore, the ADAPCP will establish good working relationships with MER Officers and other Army and civilian agencies designed to assist in "troubled employee" problems. Accordingly, the objective of the ADAPCP for civilian employees are to—

(1) Increase the efficiency, productivity, and effectiveness of the civilian work force

(2) Reduce absenteeism and the abuse of sick leave by the civilian work force through early intervention and prevention of alcohol or other drug abuse. Refer related emotional/behavioral disorders to appropriate Army or civilian agencies.

(3) Provide information or referral services to employees with personal problems.

(4) Provide assistance or rehabilitation to identified alcohol or other drug abusers among the civilian work force.

(5) Provide a management tool and resource for managers and supervisors who—

(a) Identify employee deteriorating job performance.

(b) Wish to use the ADAPCP concurrently with performance counseling for problems of alcohol and other drug abuse.

b. For family members of military and civilian personnel, the objectives are based upon the assumption that alcohol and drug abuse within the family can seriously impact upon soldier or employee job performance. Therefore, the objectives are the following:

(1) Extend ADAPCP services to family members of military and civilian personnel in accordance with public law.

(2) Prevent alcohol/drug abuse and its impact upon the soldier's or employee's family.

(3) Reduce the number of alcohol/drug related incidents among family members.

(4) Educate young adults through ADAPCP prevention activities for youth (formerly Teen Involvement Program (TIP)). (See chap 2.)

### 5-3. Responsibility for ADAPCP civilian counseling service efforts

Successful achievement of the objectives of the ADAPCP are vested in installation commanders. Major installation, activity, or organizational commanders will ensure that all management and staff official and supervisors support civilian aspects of the ADAPCP policy will be given adequate publicity to ensure that eligible civilians and family members are aware of the commander's support and of the availability for information, referral, and treatment services by the ADAPCP.

### 5-4. Responsibilities

a. Overall monitoring of ADAPCP Civilian Counseling Services are the responsibility of the MACOM CPA. The CPA is assigned full-time at MACOM level and will function under the direct operational control of the MACOM ADCO; the CPA will—

(1) Advise the MACOM ADCO on all matters pertaining to the CCS.

(2) Develop MACOM guidelines for delivery and monitoring of ADAPCP services for civilian employees and military and civilian family members.

(3) Provide staff and technical guidance to CPCs at installations/communities or activities and ensure quality control of services.

(4) Serve as staff liaison between the CPCs and HQDA on matters of manpower, budget, and the overall administration of the civilian aspects of the ADAPCP.

(5) Collect and maintain data pertaining to the status of civilian employee and family member participation in the ADAPCP.

(6) Evaluate ongoing progress made within the command, activity, or organization.

(7) Provide reports as required to HQDA.

b. The installation CPC will function under the direct operational control of the ADCO in all instances, and will—

(1) Serve as the liaison between the ADAPCP and the CPO.

(2) Assess, plan, and provide comprehensive ADAPCP services for eligible civilian employees and military and civilian family members within the military community.

(3) Establish local procedures for providing ADAPCP services to civilian employees and family members.

(4) Develop prevention campaigns. Provide education and assistance for supervisor and employee education. Publicize the services available for civilian employees through the ADAPCP.

(5) Establish and maintain appropriate liaison with MER personnel.

(6) Establish liaison with other resources to include—

(a) MEDCEN/MEDAAC, civilian employee Occupational Health Services.

(b) Mental hygiene clinics.

(c) Financial and all types of family counseling services (military and civilian available locally).

(7) Assist the EDCO in providing education and prevention programs for various civilian groups.

(8) Interview employees with possible problems to determine the nature of the problem; motivate them to seek assistance, and refer them to the appropriate resource. The CPC will also advise civilians who utilize the ADAPCP of the procedures and policies of the program.

(9) Advise supervisors of employee progress if the employee has signed a Civilian Employee consent Statement.

(10) Evaluate, develop, and implement adequate procedures for exchange of program/treatment information among local community programs, and assist the ADAPCP clinical director in approving community referral sources.

(11) Provide consultation and information to management, union representatives, law enforcement, and civilian agencies utilized by the ADAPCP.

c. The CPO will provide appropriate advice and assistance to ADAPCP CPAs, and CPCs. The CPO will—

(1) Provide information during supervisory training regarding alcohol and other drug abuse, the availability of ADAPCP consultation for supervisors, and the ADAPCP services available for civilian employees.

(2) Assist in providing information required for the annual OPM Report (NARS 0058-OPM-AN) to the CPA or CPC.

(3) Explore with supervisors all proposed adverse/disciplinary actions to determine whether alcohol or other drug use may be involved and refer appropriate cases to the ADAPCP.

(4) Develop procedures which enable civilian employees to seek confidential assistance and to use appropriate leave to attend counseling sessions during duty hours.

(5) Provide liaison in all dealings with unions that may be required for the ADAPCP.

(6) Support the CPA/CPC in establishing and conducting an orientation program for new DA civilian employees (para 2-12f(4)(b)(1) and a continuing education program for supervisors (para 2-12f(4)(b)(2)).

d. The supervisor is responsible for supporting both the ADAPCP and the employee through careful and consistent attention to the evaluation of the employee's job performance, conduct, or attendance which could indicate a pattern for alcohol or other drug abuse. After discussion with the MER representative and when usual corrective supervisory methods do not result in improvement in performance or conduct, and there is reason to suspect alcohol or other drug abuse, the supervisor will offer information on available ADAPCP services. The supervisor will not attempt to diagnose the employee's problem. The objective of ADAPCP services is to upgrade performance or prevent continued deterioration through education and rehabilitation. The

supervisor will be involved in ADAPCP counseling activities only with the client's consent. Responsibilities of the supervisor are to—

(1) Be alert, through continuing observation, to changes in the work and/or behavior of assigned employees. It is DA policy to intervene as soon as possible when alcohol or drug abuse is adversely affecting an employee's job performance. Therefore, supervisors should follow procedures described below as soon as there is reason to believe an employee's performance problems may be related to alcohol or other drug abuse.

(2) Conduct specific instances in which an employee's work performance, behavior, or attendance fail to meet minimum standards, or instances in which the employee's pattern of performance appears to be deteriorating.

(3) Consult with CPC and MER regarding questionable behavior which may indicate an alcohol or other drug problem.

(4) Conduct an interview with the employee, focusing on deteriorating work performance and informing the employee of available counseling services. This and subsequent interviews will be documented. Supervisors will not attempt to diagnose personal or health problems of an employee.

(5) Request that the employee seek appropriate counseling or medical assistance.

(6) Conduct a subsequent interview, in followup to (4) above if job performance does not improve. Provide the employee with a choice of either accepting assistance through counseling or professional diagnosis of problems, or accepting consequences for continuing unsatisfactory job performance or conduct.

(7) Offer to temporarily suspend initiation of disciplinary/adverse action if the employee agrees to seek assistance. (See para 5-5.) If the employee enrolls in the ADAPCP, such action will be suspended and subsequently canceled if the employee successfully participates in the program, and performance and conduct is satisfactory at the end of 90 days. Supervisors must coordinate these procedures closely with MER specialists in CPO. Supervisors are only required to offer to suspend disciplinary/adverse action once. Therefore, supervisors should document all offers of assistance and should continue to monitor and document all offers of assistance and should continue to monitor and document employee performance and conduct in case there is a necessity to propose adverse action or other action based on unacceptable performance or conduct.

(8) Direct personnel actions to be taken (for example, disciplinary or separate actions) in accordance with current civilian personnel regulations, when counseling and rehabilitation efforts have not been successful and the overall job performance or conduct of the employee warrants such actions.

e. Civilian employee supervisors should not confront an employee with the possibility of alcohol or other drug involvement.

(1) If the employee appears to be under the influence of alcohol or other drugs on the job the supervisor has a number of options and should act only after consultation with MER specialists. Supervisors should ensure that action taken in such cases will demonstrate to the employee that such behavior is not acceptable in the workplace. As with all incidents in which job performance appears to be impaired as a result of alcohol or other drug use, supervisors must ensure that such incidents are properly documented.

(2) If the employee is involved in illegal activities related to alcohol or other drugs, the following measures are appropriate and consistent with DA and OPM policy:

(a) If an employee has engaged in criminal conduct directed exclusively toward himself or herself, 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 supervisory has good reason to believe an employee is involved in criminal conduct directed toward or potentially harmful to the person or property of others (such as selling drugs or stealing to support a drug habit), the supervisor has an obligation first to the persons or properties in jeopardy and then to the employee. The supervisor will report the known facts to law enforcement authorities. Reports should be made through a management level at which the exercise of discretion is normally expected and through which reports of other types of criminal activity are generally made.

#### **5-5. Relationship with disciplinary and/or adverse actions**

a. The ADAPCP provides nondisciplinary procedures by which an employee with alcohol or other drug-related problems is offered rehabilitation assistance. Initiation of adverse actions for absenteeism, misconduct, and marginal or unsatisfactory job performance related to alcohol or other drug abuse will be postponed for 90 consecutive days for employees who are enrolled in and satisfactorily progressing in the ADAPCP, unless retention in a duty status might result in damage to Government property or personal injury to the employee or others. In the latter instance, consideration should be given to approving official leave for the employee for all or a portion of the rehabilitation period, if appropriate. Information pertaining to the employee's enrollment and progress in the ADAPCP can be obtained only with the employee's consent. If the employee refuses rehabilitation assistance or, upon completion of the 90-day period fails to achieve satisfactory job performance and conduct, appropriate adverse action may be initiated. Adverse action must be based on unacceptable conduct or performance and may not be initiated based upon failure to participate in or complete the rehabilitation program. Previously initiated adverse actions in which the final

decision letter has not been issued will be canceled upon the employee's enrollment in the ADAPCP, provided the employee has not previously refused rehabilitation assistance. 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 or did not successfully complete rehabilitation, the proposed adverse action need not be delayed as a result of the employee's subsequent request for rehabilitation.

b. Civilian employees may be re-enrolled in the ADAPCP at any time. However, suspension of adverse or disciplinary action during re-enrollment is not required and may be determined by the supervisor on a case-by-case basis:

c. There will be a clear delineation between the ADAPCP staff, whose function is to deal as effectively as possible with the employee's alcohol or other drug abuse problems, and the supervisor and MER specialists who deal with employee's job performance. The supervisor may be involved in ADAPCP counseling and support activities with the consent of the client.

d. The civilian aspect of the ADAPCP supplements but does not replace existing procedures and services for dealing with employees whose job performance or conduct is not acceptable. The ADAPCP is a method for improving job performance when there is reason to suspect deteriorating job performance or conduct related to alcohol or other drug abuse. The CPC and ADAPCP staff will not become involved in disciplinary action. However, the CPC will be knowledgeable of OPM and CPO procedures and regulations, and provide appropriate coordination with the MER specialist, as necessary.

#### **5-6. Identification, referral, and enrollment**

a. DA civilians may be identified and referred for screening by—

- (1) Volunteering for ADAPCP services.
- (2) Being referred by his or her supervisor, the CPC, MER, or other outside source of referral.
- (3) Referral to the ADAPCP by a physician as the result of a fitness-for-duty examination, or routine medical or emergency treatment.
- (4) Being reported as positive in a drug urinalysis conducted under guidelines of paragraph 5-14.

b. Once referred to the ADAPCP, civilian employees will be screened by the CPC who will—

- (1) Determine the nature of the problem.
- (2) Attempt to motivate the employee to seek assistance.

(3) Advise employees of ADAPCP procedures and policies.

(4) Refer the employee to appropriate assistance within the ADAPCP or in the community.

(5) Complete the DA Form 4465 and request that the employee sign the Civilian Employee Consent Statement if the employee chooses to enroll in the ADAPCP.

c. If enrolled, all civilian employees will be requested to sign the Civilian Employee Consent Statement (DA Form 5017-R) prior to entering the ADAPCP. The form is self-explanatory and is located at the back of this regulation. If the employee refuses to sign the consent form, the ADAPCP record will be so annotated and appropriate precautions will be taken against release of information to supervisors or interested others. Signing of the consent form or revoking prior consent is strictly voluntary. If signed, however, the consent enables the CPC, acting for the ADCO, to report specific information to the supervisor named on the consent form and enables two-way communication regarding clinical progress and performance during rehabilitation for the purpose of the supervisor's providing support in the work environment. Suspension of adverse/disciplinary action for 90 days will only apply to employees who signed a consent form and have an active consent form currently on file.

d. If an employee decides to withdraw from the ADAPCP prior to completion of a prescribed rehabilitation plan, the CPC will notify the supervisor if the Civilian Employee Consent Statement has been signed. If adverse action was suspended by the supervisor, it may be reinitiated upon the client's withdrawal, if the supervisor so desires.

#### **5-7. Medical evaluation**

Medical evaluations conducted for civilian employees will be provided at no charge by the designated military or civilian medical officer or occupational health physician. Cost incurred in medical evaluations not directed by Army management performed by physicians in the civilian community will be the responsibility of the employee.

#### **5-8. Employee records and procedures**

Policy for maintaining civilian ADAPCP records is as follows:

a. Client records which deal with the identity, diagnosis, prognosis, treatment, or rehabilitation of a civilian enrolled in any alcohol or other drug abuse program will not be disclosed, except as permitted by section 408, Public Law 92-255 and section 333 of Public Law 91-616 as amended by section 122, Public Law 93-282. Such records are confidential client records protected by the Privacy Act (5 USC 55a), and will remain in the ADAPCP under appropriate security at all times. Client records will not be made part of the employee's official personnel record. However, ADAPCP client folders may include information concerning efforts to rehabilitate the employee that is

related to subsequent disciplinary or separation action. Civilian records must be maintained in a separate locked file and may not be filed with military ADAPCP records.

b. A DA Form 4465 is required for civilian personnel participating in the ADAPCP, to include those participating in approved civilian community programs. ADAPCP records for civilians are maintained by appropriate ADAPCP staff in the same manner as for other clients with the above restrictions.

c. Civilian case notes will be maintained on SF 600 and will be subject to confidentiality and the Privacy Act provisions for such records. Clients will be made aware of recording and have access to records upon request. Civilian case records in the ADAPCP will be maintained in accordance with chapter 7 of this regulation.

### 5-9. Eligibility for retirement

Eligibility requirements for disability retirement and procedures for applying for retirement are contained in FPM, chapter 831 and FPM Supplement 831-1. Participation in the ADAPCP does not in itself jeopardize the employee's right to disability retirement. Either the employee or the activity may initiate an application.

### 5-10. Relationship with labor organizations

The active support of labor organizations will contribute to the success of the ADAPCP. Union stewards can be influential in developing and maintaining employee confidence in the ADAPCP. It is important that labor organizations understand and support the efforts of management to assist the employee with alcohol or other drug-related problems. Therefore, management should ensure appropriate coordination, through the CPO, with labor organization representatives.

### 5-11. Client costs

a. There will be no charge for—

(1) Medical evaluations by the Army Federal Civilian Employee Health Services Program, or by the ADAPCP physician or designee.

(2) All other outpatient ADAPCP services.

b. There will be charges associated with residential care or subsistence charge for meals when clients are not eligible for residential care in AMEDD facilities. All costs associated with the inpatient care will be the obligation of the client (or their insurance carriers) and will include necessary costs for families involved in family counseling.

c. In oversea areas, Army Civilians will be provided residential care when eligible for Army medical services in a foreign country.

### 5-12. Client management

Services provided for civilian employees will comply with ADAPCP policy and procedures prescribed by this regulation.

a. Army Civilians may participate in any aspect of the ADAPCP. Clients requiring residential care will be provided diagnostic services and referral to military or civilian community residential program. Civilians may be referred to residential programs less than 6 weeks long if approved by the CPC or clinical director. The CPC or clinical director may also approve the use of freestanding (nonmedical) facilities. Such facilities should be carefully reviewed to determine if they are covered by employee health insurance.

b. Length and type of treatment will be determined by the employee, the CPC, the supervisor (if a civilian consent form has been signed), the clinical director (if referred to ADAPCP treatment resources), or counselor from a community resource if used.

c. Referral will not be made by ADAPCP staff to civilian community resources until the programs have been visited and approved by the clinical director or CPC. To approve a community resource, a satisfactory agreement of client confidentiality and no exchange of specific information for progress reporting must be negotiated by the CPC if ADAPCP services are to be involved in monitoring, assisting, or followup.

d. Civilian employees will be granted leave to obtain treatment and rehabilitation in accordance with existing civilian personnel regulations.

e. Throughout rehabilitation, the CPC will remain in contact with all civilian employee clients in the ADAPCP, including those participating in approved civilian community programs.

### 5-13. Procedures for family members

a. Family members may participate in all aspects of the ADAPCP within the capabilities of existing resources. If ADAPCP resources are not sufficient, every effort should be made to serve this population through Civilian Health and Medical Program of the Unformed Services (CHAMPUS) referral to community or to other installation resources.

b. Military or civilian family members may be referred to the ADAPCP by—

(1) Volunteering for ADAPCP services.

(2) Being encouraged to seek assistance through the employee/soldiers supervisor.

(3) Being encouraged to seek assistance through installation resources (for example, chaplain, community mental health activity, child protective, Case Management Team, Army Community Services, schools) or other family members.

c. Once referred, family members should be screened by the CPC or an ADAPCP clinician skilled in working with family members to determine the nature of the problem and make an appropriate referral to the ADAPCP (if resources are available) or to a community resource.

(1) the originals of DA Form 4465 and DA Form 4466 will be forwarded to Patient

Administration Systems and Biostatistics Agency, Fort Sam Houston, TX 78234, for enrollment and treatment in accord with chapter 7 of this regulation.

(2) Minor family members may participate in the ADAPCP and will be encouraged to involve their parents in counseling. Consent for treatment will be in accordance with AR 40-3 and AR 40-66.

d. Occasionally, family members may seek assistance for the employee/soldiers' (spouse) alcohol or drug-related problem. In such cases—

(1) Family members will be screened by the CPC or ADAPCP clinician skilled in working with families of alcohol or drug abusers.

(2) Such family members may be enrolled in the ADAPCP (only one member should be enrolled) for the purpose of intervening to encourage the employee/soldiers to seek treatment.

(3) Maximum use of community resources, particularly Alanon and Alateen, is encouraged when working with such cases.

### 5-14. Civilian Drug Abuse Testing Program

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

(1) To assist in determining fitness for, appointment to, or retention in a critical job.

(2) To identify drug abusers and notify them of the availability of appropriate counseling, referral, rehabilitation services, or other medical treatment.

(3) To assist in maintaining national security and the internal security of the Army by identifying those whose drug abuse could cause disruption in operations, destruction of property, threats to safety for themselves or others, or the potential for unwarranted disclosure of classified information through drug-related blackmail.

b. Certain jobs or classes of jobs, are important enough to the mission or to protection of public safety that screening to detect the presence of drugs is warranted as a job-related requirement, have been designated by DA as "critical" for the purpose of drug abuse testing. A complete listing of jobs including occupational series, when possible, is found at table 5-1. These jobs fall into one or more of the following categories:

(1) Law enforcement.

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

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

**Table 5-1**  
**Classes of jobs to be included in the Army**  
**Civilian Employee Drug Abuse Testing**  
**Program**

**Aviation positions, including but not limited to**

**Job/job class:** Air Traffic Controller  
**Occupational series:** 2152

**Job/job class:** Pilot  
**Occupational series:** 2181

**Job/job class:** Aircraft Engine Mechanic  
**Occupational series:** 8602

**Job/job class:** Aircraft Overhaul Specialist  
**Occupational series:** 8801

**Job/job class:** Prop and Motor Mechanic  
**Occupational series:** 8807

**Job/job class:** Aircraft Mechanic  
**Occupational series:** 8853

**Job/job class:** Aircraft Servicer  
**Occupational series:** 8862

**Guard and Police Positions**

**Job/job class:** Guard  
**Occupational series:** 085

**Job/job class:** Police  
**Occupational series:** 083

**Job/job class:** Criminal Investigator  
**Occupational series:** 1181

**Job/job class:** Correctional Officer  
**Occupational series:** 06/07

**Personnel in personal reliability program**

**Job/job class:** Chemical and nuclear surety positions  
**Occupational series:** None

**Alcohol and Drug Abuse Prevention and Control Program**

**Job/job class:** Direct service staff  
**Occupational series:** None

**Job/job class:** All employees at Army forensic drug testing laboratories  
**Occupational series:** None

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

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

(a) Prospective employees being considered for critical jobs.

(b) Current employees being considered for critical jobs.

(2) Individuals being considered for or currently in jobs covered by this program must sign the DA Form 5019-R (Condition of Employment for Certain Civilian Positions Identified as Critical Under the Drug Abuse Testing Program). Completion of the form acknowledges the Department of the Army's right to require the applicant or employee to participate in urinalysis testing. DA Form 5019-R is located at the back of

the regulation. The form will be reproduced locally on 8½- by 11-inch paper.

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

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

(b) Current employees may be subject to adverse action proceedings under FPM chapter 752, FPM Supplement 752-1, and AR 690-700, chapter 751. Current employees in critical jobs will be either reassigned or demoted to a noncritical job; or, if there is no job available for which the employee is qualified, separated from the service. If eligible, they may be offered counseling and treatment as described in e(4) below.

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

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

(b) Removed from Federal service.

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

d. There may be certain jobs which a local commander considers as critical for the purpose of drug abuse testing, but which do not fall within those listed in table 5-1. These may be included in the testing program with prior approval of MACOM, DA, and DOD. A formal request for authorization to test these specific, local jobs must be forwarded through channels and must satisfy the requirements listed below. Decisions will be made on a case-by-case basis. Under no circumstances does an earlier decision to identify a specific job as critical carry over to any other job or job class, or to a similar job in any other location or situation.

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

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

(3) A copy of the job description must be provided, with a schematic of the chain of supervision attached. The job description must be current and properly executed. If more than one individual is to be included in testing, the total number of employees covered will be provided. If the positions are being established or a change in the number of employees is expected, it must be

so stated. Under no circumstances should the inclusion of a small number of employees be requested when rapid growth in that job class is forecast. If turnover is a problem, turnover rates should be specified.

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

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

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

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

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

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

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

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

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

(a) The reasons for the urinalysis test.

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

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

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

(e) The requirement for execution of DA Form 5019-R.

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

(4) An employee whose urinalysis has been confirmed as positive shall, if eligible, be offered counseling or treatment through the local employee assistance program in accord with FPM 792-2. This may be done in conjunction with other actions outlined in c(3) above. Nothing in this provision precludes the use of a confirmed positive urinalysis result in an authorized adverse action proceeding or for other appropriate

purposes, except as otherwise limited by rules issued by the Department of the Army.

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

f. Following are the general procedures for urinalysis testing. Should questions or procedures arise, they should be directed to the installation ADCO or the installation biochemical test coordinator (IBTC).

(1) Urine samples shall be processed under the strict chain of custody procedures as set forth in appendix E. These requirements will be followed with the word or title substitutions listed below. Any questions concerning terminology should be directed to the civilian personnel office and/or the ADAPCP.

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

(b) UADC, see paragraph 10-4e(1) GS-7 or higher or the equivalent.

(c) Observer, paragraph 10-4e (2).

(d) Service member and soldier mean employee.

(e) Section leader means supervisor or designee.

(2) Urine samples shall be tested only at a laboratory certified under enclosure 4 of DOD Directive 1010.1 only using procedures set forth in enclosure 3 of that Directive.

(3) In the event that a sample tested and confirmed as positive must be retained beyond the time frame specified in paragraph 10-4e; the requirements found there must be followed.

(4) In the event that a retest is required, the requirements found in DOD Directive 1010.9 will be followed.

(5) Field testing may be conducted, but strict adherence to the following guidelines is required:

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

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

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

(d) If an applicant is not a current Federal employee, and does not have re-employment rights, an admission of drug use may be used as a valid reason for nonselection for a critical job. If an accession sample of an applicant is found to be positive by a certified field test and the applicant does not

admit drug use, the sample must be forwarded for confirmation. The hiring action for applicants in this circumstance will be held in abeyance until the confirmatory testing is complete. If the final result is negative, the hiring action can be completed. However if the final result confirms the field test positive, the applicant will not be assigned to any critical job. This does not preclude that individual from being considered for a critical job at a later date.

(6) The guidelines covering biochemical testing for illegal drugs, clearly delineate the responsibilities of unit commanders in the conduct of testing (para 10-4e). With the simple substitution of the term "supervisor" for "unit commander," all these guidelines apply to civilians: Any questions concerning testing procedures should be directed to the ADCO or IBTC. Questions that concern management responsibilities, disciplinary actions, and other related areas should be directed to the Civilian Personnel Office.

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

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

## Chapter 6 Legal Aspects of the ADAPCP

### Section I Overview

#### 6-1. General Policy

Legal requirements and guidelines for the ADAPCP must be consistent with the provisions of public law, civil court determinations, DOD directives, and other Army regulations. (See AR 340-21; 5 USC 552a (Privacy Act); part 2, chapter 1, title 42, Code of Federal Regulations; and AR 40-66 concerning medical confidentiality). It is essential that the legal issues of the ADAPCP be clearly understood by all levels of command and supervision and that legal procedures and protections be understood by all potential clients. The intent of applicable laws and regulations is to protect the privacy and personal confidences of the ADAPCP client. These laws and regulations do not conflict with the Army mission

of standards of discipline when applied properly. Program effectiveness, as well as quality of client care, will depend upon the manner in which the ADAPCP is executed. These restrictions apply to individual client personal information and should not impair exchange of general information between staff agencies.

#### 6-2. Confidentiality of military client ADAPCP information

The release and/or discussion of information within the Armed Forces concerning a soldier's abuse of alcohol and other drugs is governed by the restrictions contained in the 5 USC 552a, AR 40-66; and AR 340-21. Such information will be made known to those individuals within the Armed Forces who have an official need to know. The restrictions on release of information outside the Armed Forces concerning soldiers and on all releases of information concerning civilian clients are prescribed by the CFR cited above.

a. Limited use does not grant immunity for present or future use, illegal possession of drugs, or for other illegal acts, past, present, or future, (para 6-2). For example, information that the client presently possesses illegal drugs or that the client assaulted a person while under the influence of drugs is not exempt under this policy. (See sec II and table 6-1.)

b. Limited use does not prevent a counselor from revealing, to the appropriate authority, knowledge of illegal acts. These would be acts which may have an adverse impact on mission, national security, or the health and welfare of others. The reporting in such an instance is from counselor, to clinical director, to ADCO, to the client's commander. The commander will report the information to the appropriate authority.

(1) ADAPCP records are medical records and are protected by AR 40-66. All ADAPCP records will be maintained and stored for a period of 12 months after closing the case by the ADAPCP per AR 340-18-9.

(2) The ADAPCP clinical director will periodically review ADAPCP client files. He or she will ensure that counselors maintain high ethical standards in recording only relevant ADAPCP clinical information.

(3) Commanders seeking information from an individual's ADAPCP record must specify their need to know specific information. Their request must be made to the responsible MEDCEN/MEDDAC commander for proper release of information. Commanders do not have unlimited access to review a client's ADAPCP clinical notes or records.

(4) For clients in certain sensitive positions or with the PRP, counselors or other medical personnel will immediately advise the commander if any information is provided by the client which would serve to disqualify the person for continuation in any sensitive duty position. If the need to release the information is in doubt, it should

be released to the commander based on that requirement to protect the interest of the United States Government. The decision in such cases will be made by the commander.

(5) The ADAPCP is a command program. The rehabilitation process involves the client, his or her unit commander and intermediate supervisors, and the ADAPCP staff. Normally, there is no reason for anyone other than these individuals to learn of a soldier's alcohol or other drug problem. While commanders above the unit level may on rare occasions have an official need to know the specific identity of an abuser within their commands, their knowledge of the number of abusers enrolled in the ADAPCP is usually sufficient information. No lists of individuals from the unit who are enrolled in the ADAPCP will be maintained.

(6) Any seeking assistance through the ADAPCP prior to official enrollment is protected by the confidentiality requirements of the program. Information given to such inquiries will include a description of the local program including an explanation of limited use, confidentiality, and enrollment procedures. Military personnel must be officially enrolled by their commanders regardless of the source of referral. The ADAPCP will not provide rehabilitation counseling for anyone who is not enrolled in one of three program tracks. Nor will services be provided to anyone for whom accountability has not been established through the ADAPCP client reporting system.

## Section II Limited Use Policy

### 6-3. Objective

The objective of the Limited Use Policy is to facilitate the identification of alcohol and drug abusers through self-referral, and the treatment and rehabilitation of those abusers who demonstrate the potential for rehabilitation and retention. It is not intended to protect a member who is attempting to avoid disciplinary or adverse administrative action.

### 6-4. Definition of Limited Use Policy

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

(1) Mandatory urine or alcohol breath test results taken to determine a soldier's fitness for duty and the need for counseling, rehabilitation, or other medical treatment or in conjunction with a soldier's participation in ADAPCP. (See para 10-3a(1) and table 6-1.)

(2) A soldier's self-referral to ADAPCP.

(3) Admissions and other information concerning drug or alcohol abuse or possession of drugs incidental to personal use occurring prior to the date of initial referral to ADAPCP provided voluntarily by a soldier as part of his or her initial entry into ADAPCP.

(4) Admissions made by a soldier enrolled in ADAPCP to a physician or ADAPCP counselor during a scheduled interview concerning drug or alcohol abuse or possession of drugs incidental to personal use occurring prior to the date of initial referral to ADAPCP.

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

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

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

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

e. The Limited Use Policy does not preclude either of the following:

(1) The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse (or lack thereof) first has been introduced by the soldier.

(2) The initiation of disciplinary or other action based on independently derived evidence, including evidence of continued drug abuse after initial entry into the ADAPCP.

### 6-5. Implementation

a. Commanders will explain the Limited Use Policy to soldiers during the commander's interview as set forth in paragraph 3-8. Commanders will not make any agreement or compromise expanding the Limited Use Policy in any way.

b. When a soldier receives emergency treatment from a military medical facility for an actual or possible alcohol or other drug overdose, his or her commander is notified of the event as a routine matter. When a soldier receives such emergency treatment from a civilian medical facility; however, there is no routine procedure to notify the soldier's commander. Further, physicians at any federally supported civilian alcohol or other drug treatment facility are prohibited by statute from releasing such information without written consent of the patient.

Hence, in cases where information of the emergency treatment does not come to the attention of the soldier's unit commander, the following requirements must be met before the policy becomes effective:

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

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

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

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

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

(1) The soldier may seek help for his or her own alcohol or drug problem from—

(a) His or her commander.

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

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

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

(a) Inform the soldier of these suspicions.

(b) Ensure that the soldier is aware of the treatment and rehabilitation services available.

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

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

d. A soldier protected by the Limited Use Policy may be recommended for administrative discharge on the basis of evidence other than information obtained directly or indirectly from the soldier's involvement in the ADAPCP. Such a soldier may receive a discharge characterized as honorable, general, or under other than honorable conditions. (See AR 635-100.

AR 635-200, and other regulations authorizing separation with less than an honorable discharge certificate.) The soldier will receive an honorable discharge certificate, regardless of his or her overall performance of duty, if discharge is based on proceeding where the Government initially introduces limited use evidence except as authorized in paragraph 6-3e(1). The Government includes the following:

(1) The commander, or intermediate commanders (in a recommendation for discharge or in documents forwarded with such a recommendation).

(2) Any member of the board of officers or an administrative separation board adjudicating the service.

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

(4) The separation authority.

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

f. On the other hand, if the soldier (respondent) or his or her counsel initially introduces such evidence, the type of discharge certificate issued is not restricted to an honorable discharge certificate. (See also para 6-3e.)

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

### Section III

#### Release of Personal Client Information

##### 6-6. Authority

a. Section 408 of Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972 (21 USC 1175), as amended by section 303 of Public Law 93-282 (88 Stat 137).

b. Section 333 of Public Law 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 USC 4582), as amended by section 122(a) of Public Law 93-23 (88 Stat 131).

c. Chapter 1, title 42, Code of Federal Regulations.

##### 6-7. Scope

a. This section prescribes policy and provides guidance on the release of information on abusers of alcohol or other drugs who

are or have been enrolled in the ADAPCP. The primary intent of the references in paragraph 6-6 and of the policies in this section is to remove any fear of public disclosure of past or present abuse. It is also intended to encourage participation in a treatment and rehabilitation program.

b. The restrictions on disclosure prescribed in this section are allowed by the Freedom of Information Act (5 USC 552) or the Privacy Act (5 USC 552a)

##### 6-8. Penalties

The provisions of this section apply to individuals responsible for any client record and to individuals who have knowledge of the information contained in client records. Such records would be those maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research. The criminal penalties for unauthorized disclosure of information prohibited by the Federal statutes and regulations listed are a fine of not more than \$500 in the case of the first offense and not more than \$5000 in the case of each subsequent offense.

##### 6-9. Policy

No person subject to the jurisdiction or control of the Secretary of the Army shall divulge any information or record of identity, diagnosis, prognosis, or treatment of any client. This includes any information which is maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research, except as authorized in a through c below.

a. Subject to the provisions of section IV of this chapter disclosure of information on military clients is authorized within the Armed Forces; if the individual seeking the information has an official need to know. This includes those components of the Veterans Administration furnishing health care to veterans. The provisions of section IV and of this section apply to further disclosure within the Armed Forces; the provisions of the legal citations listed in paragraph 6-6 apply to further disclosures by the VA.

b. With the consent of the client (para 6-10f) and subject to other applicable restrictions of this section, disclosure to the following is authorized:

(1) To medical personnel or to treatment or rehabilitation programs where such disclosure is needed to furnish better services to the client (para 6-10b).

(2) To the client's family or to any person with whom the client has a personal (para 6-10c).

(3) To the client's attorney, when a bona fide attorney-client relationship exists (para 6-10d).

(4) To the following designees of the client for the purpose of benefiting the client (para 6-10e):

(a) To the President of the United States or to members of the US Congress when they are acting in response to an inquiry or complaint from the client (para 6-10e(8)).

(b) To civilian criminal justice system officials where the client's participation in the ADAPCP is made a condition of—

1. The individuals release from confinement.

2. The disposition or status of any criminal proceedings against the individual.

3. The execution or suspension of any sentence imposed on the individual (para 6-10e).

(c) To employers or employment agencies (para 6-10e).

(d) To other designees for the purpose of benefiting the client (para 6-10e).

c. Without the written consent of the client, but subject to other applicable restrictions of this section, disclosure of information is authorized—

(1) To medical personnel, to the extent necessary to meet a bona fide medical emergency to include family violence (spouse/child abuse) of a potentially life-threatening nature (para 6-10b(1)).

(2) To qualified personnel conducting scientific research, management or financial audits, or program evaluation (para 6-10f).

(3) To any person designated by a court to receive such information, upon issuance by that court of an order under the provisions of 21 USC 1175 (b), (2) (C) or 42 USC 4582(b) (2) (C). (See para 6-10h.)

##### 6-10. Implementation

###### a. Overview

(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 (for example, from a parent) or through an intermediary (for example, a member of Congress inquiring for a parent). They may be received by written correspondence, by telephone; or during face-to-face conversation. Further, alcohol or other drug involvement may not surface until after an investigation has been initiated to provide information upon which to base a reply. The guidance contained in this section is intended to assist commanders or other officials receiving requests for information in preparing replies and complying with the policy contained in paragraph 6-9.

(2) In all cases where disclosure is prohibited or is authorized only with the client's written consent, every effort should be made to avoid inadvertent disclosure. Even citing a referenced statute, the CFR, or this regulation as the authority for withholding information would identify the client as an abuser. Accordingly, replies to such inquiries should state that disclosure of the information needed to fully respond to the inquiry is prohibited by regulations and statutes. As appropriate, the reply may suggest that the inquirer contact the client directly. Where disclosure is permitted with the client's written consent, an interim reply may state that an attempt will be made to obtain the client's written consent.

(3) The disclosure that an individual is not or has not been a client in the ADAPCP is fully as much subject to the prohibitions and conditions of the statutes, the CFR, and this regulation as a disclosure that such a person is or has been a client. Any improper or unauthorized request for disclosure of records or information subject to the provisions of this section must be met by a noncommittal response.

*b. Disclosure to medical personnel or to treatment or rehabilitation programs.*

(1) Disclosure to medical personnel, either private or governmental, to the extent necessary to meet a bona fide medical emergency, is authorized without the consent of the client. This includes emergency situations such as family violence where there is spouse/child abuse of a potentially life threatening nature. If an oral disclosure is made under the authority of this paragraph, the ADCO will make a written memorandum for the record. This memorandum will be filed in the same manner as a written consent. (See *i* below.) It will show the following:

- (a) The client's name.
- (b) The reason for the disclosure.
- (c) The date and time the disclosure was made.
- (d) The information disclosed.
- (e) The name of the individual to whom it was disclosed.

(2) In other than emergency situations, the written consent of the client is required (*i* below). Such disclosure may be made to medical personnel or to nonmedical counseling and other treatment and rehabilitative services to enable such individuals or activities to furnish services to the client.

*c. Disclosure to a family member or to any person with whom the client has a personal relationship.*

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

(2) Written approval of a program physician or the clinical director that disclosure will not be harmful to the client is required. (See *i(4)* and *(5)* below.)

(3) The only information that is releasable is an evaluation of the client's current or past status in the ADAPCP.

*d. Disclosure to the client's attorney.*

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

(2) A bona fide attorney-client relationship must exist between an attorney and the ADAPCP client.

(3) The attorney must endorse the consent form.

(4) Subject to the limitations stated by the client in his or her written consent form, any information from the client's ADAPCP records may be disclosed.

(5) Information so disclosed may not be further disclosed by the attorney, even if the client waives the protection of the attorney-client relationship. The attorney's attention will be directed to section 2.35 chapter 1, 42 CFR.

*e. Disclosure to client's designee for the benefit of the client.*

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

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

(3) For the purpose of this section, the circumstances under which disclosure may be deemed for the benefit of a client include, but are not limited to, those in which the disclosure may assist the client in connection with any public or private—

- (a) Claim.
- (b) Right.
- (c) Privilege.
- (d) Gratuity.
- (e) Grant.
- (f) Or, other interest accruing to, or for the benefit of, the client or the client's immediate family.

(4) Examples of the foregoing include—

- (a) Welfare.
- (b) Medicare.
- (c) Unemployment.
- (d) Workmen's compensation.
- (e) Accident or medical insurance.
- (f) Public or private pension or other retirement benefits.
- (g) Any claim or defense asserted or which is an issue in any civil, criminal, administrative, or other proceeding in which the client is party or is affected.

(5) The criteria for approval of disclosure are the following:

(a) The statutes and implementing regulation, chapter I, title 42, CFR, provide specific criteria for disclosure in two of the circumstances under which such disclosure may be deemed for the benefit of the client. These criteria are contained in (5) and (6) below.

(b) In any other benefit situation (such as those listed in (3) above), disclosure is authorized with the written consent of the client only if the ADCO determines that all of the following criteria are met:

1. There is no suggestion in the written consent or the circumstances surrounding it, as known to the ADCO, that the consent was not given freely, voluntarily, and without coercion.

2. Granting the request for disclosure will not cause substantial harm to the relationship between the client and the ADAPCP. Nor will it cause harm to the ADAPCP's capacity to provide services in general. This determination is to be made with the advice of the clinical director.

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

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

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

(b) Ordinarily, disclosures pursuant to this paragraph should be limited to a verification of the client's status in treatment or a

general evaluation of progress in treatment. More specific information may be furnished where there is a bona fide need to evaluate hazards which employment may pose to the client or others or where such information is otherwise directly relevant to the employment situation.

(c) Subject to the provisions of (a) and (b) above, disclosure is authorized if the ADCO determines that the following criteria are met:

1. There is reason to believe, on the basis of past experience or other credible information (which may in appropriate cases consist of a written statement by the employer), that such information will be used for the purpose of assisting in the rehabilitation of the client. Such information must not be disclosed for the purpose of identifying the individual as a client in order to deny him or her employment or advancement because of his or her history of alcohol or drug abuse.

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

(7) Disclosures in conjunction with Civilian Criminal Justice System Referrals (para 6-9b(4) (b)).

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

(b) Disclosure may be made—

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

2. To a parole board or other authority granting parole.

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

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

(d) Such consent shall expire 60 days after it is given or when there is a substantial change in the client's criminal justice system status, whichever is later. For the purposes of this paragraph, a substantial change occurs in the criminal justice system status of a client who, at the time such consent is given, has been sentenced, or when the sentence has been fully executed. Examples of substantial changes are the following:

1. Arrested, when such client is formally charged or unconditionally released from arrest.

2. Formally charged, when the charges have been dismissed with prejudice, or the trial of such client has been commenced.

3. Brought to a trial which has commenced, when such client has been acquitted or sentenced.

(e) A client's release from confinement, probation, or parole may be conditioned upon his or her participation in the ADAPCP. Such a client may not revoke his or her consent until there has been a formal and effective termination or revocation of such release from confinement, probation, or parole.

(f) Any information directly or indirectly received by an individual or agency may be used only in connection with their official

duties concerning the particular client. Such recipients may not make such information available for general investigative purposes. Nor may such information be used in unrelated proceedings or made available for unrelated purposes. The recipient's attention will be directed to section 2.38, chapter 1, title 42, CFR.

(8) Disclosures to the President of the United States or to Members of the U.S. Congress acting in response to an inquiry or complaint from the client:

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

(b) Any information not otherwise prohibited from release by other regulations or directives may be disclosed. This is subject to the limitations stated by the client in his or her written consent form.

(c) This authority for disclosure from a client's record does not extend to situations where the President or a Member of Congress is acting as an intermediary for a third party (such as the client's parents or spouse). However, most correspondence concerning Army personnel that is addressed to the President is forwarded to the Army for direct reply to the inquirer. Such correspondence addressed to the President may be treated as inquiries directed initially to the Army.

(d) The limitation in (c) above should not be interpreted as a restriction on complete and accurate responses to inquiries on behalf of third parties concerning—

1. The nature and extent of the drug and alcohol problem in a unit, installation, or command.

2. A description of the ADAPCP, program facilities, techniques, or the like.

f. *Disclosure for research, audits, and evaluations.* Subject to (1) through (3) below, paragraph 6-8 of this regulation, AR 340-1, and AR 340-17, a disclosure to qualified personnel for the purpose of scientific research, management or financial audit, or program evaluation is authorized whether or not the client gives consent.

(1) The term qualified personnel means persons whose training and experience are appropriate to the nature and level of work in which they are engaged. These are persons who, when working as part of an organization, are performing such work with adequate administrative safeguards against unauthorized disclosures.

(2) The personnel to whom disclosure is made may not identify, directly or indirectly, any individual client in any report of such research, audit, or evaluation. They may not otherwise disclose client identities in any manner. Personnel to whom disclosure is made will be reminded that sections 2.52 through 2.56, chapter I, title 42, CFR apply.

(3) In cases of scientific research, the restrictions contained in AR 340-1 apply.

g. *Disclosure in connection with an investigation.* Release of information to conduct an investigation against a civilian client or to conduct an investigation outside the

Armed Forces against a military client is prohibited; the only exception is by order of a court of competent jurisdiction (h below). An investigation conducted by governmental personnel in connection with a benefit to which the client may be entitled (for example, a security investigation by an FBI agent in conjunction with the client's application for Government employment) is not considered to be an investigation against the client. Hence, with the written consent of the client, the required information may be disclosed under the provisions of e above.

h. *Disclosure upon court orders.* Under the provisions of 21 USC 1175(b)(2)(c); 42 USC 4582 (b)(2)(c), and subpart E, chapter 1, title 42, CFR, a court may grant relief from duty of nondisclosure of records covered by 21 USC 1175 and 42 USC 4582 and direct appropriate disclosure.

(1) Such relief is applicable only to records as defined in the glossary. Such relief is not applicable to secondary records generated by disclosure of primary records to researchers, auditors, or evaluators in accord with f above.

(2) Such relief is limited to only that objective data such as facts or dates of enrollment, discharge, attendance, and medication that are necessary to fulfill the purpose of the court order. And, in no event, may such relief extend to communications by a client to ADAPCP personnel.

(3) Such relief may be granted only after strict compliance with the procedures, and in accord with the limitation, of subpart E, chapter 1, title 42, CFR. This is whether the court order deals with an investigation of a client, an investigation of the ADAPCP, undercover agents, informants, or other matters.

i. *Written consent requirement.*

(1) Where disclosure of otherwise prohibited information is authorized with the consent of the client, such consent must be in writing and signed by the client, except as provided in (10) and (11) below.

(2) The client will be fully informed of the nature and source of the inquiry. And, he or she will be informed that his or her voluntary written consent is required to release information upon which to base a reply.

(3) If the client consents to the release of all or part of the requested information, he or she will confirm that fact by signing the DA Form 5018-R, (ADAPCP Client's Consent Statement for Release of Treatment Information). DA Form 5018-R is located at the back of this regulation and is self-explanatory. This form will be reproduced locally on 8½ by 11-inch paper.

(4) As indicated in c above, the only information releasable to the client's family or to a person with whom the client has a personal relationship is information evaluating the client's present or past status in a treatment or rehabilitation program. Release of such an evaluation requires not only the consent of the client, but also the approval of the MEDCEN/MEDDAC commander.

The commander must signify that in his or her judgement 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 or her designated representative (program physician or clinical director only) as shown on DA Form 5018-R.

(5) In the judgment of the MEDCEN/MEDDAC commander or the designated physician or clinical director, release of information may be considered to be harmful to the client although the client has already signed the consent form. In this event, the inquirer will be informed that statutes and regulations prohibit the release of certain personal information.

(6) The consent will be prepared in an original only—reproduction is not authorized. For a client actively participating in the program, it will be filed in the client's ADAPCP records. When these records are destroyed or when the client leaves an installation program for any reason, the form will be transferred to the client's health records. For a soldier or Army 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 criminal justice referrals is prescribed in e(7)(d) above.

(8) Where the client's unit commander provides information for a higher headquarters reply to an inquiry, the forwarding correspondence will specifically verify that the consent—

(a) Has been signed by the client and, where applicable, signed by the appropriate MEDCEN/MEDDAC commander, program physician, or clinical director.

(b) Has been, or will be, filed in the client's ADAPCP records.

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

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

(b) He or she will be informed that the reply to the inquiry will state that if no consent is given, statutes and regulations prohibit the release of personal information and will state that he or she has been requested to correspond directly with the inquirer. Or, if the client authorizes only the release of limited information, he or she will be informed that the reply will state this, and will state that he or she has been requested to correspond directly with the inquirer.

(c) Where the client's unit commander provides information for a higher headquarters' reply to an inquiry, forwarding correspondence will include a statement that—

1. The client refused to sign a form of consent or authorized the release of only limited information.

2. The client has been encouraged to correspond directly with the inquirer.

(10) When disclosure is authorized with the consent of the client, such consent may be given by a guardian or other person authorized under State law to act in the client's behalf; this would only be in the case of a client who has been adjudged as lacking the capacity to manage his or her own affairs. Such consent may also be given by an executor, administrator, or other personal representative, in the case of a deceased client.

(11) When any individual suffering from a serious medical condition resulting from alcohol or other drug abuse is receiving treatment at a military medical facility, the treating physician may, at his discretion, give notification of such condition to a member of the individual's family. Or, notification may be given to any other person with whom the individual is known to have a responsible personal relationship. Such notification may not be made without such individual's consent at any time he or she is capable of rational communication.

*j. Inquiry made by telephone.*

(1) Without violating the requirements of this section or other policies on the release of personal information, every effort should be made to provide the requested information.

(2) If the caller specifically requests information on a client's abuse of alcohol or other drugs, the following actions will be taken: (Such actions will also be taken if the answer to a more general question, such as health and welfare, would require the divulgence of information prohibited under the provisions of this section.)

(a) Inform the caller that statutes and regulations prohibit the disclosure of such information.

(b) Request that the caller submit a written request stating the specific type of information desired. Included must be the purpose and need for such information.

*k. Inquiries made in face-to-face conversation.* The policy and implementing guidance of this section make no exceptions for face-to-face inquiries. Commanders, supervisors, and staff officers should anticipate and be prepared to respond to such inquiries without compromising the client's personal privacy. The guidance on telephone inquiries (j above) should be utilized for the disclosure.

*l. Limitations on information.* Any disclosure made under this section, with or without the client's consent, shall be limited to information necessary in light of the need or purpose for the disclosure.

*m. Written statements.* All disclosures shall be accompanied by a written statement

substantially as follows: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose." An oral disclosure, as well, should be accompanied or followed by such a notice.

*n. Regulations governing release of information.*

(1) To the extent that the contents of this section are in conflict with any other regulatory directives, the contents of this section will prevail.

(2) Disclosures authorized by this section are subject to further restrictions imposed by other regulatory directives pertaining to the release of information that are not in conflict with this section.

(3) This section does not prohibit release of information concerning the abuse of alcohol or other drugs from records other than those specified in paragraph 6-9. For example, a record of trial is not a record maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research. If, in the judgment of the commander, disclosure of information not otherwise prohibited by this section would assist in providing an appropriate reply to an inquiry, the information may be released.

#### **Section IV Release of ADAPCP Information to the Media**

##### **6-11. Scope**

This section provides guidance for the release to the news media of program information that does not identify any individual, directly or indirectly, as either an abuser or nonabuser of alcohol or other drugs. This includes information concerning a former abuser of alcohol or other drugs. (See secs II and III.)

##### **6-12. Objectives**

The objectives of this section are the following:

a. To provide the public with appropriate information about the Army's ADAPCP in accord with AR 360-5.

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

##### **6-13. Concept**

Release of information pertaining to DOD activities remains the responsibility of the Office of the Assistant Secretary of Defense (Public Affairs). The office of the Chief of Public Affairs (OCA), HQDA, is responsible for coordinating, planning, and monitoring the execution of appropriate Army information activities.

#### **6-14. Implementation**

a. Guidelines for release of information are as follows:

(1) Unclassified factual information on the following may be provided to the news media in response to queries:

(a) The Army's alcohol or other drug problems.

(b) The Army's prevention and control program as described in this regulation.

(2) Tours of facilities and discussion with ADAPCP staff personnel must have the prior approval of the installation command and, if appropriate, the MEDCEN/MEDDAC commander. Such tours or discussions will not be conducted at a time or location that could result in the identification of a client as an alcohol or other drug abuser.

(3) Information on quantitative results of the urine testing program will not be given unless or until it has been released by ODCSPER, HQDA. Overall ADAPCP statistics will be cleared with the HQDA Alcohol and Drug Policy Office prior to release in any form.

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

#### **6-15. Administration**

a. Public affairs officers may communicate directly with Public Affairs Office (PAO), HQDA.

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

### **Chapter 7 Management Information System**

#### **Section I Records and Reports**

##### **7-1. General**

A system of reports will be used to provide essential management information on the ADAPCP at each level of command. The data generated by the reports will provide—

a. A measure of the magnitude of alcohol and other drug abuse.

b. A measure of the progress made in the ADAPCP preventive education effort.

c. A measure of the progress made in the rehabilitative and medical treatment aspects of the ADAPCP.

d. Statistical trends to support requisite policy and procedural changes.

e. Information to support and justify funding and manpower requirements for the ADAPCP.

f. Statistical information required to reply to public, media, congressional, or other Government agency inquiries.

g. Information upon which to complete DOD Directive 1010.3. This directive prescribes the formats for Drug and Alcohol Abuse Reports requirements. These reports are due to ASD(HA) and (FM+P) on

a semiannual basis. (Oct-Mar and Apr-Sep). USADAOA is the office of record for collecting feeder reports and consolidating and transmitting the reports to OSD. Completed forms must be provided to USADAOA for consolidation not later than 45 days after the end of the report period or, 15 November and 15 April respectively. Feeder reports are required from the following:

- (1) Army Judge Advocate General—DD Form 2395, (Report on Legal or Administrative Disposition of Drug Abuse Offenders).
- (2) The Army Provost Marshal—DD Form 2394; (Report on Drug-Related Military Law Enforcement Activity).
- (3) The U.S. Army Drug and Alcohol Technical Activity—DD Form 2396, (Report on Urinalysis Testing for Drug Abuse); DD Form 2397, (Report on Drug or Alcohol Awareness Education or Rehabilitative Program); and DD Form 2398, (Report on Civilian Employee Alcohol and Drug Abuse).

## 7-2. Client categories

A thorough understanding of client categories is critical to the efficient administrative and clinical processing of individuals participating in the ADAPCP. For administrative reporting requirements, ADAPCP clients and potential clients will be placed in the following three categories:

- a. Army—Active duty or active duty for training Army personnel.
- b. Civilian employee—U.S. citizen civilian employees of the Army. This includes the DA civilian employees and NAF civilian employees.
- c. Other clients—This includes retired military, dependents of active duty and retired military, members of other military services, DOD civilian employees who are not DA or NAF civilian employees, dependents of U.S. citizen civilian employees, and where care is authorized, certain foreign nationals. USAR and ARNG personnel on active duty for training for less than 30 days and participating in the ADAPCP, will be reported as "other clients."

## 7-3. Alcohol and Drug Abuse Prevention and Control Program Summary. (RCS CSGPA 1291-R4)

a. DA Form 3711-R, (ADAPCP summary) provides management information on many aspects of the local program. These include compliance with policy, effectiveness of procedures, workload, and adequacy of resources. The summary also provides much of the data required of HQDA by the Office of the Secretary of Defense and other federal agencies: DA Form 3711-R is located at the back of this regulation. This form will be reproduced on 8½ by 11-inch paper. Instructions for completing this form are in appendix B.

b. Responsibilities for preparation, transmission, and review of the ADAPCP are as follows:

- (1) The DCSPER will—

(a) Use data provided in the ADAPCP summary for overall program management.

(b) Periodically disseminate data based on consolidated reports, to major Army commands.

(2) The Director, USADAOA will—

(a) Review incoming reports for completeness and statistical accuracy.

(b) Provide consolidated ADAPCP Summary reports to ODCSPER, HQDA (DAPE-HRL), WASH DC 20310, for evaluation.

(c) Prepare and forward to ODCSPER, HQDA (DAPE-HRL) appropriate reports required by the Office of the Secretary of Defense.

(3) MACOM commanders will monitor the submission of ADAPCP Summaries by subordinate elements and prepare consolidated reports for oversea areas indicated in table 7-1.

(4) MEDCEN/MEDDAC commanders will provide the ADCO with information required to complete appropriate parts of the report.

(5) Installation and oversea ADCOs will—

(a) Prepare the ADAPCP summary (DA Form 3711-R) each month for those installations and oversea areas listed in paragraph 17-4.

(b) Submit ADAPCP summary by letter (para 7-5) through command channels to the MACOM commander concerned:

## 7-4. CONUS Installations and oversea areas

ADAPCP summaries (DA Form 3711-R) are required each month from the following CONUS installations and oversea areas:

a. FORSCOM.

- (1) Ft Bragg, NC.
- (2) Ft Campbell, KY.
- (3) Ft Carson, CO.
- (4) Ft Devens, MA.
- (5) Ft Drum, NY.
- (6) Ft Hood, TX.
- (7) Ft Indiantown Gap, PA.
- (8) Ft Irwin, CA.
- (9) Ft Lewis, WA.
- (10) Ft McPherson, GA.
- (11) Ft Meade, MD.
- (12) Ft Ord, CA.
- (13) Ft Polk, LA.
- (14) Presidio of San Francisco, CA.
- (15) Ft Riley, KA.
- (16) Ft Sam Houston, TX.
- (17) Ft Sheridan, IL.
- (18) Ft Stewart, GA.

b. TRADOC.

- (1) Ft Belvoir, VA.
- (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, M. D.

(15) Ft McClellan, AL.

(16) Ft Monroe, VA.

(17) Ft Rucker, AL.

(18) Ft Sill, OK.

c. AMC, AMC installations and activities not listed below will submit data to the next higher command or servicing installation which will submit a consolidated report:

- (1) HQ, AMC, Alexandria, VA.
- (2) HQ, ARMCOM, Rock Island, IL.
- (3) HQ, TSARCOM, St. Louis, MO.
- (4) HQ, CECOM, Ft Monmouth, NJ.
- (5) HQ, MICOM, Redstone Arsenal, AL.
- (6) HQ, TACOM, Warren, MI.
- (7) HQ, TECOM, APG, MD.
- (8) Anniston Army Depot, Anniston, AL.
- (9) Corpus Christi Army Depot, Corpus Christi, TX.
- (10) Letterkenny Army Depot, Chambersburg, PA.
- (11) Lexington-Bluegrass Army Depot, Lexington, KY.
- (12) New Cumberland Army Depot, New Cumberland, PA.
- (13) Red River Army Depot, Texarkana, PA.
- (14) Sacramento Army Depot, Sacramento, CA.
- (15) Seneca Army Depot, Romulus, NY.
- (16) Sharpe Army Depot, Lathrop, CA.
- (17) Sierra Army Depot, Herlong, CA.
- (18) Tobyhanna Army Depot, Tobyhanna, PA.

(19) Tooele Army Depot, Tooele, UT.

d. Other CONUS installations/activities.

- (1) Ft Detrick, MD (HSC).
- (2) Fitzsimons Army Medical Center, CO (HSC).
- (3) Walter Reed Army Medical Center, DC (HSC).
- (4) Ft Huachuca, AZ (ISC).
- (5) Ft Richie, MD (ISC).
- (6) Military District of Washington (MDW).
- (7) USMA, West Point, NY (DCSPER).
- (8) MTMC, Eastern Area, Bayonne, NJ (MTMC).
- (9) MTMC, Western Area, Oakland, CA (MTMC).

e. Oversea areas and responsible commands.

- (1) Europe; USAREUR (Designated USAREUR Counseling Centers).
- (2) Alaska, FORSCOM.
- (3) Panama, FORSCOM.
- (4) Hawaii, WESTCOM.
- (5) Korea, EUSA.
- (6) Japan, USARJ.
- (7) Okinawa, USARJ.
- (8) Puerto Rico, FORSCOM.

## 7-5. Transmission of ADAPCP Summary

a. The ADAPCP Summary, DA Form 3711-R, will be submitted by letter through command channels to the MACOM commander concerned. To assist in meeting deadlines imposed on HQDA, a copy of

both the summary and the letter from each CONUS installation and oversea area will be mailed directly to the Director, U.S. Army Drug and Alcohol Technical Activity, PEDDA, ATTN: DAMIS, 5600 Columbia Pike, Suite 300, Falls Church, VA 22041, for statistical review and processing. Direct communication is authorized between Director, USADAOA and ADCOs of CONUS installations and oversea areas. If in this direct communication, a corrected copy summary is required, copies of the revised summary will be submitted directly to USADAOA and through command channels to the MACOM commander concerned.

b. A letter of transmittal signed by the appropriate commander will accompany the summary. The letter should include any information necessary to interpret data appearing in the program summary. Commanders providing support to off-installation military and civilian activities will list these activities. They will indicate the hours provided and the resources utilized. If no medical treatment facility is located on the installation, the letter will indicate the name of the facility that provides medical evaluation, detoxification, and related medical care.

c. The report period will begin on the first day of the month and will end on the last day of the same month. Completed summaries will be dispatched as follows:

(1) CONUS installations will submit summaries to arrive at USADAOA not later than 7 working days after the end of the report period.

(2) Oversea areas will submit a consolidated summary to arrive not later than 12 working days after the end of the report period.

d. Data concerning individuals from other military services participating in the ADAPCP will be reported as part of the data compiled for other clients in the report.

## Section II Client Oriented Drug Abuse Reporting System (CODARS)

### 7-6. ADAPCP Military Client Referral and Screening Record

The DA Form 2496, will be completed in triplicate by the commander. A sample completed DA Form 2496 is shown in figure B-1. The ADAPCP Military Client Referral and Screening Record is forwarded from the commander to the CCC to enable the CCC staff to evaluate the soldier for possible alcohol or drug abuse problems. The original and one copy are forwarded to the CCC and placed on file. Since units from major commands may be physically located on installations/communities belonging to other MACOMs, company commanders must identify in the "from" block of the referral DF the MACOM to which his or her unit belongs (for example; FORSCOM unit when on a TRADOC installation). This is necessary in order that the counselor can complete block 26A of DA

Form 4465. This form will be hand-carried from the unit to the CCC or placed in a properly addressed and sealed envelope and mailed to the attention of the servicing CCC. Under no circumstances will the ADAPCP Referral and Screening Record be forwarded in any other manner than described above. This will be done for all soldiers referred to the ADAPCP for an initial screening interview. The completed record will be maintained in the ADAPCP client case file.

### 7-7. ADAPCP Client Intake Record (CIR) (RCS CSGPA-1400-R2) (DA Form 4465)

a. DA Form 4465 (fig B-2) will be completed for each client who is to receive a medical evaluation or who is enrolled in any track of the ADAPCP. The ADAPCP staff will prepare DA Form 4465 (the CIR) prior to medical evaluation or upon enrollment. The ADAPCP staff will ensure proper internal distribution of the form when medical evaluation or enrollment in the ADAPCP is completed.

b. The CIR will be completed in triplicate for all soldiers and duplicate for civilian employees and other clients. Upon completion of the CIR for enrollment, the ADCO will authenticate the form. The ADAPCP staff will ensure proper distribution.

c. Distribution of completed CIRs.

(1) The original CIR for all clients enrolled in the ADAPCP will be forwarded to the Director, USADAOA. Any record or report forwarded to USADAOA (DAMIS) with incomplete or incorrect data will be returned to the ADCO for completion or correction. Under no circumstances will the original contain the client's name or duty unit/office.

(2) The original CIR for soldiers screened and/or medically evaluated, and not enrolled also will be forwarded to Director, USADAOA. All other copies and the DA Form 2496 will be placed in the inactive section of the ADAPCP Client files.

(3) A copy of the CIR will be placed in each enrolled individual's ADAPCP client case file.

(4) A copy of the CIR will be filed in the soldier's health record that is maintained by the MTF which provides the primary health care. (See AR 40-66.)

(5) Any additional copies not necessary for the above described distribution will be destroyed.

(6) Additional reproduction and distribution of completed CIRs is prohibited.

(7) ADAPCP services will be available for all former ADAPCP clients. Re-enrollment in the ADAPCP requires the submission of a new CIR and will be treated as a new case for administrative reporting.

### 7-8. ADAPCP Client Progress Report (CPR) (RCS CSGPA-1400-R2) (DA Form 4466)

a. DA Form 4466 (fig B-3) will be used for all clients enrolled in the ADAPCP with

a CIR. For clients enrolled in Track I, a CPR will be completed at the end of Track I. For Track II and III clients, DA Form 4466 (CPRs) will be completed at the termination of rehabilitation or at 90-, 180-, 270-, or 360-day anniversary dates of enrollment in the ADAPCP. Any client moving from Track I to another track or from Track II to Track III must have a CPR completed at the time of transfer indicating the new track. Clients will not be transferred from Track III to Track II or I. Clients leaving an inpatient status (Trk III) will go to followup and a CPR will be completed. Transfers between tracks will be explained in the remarks section of the CPR. CPRs of clients administratively released from the program should be clearly marked as released from the program or as 4th CPR and program completed. No reporting is required beyond 360 days unless the client is re-enrolled by submission of a new CIR. If re-enrolled, CPRs are required at times and intervals previously described. A CPR is also required for all Active Army soldiers who are either a PCS loss or gain to an installation or activity (para 7-9).

b. The CPR for soldiers will be prepared by the ADAPCP counselor in consultation with the unit commander. The unit commander will provide an evaluation of duty performance and conduct as part of each CPR. On the termination CPR, the unit commander must authenticate the individual's status and progress in rehabilitation. The ADAPCP counselor may request information pertinent to the client from other ADAPCP staff members, military law enforcement officials, medical personnel, and other military or civilian personnel within DOD as required. Inquiries to non-DOD personnel or agencies are not authorized without the soldier's consent. The ADAPCP counselor will obtain all information for completion of the CPR from the soldier's unit commander. The use of written reports or telephone contacts is discouraged when it is possible to obtain the information through personal contact with the commander. Termination CPRs will be signed personally by the soldier's unit commander.

c. The CPR for civilian employees in the program will be prepared jointly by the employee's ADAPCP counselor and the CPC. The CPC will provide an opinion of the employee's progress as of the report date. The CPC's input will be based upon input from the civilian employee's supervisor provided the civilian employee gives consent for contact with the supervisor and the statement has been signed or consent has not been withdrawn. ADAPCP personnel are not authorized to request information directly from the civilian employee's supervisor, except through the CPC who may, if appropriate, arrange ADAPCP consultation with the supervisor named on the client consent form.

d. The CPR for other personnel participating in the program will be prepared jointly by the individual's ADAPCP

counselor and the clinical director. Input for the CPR, in these cases, will be limited to information gathered during the clinical treatment of the individual.

e. Distribution of the completed CPR is identical to that for CIRs (para 7-7c). Exceptions are soldiers who are either a PCS loss or gain to an installation ADAPCP. For PCS loss or gain CPRs see paragraph 7-9. Under no circumstances will the original CPR contain the client's name or duty unit/office.

f. Additional reproduction and distribution of completed CPRs is prohibited.

### 7-9. Reassignment while enrolled in the ADAPCP (PCS loss or gain)

a. A commander may suspend PCS movement for up to 30 days to enable a soldier to obtain necessary rehabilitation services. The ADCO will monitor soldiers departing the rehabilitation program until they are officially enrolled in the ADAPCP at the gain installation. Normally, individual soldiers receiving Track III treatment will not be transferred prior to completion of the treatment phase of the program. Track III provides residential treatment for a minimum of 6-8 weeks duration with a mandatory nonresidential followup period of a minimum of 44 weeks, or a total treatment program of 1 year. Followup services are provided by the local servicing ADAPCP. This program can be shortened only through client discharge from the military service. If needed, additional client time in Track III will be determined by clinical assessment. Clients enrolled in Track III will not be required to PCS until the year's program is complete, without a special waiver from HQDA. Installation ADCOs will provide the effective date of stabilization, that is, date of enrollment into residential treatment phase, to the soldiers servicing MILPO (AR 614-5, table 2-2).

b. Upon the soldier's departure for the new assignment, the ADAPCP counselor will prepare DA Form 4466. This will serve as a PCS loss report. It will be prepared for all soldiers who require further rehabilitation:

c. Distribution of the completed PCS loss report will be made as follows:

(1) The original PCS loss report will be forwarded to USADAOA (DAMIS). Under no circumstances will the original contain the soldier's name or duty unit/office.

(2) A copy of the PCS loss report will be placed in the soldier's health record.

(3) A second copy of the PCS loss report will be forwarded by first class mail to the gaining installation ADCO. Included will be information outlined in figure 7-1. For mailing addresses see table B-1.

d. Upon receipt of the PCS loss report and the client information, the gaining installation ADCO will contact the local in-processing facility or the commander of the soldier's new unit. This is to ensure continuation in the ADAPCP at the new installation.

When soldiers are received by the gaining ADAPCP, the gaining ADCO will prepare a PCS gain report using DA Form 4466. Distribution will be as follows:

(1) The original PCS gain record will be forwarded to USADAOA (DAMIS) per paragraph 7-10.

(2) A copy will be placed in the individual soldier's health record.

(3) Another copy will be forwarded, by first class mail to the losing installation ADCO. Included will be a request for the soldier's complete ADAPCP client case file (fig 7-2).

f. Upon receipt of the request, the losing ADCO will forward the soldier's complete ADAPCP client case file to the gaining ADCO.

g. When the losing installation ADCO cannot determine 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 only a duty unit mail address, the losing ADCO will forward only the required information in figure 7-3 to the soldier's new commander.

(2) For soldiers whose oversea assignment instructions fail to list a specific duty unit and indicates assignment to a replacement activity, the losing installation ADCO will forward information to the replacement activity commander specified in the individual's orders (fig 7-4).

h. No information that would identify the soldier as an ADAPCP client will appear on the mailing envelope. The return address will not indicate ADAPCP or CCC. Correspondence to the commander of the replacement activity will include a request that the information pertaining to the soldier be immediately forwarded to the commander of the soldier's new unit of assignment.

i. Normally, client information on participation in the ADAPCP is forwarded from ADCO to ADCO. In no instance will the client's case file be forwarded to anyone other than the gaining ADAPCP.

j. Upon receipt of the information forwarded by the losing ADCO, the commander's enrollment of the soldier will be automatic, if rehabilitation has not been completed. The new commander will then coordinate with the ADAPCP counseling staff regarding the client's rehabilitation plan.

### 7-10. Procedures for special situations

a. TDY soldiers who are absent from their permanent duty station for 31 days or more will be processed according to the PCS transfer procedures.

b. Clients admitted to an installation MTF or to a local (short-term) military or civilian confinement facility will be continued in the local program. ADAPCP counselors will go to the client's location. CPRs will be submitted as usual.

c. Clients admitted to an RTF will be continued in the local ADAPCP for reporting purposes. CPRs will be submitted as usual.

d. For soldiers transferred from the local ADAPCP to a correctional facility, the PCS transfer procedure applies. Exceptions are for individuals who are being separated/discharged from the Army and require a program termination CPR to USADAOA (DAMIS).

e. Former (soldiers) clients returned to military control from deserter status will be treated as new clients. Item 18, CIR will be checked "Army." Such clients will be required to restart and complete the rehabilitation program.

f. Submission of termination CPR to USADAOA (DAMIS) by oversea ADCO is required for clients returned to CONUS for separation.

### 7-11. Deletion of erroneously identified clients from the ADAPCP

If a client's entry into the ADAPCP is discovered to have been in error, the ADCO will cease submission of CPRs. The ADCO will terminate the case by forwarding a written request to USADAOA (DAMIS) to delete the record from the data files. Requests will contain only the client ID code, initial MTF code, and the reason for termination. Deletion request will be signed by the requesting ADCO.

### 7-12. ADAPCP record transmission

The ADCO is responsible for the scheduled transmission of authenticated CIRs (DA Form 4465) and CPRs (DA Form 4466) to USADAOA. The original CIRs and CPRs will be compiled and forwarded weekly to USADAOA. (See fig 7-5 for a sample letter of transmittal.)

### 7-13. Management information feedback reports

a. Direct communication between Director, USADAOA and ADCOs is authorized. A file of aggregate ADAPCP data will be maintained as a source of information essential for program management, evaluation, and research. This data will be based on the weekly submission of CIR, CPR, PCS loss or gain records, and the monthly ADAPCP Summary.

b. In addition to receiving quarterly management reports, each ADCO will receive periodic feedback reports directly from USADAOA. This is for the purpose of maintaining an accurate data base. Included will be an indication of the number of clients contained on the data base. The reports will show current reporting status, including overdue progress reports and incomplete PCS loss and gain transactions.

### 7-14. Other management information reports

Other reports, particularly those required for budget or resource actions, may be required from time to time. Requests for all reports and surveys will be coordinated with

MACOMs and submitted through the MACOMs with 30-45 days advance notice wherever possible.

### Section III Internal Administration

#### 7-15. General

Unless otherwise specified, the term "client" used in terms of procedures, refers to soldiers civilian employees and other participants enrolled in the ADAPCP.

#### 7-16. Responsibilities

The ADCO will—

a. Ensure that an ADAPCP referral and screening record (DA Form 2496) is received for all soldiers who are referred to the ADAPCP by their commander, or who self refer.

b. Ensure that DA Form 5017-R is signed by the employee before information is released to the named supervisor through the CPC.

c. Ensure that a CIR is prepared for each client that receives a medical evaluation or is enrolled in any track of the ADAPCP. Also ensure that a partial CIR is prepared on individuals screened, but not enrolled.

d. Ensure that a CPR is prepared; when required, for all clients enrolled in any track of the ADAPCP.

e. Authenticate and ensure proper distribution of individual CIRs and CPRs for all clients participating in the ADAPCP.

f. Notify the gaining installation ADCO of a soldier's projected PCS.

g. Forward individual soldier case files to the gaining installation ADCO and ensure that they have been received.

h. Have administrative responsibility for maintaining ADAPCP client case files. This includes proper recording, security, confidentiality, and destruction per this regulation and AR 340-18-9, AR 40-66, and professional and ethical standards.

i. Ensure that ADAPCP staff urinalysis is carried out according to current DOD requirements. Ensure that all civilians employed in the ADAPCP are aware of this requirement and have a signed condition of employment statement on file in their ADAPCP personnel file as well as with the CPO.

j. Ensure that a formalized ADAPCP log is maintained by the ADAPCP staff. This log will contain a record of all clients referred by others or referred by themselves (walk-in) for any services. The information solicited from the potential client to enter in the log is covered by the Privacy Act. A Privacy Act statement for the ADAPCP log is shown in figure 7-6. The reason for soliciting information will be explained to each potential client. Each potential client will be given the opportunity to read the provisions of the Privacy Act Statement shown in figure 7-6. The ADAPCP log is for the purpose of documenting work load accurately. It will be an internal record of the number of contacts and man-hours expended in the initial screening process. The ADAPCP log

will be treated as though it were a client case file and therefore will be maintained in a secure area when not in use. The ADAPCP client log will record by date and source of referral only the following information on clients or potential clients:

- (1) Soldiers referred or self-referred.
  - (a) Name.
  - (b) Rank.
  - (c) Social security number.
  - (d) Service provided; that is, screening.
  - (e) Disposition of the referral; that is, enrollment, unit counseling; no ADAPCP services required or other disposition.

(2) For Army and NAF civilian employees referred or self-referred (listed separately from soldiers) list the following:

- (a) Name.
- (b) Date of birth and first three numbers of SSN.
- (c) Reason for referral (for example, alcohol problems, family problems, children's drug use).
- (d) Service provided; that is screening or information services.
- (e) Disposition of the referral, that is, enrollment for counseling (specify whether for alcohol abuse, drug abuse, or other emotional disorder associated with alcohol or other drug abuse); no ADAPCP services required; or referral to another agency.

(3) Other clients (listed separately from soldiers and Army and NAF civilian employees):

- (a) Name.
- (b) Date of birth.
- (c) Reason for referral; that is, alcohol problems in the family, children's drug use, etc.
- (d) Service provided; that is, screening, information or intervention.
- (e) Disposition of the referral; that is enrollment, no ADAPCP services required, or referral to another agency.

k. The Clinical Director will—

- (1) Review all CPRs for clinical and administrative accuracy before submission to the ADCO.
- (2) Provide technical guidance and training to subordinate counselors for recording individual and group counseling sessions in client case files.
- (3) Ensure that personal client information entered in case records is appropriate and necessary.

l. The MEDCEN/MEDDAC commander will—

- (1) Ensure that the health records of newly assigned soldiers are screened for possible evidence of untreated alcohol or other drug abuse (or a diagnosis thereof) within the previous 360 days.
- (2) Ensure that ADAPCP clients case files are maintained and disposed of as medical records per AR 340-18-9
- (3) Be responsible for the release of information from ADAPCP client case files.
- (4) Ensure that periodic assistance and coordination is provided to the ADAPCP staff through the local MEDCEN/MEDDAC Patient Administration Division (PAD).

#### 7-17. ADAPCP client case files

ADAPCP clients case files are medical records and will consist of official ADAPCP forms and case notes recorded on SF 600. For legal reasons, no other official forms will be created without MACOM and DA approval. Any exceptions to policy will be approved by the ODCSPER (HQDS, DAPE-HRA WASH DC 20310). Clinical correspondence and reports from outside agencies will be maintained in clients case files. Every document contained in an ADAPCP client case file will comply with the requirements of the Privacy Act of 1984.

#### 7-18. ADAPCP client case filing procedures

a. ADAPCP clients case files will be maintained in two categories.

(1) *Active client case files.* These files will include clients being seen on a regular, scheduled basis. Clients in residential facilities will be included in the active case file during residential treatment and until the end of all counseling activities.

(2) *Inactive client case files.* Inactive clients and clients pending transfer of record (PCS) will be maintained in the inactive files. Inactive clients include former enrollees or those who were screened and returned to units with no further action indicated. Former participants of Tracks I, II, or III are filed in the inactive files when not receiving followup, supportive counseling services.

b. Access to individual ADAPCP clients files will be restricted to the following:

- (1) ADCO.
- (2) Rehabilitation staff members.
- (3) AMEDD personnel concerned with treatment of individual client cases and evaluators who will be charged with determining the extent of compliance with this regulation. Specifically, these are DA and MACOM AMEDD personnel, detailed inspectors general, and appropriate AMEDD personnel participating as members of official inspection teams.

c. MEDCEN/MEDDAC commanders may authorize research personnel, on a project-by-project basis, to extract information from client case files. This is allowed only if there is compliance with restrictions imposed by AR 40-66 and this regulation.

#### 7-19. Federal Employees Occupational Health, Alcoholism and Drug Abuse Programs; Annual Report (NARS 0058-OPM-AN)

Civilian Program Coordinators (CPCs) will prepare the OPM Alcoholism and Drug Abuse Annual Report. Installation reports will be submitted by letter through command channels to the MACOM normally during the month of December following the close of the fiscal year. MACOMs will submit a consolidated report; together with the individual installation or activity reports, to HQDA (DAPE-HRL), WASH DC 20310. Suspend dates and guidance for

submission of the report will be announced each year by the ODCSPER, HQDA.

## Chapter 8 Evaluation

### 8-1. General

Operation of the ADAPCP must include a comprehensive program of evaluation. The following guidelines address minimum evaluation standards. Evaluation will—

- a. Stress the impact of the program on the recipients.
- b. Be primarily objective rather than subjective.
- c. Attempt to compare the relative effectiveness of the various approaches to prevention and rehabilitation.
- d. Consider guidance contained in FPM Supplement 792-2, appendix B, concerning civilian aspects of the ADAPCP.
- e. Ascertain the relative effectiveness of various approaches with different target groups.

### 8-2. Objectives

Program evaluation will—

- a. Ensure integration of all facets of the ADAPCP at every level of command.
- b. Permit priority setting among program efforts and alternatives.
- c. Provide feedback as a basis for program improvement and allocation of scarce dollar and staff resources for economy and efficiency.
- d. Identify areas for possible research by HQDA.

### 8-3. Concept

a. Evaluation is an integral part of program planning, decision-making, and management. It is intended to help administrators and managers at all levels of the Army make informed decisions by communicating available program alternatives and alternatives that are most applicable for their particular circumstances. Evaluation will—

- (1) Determine if program objectives are being met and provide the flexibility for change as goals are met.
- (2) Determine program effectiveness and efficiency, including client perceptions.
- (3) Obtain data for development of policies and procedures and resource requests or allocations.
- (4) Determine problem areas and need for technical assistance at specific installations or commands.
- (5) Determine compliance with pertinent directives.
- (6) Determine what effect the program has or what difference it makes.

b. Evaluation cannot be based solely on the compilation of statistical data. Records and reports represent only one facet in the index of program progress. To be effective, evaluation must be combined with planning and programming. Program indicators are

prevalent at all command levels for both subjective and analytical information.

### 8-4. Responsibilities

a. The ODCSPER, HQDA (DAPE-HRL) will maintain a continuous objective evaluation based on reports submitted. MACOMs will submit copies of all trip reports on MACOM assistance visits to USADAOA. Staff assistance visits will be made by USADAOA when onsite evaluation of installation ADAPCPs are desired by ODCSPER, HQDA. Staff assistance visits by USADAOA will be coordinated through the MACOM alcohol and drug control office.

b. Each MACOM commander will maintain a continuous assessment of the ADAPCP through reports, staff visits, and drug and alcohol assistance teams. DA Form 3711-R and inspector general reports should be used to assist in programming and structuring staff and team visits. Additionally, development of a Program Evaluation Worksheet is recommended for use as the basis for continuing local program evaluation. Accurate and current information should allow ADAPCP personnel to correct program deficiencies and to improve overall program effectiveness. If automated data processing is used in program evaluation, methods must be formulated to preclude identification of individuals and to preserve confidentiality.

### 8-5. USADAOA

a. Representatives of USADAOA will visit installations and activities upon the request of the commander. This will be done with a view to providing technical support and assistance as determined by the installation commander. (See AR 10-78.)

b. USADAOA visits will normally be made after the annual MACOM assistance team's visit and will be coordinated with the MACOM alcohol and drug control office.

### 8-6. MACOM assistance teams

a. *General guidance* Each MACOM commander will establish an assistance team to visit selected subordinate installations and activities on a regular basis. The team will—

- (1) Determine if program objectives are being met.
- (2) Explain program policy.
- (3) Respond to queries.
- (4) Collect and disseminate information.
- (5) Make recommendations on local program operation and organization.

#### b. Procedures.

(1) Assistance teams will visit each subordinate installation or activity within the MACOM area of responsibility a minimum of once each fiscal year. Additional visits may be scheduled as required.

(2) Representatives of HSC will participate in assistance team visits to installations having an HSC MEDCEN/MEDDAC, insofar as possible, and will observe program activities listed in (3)(d) below.

(3) Assistance team visits to installations will include, as a minimum, observations of the following:

(a) *Total program effectiveness.* This includes command support to all levels, administration, organization, management, personnel, and funding.

(b) *Prevention.* This includes law enforcement activities, community action, and preventive education and training efforts.

(c) *Identification and referral procedures.*

(d) *Rehabilitation.* This includes medical support, reports, and records (including intake and followup records).

(e) *All aspects of service for civilian employees.*

(4) Following visits, written reports of significant findings and observations, including recommendations for local program improvement, will be provided to subordinate elements directly or through command channels, depending on local policy.

## Chapter 9 Army National Guard and Army Reserve

### 9-1. General

This chapter prescribes procedures for the implementation and management of the ADAPCP for the ARNG and the USAR.

### 9-2. Applicability for Reserve Components

The provisions of this chapter are applicable to members of the ARNG and USAR when not on active duty or any type of (ADT) (other than annual training) or attending annual training in accordance with AR 140-1 or NGR 350-1. This applies regardless of whether the members are in a State or Federal status during such training.

### 9-3. Background and policy

a. Alcohol and drug abuse has been documented as a serious problem in the active services and in civilian society in general. It is reasonable to conclude that such problems have an impact on soldiers in the ARNG and USAR.

b. The focus of this program centers on the impact that alcohol and other drug abuse may have on the performance of Reserve Component (RC) soldiers. Alcohol and other drug abuse may affect the performance of an individual soldier, but the actual use or abuse of the substance may never be witnessed by the commander. This is especially true in the normal RC setting of infrequent personal contact, limited principally to period of inactive duty training.

c. It is important that commanders be alert to potential failure in performance due to alcohol and other drug abuse and that they take timely and appropriate action when problems are identified. The emphasis of the program is that alcohol and other drug abuse are treatable and preventable. Successful rehabilitation is encouraged and

supported. However, if rehabilitation fails, separation action may be taken, if appropriate. (See AR 135-178.)

d. The detrimental effect that alcohol and other drug abuse can have on individual performance and on unit readiness is strong reason for an effective ADAPCP in the ARNG and USAR. This is especially so in light of increased mobilization demands placed on the RC by the Total Force Policy.

#### 9-4. Responsibilities

To assure unit readiness for mobilization, in accordance with Total Force Policy, the Chief, National Guard Bureau (CNGB), is responsible for development and implementation of an effective ADAPCP in the ARNG. The CG, U.S. Army Forces Command (FORSCOM), is responsible for development and implementation of an effective ADAPCP in the USAR.

#### 9-5. Implementation

The basics of the RC ADAPCP will include prevention, identification, referral, and followup.

##### a. Resources.

(1) ARNG. Each State adjutant general will appoint a State ADAPCP coordinator, on a collateral duty basis, to coordinate the program for the State.

(2) USAR. Each Army and Major U.S. Army Reserve Command (MUSARC) commander will appoint an ADAPCP coordinator, on an additional duty basis, to coordinate the program for the command. ADAPCP coordinators should be mature, stable personnel. They should have had previous education or experience in the area of alcohol and other drug abuse prevention, control, rehabilitation counseling, or related fields.

##### b. Prevention.

(1) Commanders, staff members, and other members of the chain of command must be aware of the contributory factors which lead to alcohol and other drug abuse. This awareness must be developed through preventive education and improved communication.

(2) The primary means of disseminating education information on the ADAPCP will be through the Command Information Program. The National Guard Bureau (NGB) and Office of the Chief, Army Reserve (OCAR) will provide command information material to support the ADAPCP. This will include learning objectives and instructional guidance and information regarding training resources. In addition, maximum use will be made of support materials available through Active Army channels. All information and materials utilized will have the approval of the DOD Media Committee.

(3) The RC ADAPCP coordinators will be provided training to administer the program through special RC ADAPCP training courses. These will be developed jointly by ODCSPER (DAPE-HRA), NGB, and OCAR.

(c) Identification. The key to identification of alcohol and other drug abusers will be their duty performance.

(1) Voluntary identification. Commanders should strive to maintain an atmosphere which encourages alcohol or other drug abusers to identify themselves and ask for assistance.

(2) Involuntary identification. Commanders should be alert to the following:

(a) Deteriorating duty performance.

(b) Errors in judgment.

(c) Periods of being unfit duty.

(d) Increasing incidence of disciplinary, health, and personal problems.

(3) Assistance. When it is believed that the above circumstances are caused by alcohol or other drug abuse, commanders should seek assistance from the ADAPCP coordinator. They should advise the individual to seek help from an appropriate community program for professional assistance.

##### d. Referral.

(1) The RC ADAPCP coordinator will develop a list of local resources available in the civilian community from which RC soldiers may voluntarily seek professional assistance. ADAPCP coordinators should take advantage of existing Government contacts in developing referral lists. This may include Active Army or other Services installations with ADAPCP resources, Air National Guard (ARNG), Drug and Alcohol Social Actions offices of ARNG flying units, and alcohol and drug offices (agencies) in State and local government. Information or availability of local resources may also be obtained by writing the National Institute for Alcoholism and Alcohol Abuse (NIAAA), and the National Institute for Drug Abuse, (NIDA), both located in Rockville, Maryland 20857.

(2) Emphasis in the referral program will be on positive encouragement of the individual to change and positively influence his or her job performance. Performance will be the major criteria for judging improvement or success in this program.

##### e. Followup.

(1) In cases where individuals are successfully rehabilitated and duty performance is improved to a satisfactory level, the individual should continue normal duty in the unit. He or she should be provided appropriate encouragement, assistance, and support.

(2) In cases where successful performance is not achieved after attempts at local rehabilitation or in cases where an individual refuses rehabilitation assistance, elimination action under appropriate USAR or ARNG regulations shall be considered.

f. Annual training. ARNG and USAR personnel on AT status may seek assistance from the ADAPCP at the training installation. The local ADAPCP will provide whatever resources are available to assist RC personnel on AT status within the scheduled AT period. The ADAPCP will coordinate with the appropriate RC commanders to facilitate necessary referral or

followup action that takes place after the AT period.

g. Full-time military tours. ARNG personnel on full-time military tours (title 32 USC or title 10 USC) and USAR personnel on full-time military tours (title 10 USC) are eligible for assistance from local ADAPCP resources on a full-time basis.

h. Applicants for RC membership. Chronic alcoholism, alcohol dependency, and other drug dependency are causes for enlistment rejections, in accord with AR 40-501 and NGR 40-501. Such causes for rejection will not apply to individuals with demonstrated, successful recovery.

#### 9-6. Urinalysis testing

a. Urine testing is authorized during annual training (AT) or inactive duty training (IDT) for all USAR and ARNG personnel assigned to aviation position. Such testing will be administered following the procedures set forth in chapter 10 and appendix E of this regulation.

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

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

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

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

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

## Chapter 10 Biochemical Testing

### 10-1. General

a. The DOD Biochemical Testing Program was established in 1971 by the Secretary of Defense and is promulgated by DOD Directive 1010.1. Each of the services is required to implement procedures for biochemical testing to screen for drug abuse of detectable drugs. Procedures are established

for commander and physician directed testing. Biochemical testing of urine can detect various drugs, including amphetamines, barbiturates, opiates, methaqualone, phenylcyclidine, cannabis, and cocaine with a high degree of specificity. Therefore, a product containing any of these drugs even if taken into the body several days prior to the test, may yield a positive result.

b. Policy. It is Army policy to use biochemical testing to—

(1) Preserve the health of soldiers of the U.S. Army by identifying alcohol or drug abusers in order to provide appropriate counseling, rehabilitation, or other medical treatment.

(2) Permit commanders to assess the security, military fitness, good order, and discipline of their commands and to take appropriate action based upon such an assessment.

c. Objectives. The objectives of biochemical testing are as follows:

(1) Early identification of alcohol or drug abuse.

(2) Deterrence of drug abuse.

(3) Monitoring of rehabilitation progress for those who require testing as part of their rehabilitation plan.

(4) Development of data on the prevalence of alcohol and drug abuse within the Army.

### 10-2. Purpose of testing.

Biochemical testing for controlled substances or alcohol is a tool for the commander to use for the purpose listed in a through g below. In addition, biochemical testing is a tool for the physician to use for the purpose listed in a, b, and e below. Individuals may use an alcohol breath test for the purpose listed in g below. Tests may be taken—

a. To determine a soldier's fitness for duty and the need for counseling, rehabilitation, or other medical treatment.

b. To determine the presence of controlled substances in a soldier's urine or blood content during participation in the ADAPCP.

c. To gather evidence to be used in actions under the UCMJ.

d. To gather evidence to be used in administrative actions.

e. To determine the presence of controlled substance in a soldier's urine or blood content for a valid medical purpose.

f. To determine the presence of controlled substance in the urine soldiers or the blood alcohol content during inspections.

g. To serve as a safeguard at social gatherings where alcoholic beverages are served to individuals who might otherwise not realize how much alcohol they have consumed.

### 10-3. Testing programs

a. *Commander-directed.* Commanders may direct individual soldiers, parts of units, or entire units to submit to urine testing or alcohol breath testing in one or more of the ways listed below. The decision to

test is a command judgment. Urine and alcohol tests will be conducted at the unit or elsewhere as the commander directs. Commander-directed urine tests will be administered by the unit alcohol and drug coordinator (UADC) following the procedures set forth in appendix E. Soldiers must be directly observed when providing urine specimens as required in appendix E; however, they will be accorded maximum respect and concern for human dignity as much as possible under the particular circumstances. Coordination with the ADCO is necessary to ensure that adequate laboratory support and supplies are on-hand to support the planned testings.

(1) When there is reasonable suspicion that a soldier is using a controlled substance or has a blood alcohol level of .05 percent or above while on duty, a urine or alcohol breath test for the valid medical purpose under Military Rule of Evidence 312(f) of determining the soldier's fitness for duty and the need for counseling, rehabilitation, or other medical treatment. (See paras 6-4, and table 6-1 for limitations on use of the results produced by this method.)

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

(3) A urine or alcohol breath test of part of the unit, or entire unit, as an inspection under Military Rule of Evidence 313.

(4) A urine test of all personnel assigned to aviation, military police positions, and personnel who are members of the Nuclear or Chemical Personnel Reliability Program as part of an inspection under Military Rule of Evidence 313 a minimum of once a year. Testing can be on an individual basis. Aviation specialties which require annual testing are listed in paragraph E-17.

b. *Physician-directed.* Physicians may direct a soldier patient to submit to a urine or alcohol breath test—

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

(2) For any other valid medical purpose.

c. *Rehabilitation testing.* Testing during rehabilitation or treatment will be performed for the following categories:

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

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

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

d. *ADAPCP staff testing.* Military and civilian alcohol and other treatment staff personnel whose duties involve direct contact with clients will be tested periodically at the discretion of the ADCO on an unannounced basis. Applicants for civilian positions must be notified before they are employed that their position in the ADAPCP will require urinalysis as a continuing condition of employment. A current listing, by name, position, title, and position number of those to be tested will be maintained by the ADCO but will not be posted on the staff bulletin board. 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.

### 10-4. Responsibilities

a. The DCSPER will provide Army General Staff supervision of biochemical testing to include coordination with TSG, TJAG, and the appropriate MACOMs for quarterly quality assurance inspections of each Army and contractor drug testing laboratory. A report of each inspection will be provided to the OASD (HA).

b. TSG will—

(1) Provide the Forensic Toxicology Drug Testing Laboratory (FTDTL) capability to support the Army's biochemical testing responsibilities.

(2) Prescribe the methodology to be used by the Army laboratories supporting testing, to include issuance of standardized forensic toxicology drug testing laboratory operating procedures for use in all Army and contract laboratories which will establish standards and/or procedures for the following:

(a) Intralaboratory chain-of-custody.

(b) Initial (screening) test, confirmatory test and retests for each drug analyzed.

(c) An internal quality control program consisting of standards and controls of at least 10 percent of the total number of urine specimens analyzed on a monthly basis.

(d) Submit through the DCSPER (DAPE-HRL-A) to ASD (HA) a copy of the standard procedures, and any subsequent changes for approval.

(3) Provide technical guidance for the collection and shipment of specimens.

(4) Collect and evaluate biostatistical data related to testing and provide to USADAOA on a monthly basis. This data will include the following at a minimum:

(a) Total specimens received.

(b) Total specimens tested by drug type.

(c) Total initial (screening) positives by drug type.

(d) Total confirmed positives by drug type.

(e) Number of specimens that were not testable because of an insufficient quantity or handling errors.

(f) For each positive specimen reported, information regarding the category of urinalysis and an appropriate code for the grade/rank of the tested soldier.

(g) Forensic Toxicology Drug Testing Laboratories will also monitor, and report separately, all prescreened specimens. (See para 10-4b (4) to include total number received and number confirmed.)

c. MACOM Commanders will—

(1) Coordinate and monitor biochemical testing within their command.

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

(3) Designate points at appropriate locations to collect and ship specimens to the servicing laboratory.

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

(5) Allocate available urinalysis quotas within their command and monitor utilization.

d. Installation commanders will—

(1) Appoint an officer, normally the ADCO, as Installation Biochemical Test Coordinator and installation point of contact.

(2) Establish and maintain coordination with the laboratory providing support to the installation.

(3) Ensure that the installation biochemical testing conforms to DA policy in this regulation, to include chain of custody procedures and the installation prescreening program.

(4) Establish procedures to inform unit commanders of all laboratory positive results concerning personnel in their unit in the most expeditious way possible.

(5) Establish a biochemical collection point, administered by the IBTC, to review chain of custody documents and specimen bottle labels for completeness and accuracy (app E) package for shipment, and ship urine specimens in accord with procedures in this regulation.

e. Unit commanders will—

(1) Appoint one or more soldiers, grade E-5 or above, to serve as unit alcohol and drug coordinators. These soldiers should possess sufficient skill, integrity, and maturity to carry out the highly sensitive duties required, as well as have maximum retainability to stabilize the position.

(2) Designate one or more soldiers, grade E5 or above, to serve as observers during urinalysis. Observers should possess sufficient maturity and integrity to ensure that urine specimens they observe being provided are not contaminated or altered in any way. Where possible, observers should be superiors in the chain of command of the soldiers being observed (for example, squad leader, section leader, platoon sergeant, platoon leader, first sergeant, and so forth).

(3) Ensure that commander-directed urine tests and breath tests conform to the provisions of this regulation.

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

(5) Ensure that those positive specimens that will be used in UCMJ or adverse administrative actions are retained by the FTDTL until the action is complete. Supporting staff judge advocates should be consulted to determine when UCMJ and adverse administrative actions are complete for the purpose of retaining positive specimens. (Examples of completed actions include nonjudicial punishment under Article 15, UCMJ, which is complete on the date punishment is imposed; courts-martial are complete on the date approved by the approving authority.) The FTDTL will automatically retain positive specimens for a period of 60 days from the date the laboratory certifying official signs DA Form 5180-R (Urinalysis Custody and Report Record) containing the results for the particular specimen. A completed sample of this form is shown at figure E-1. Instruction for completing the form are also shown in figure E-1. DA Forms 5180-R will be locally reproduced on 8½-by-11-inch paper. This form is located at the back of this regulation. If retention beyond this 60-day period is necessary, the unit commander will send an electronic message or letter to the laboratory requesting the positive specimen to be retained. In response to this request, FTDTL will retain the specimen for an additional 120 days after the end of the initial 60-day period. Should retention beyond this total period of 180 days be necessary, the unit commander must request an additional period of retention. This request must specify the period for which the specimen is to be retained and provide justification for this additional period.

f. Trial counsel will ensure that personnel from FTDTLs required to testify in courts-martial are given a minimum of 10 days notice before the trial date unless otherwise directed by order of a military judge. Notice will be given by electronic message. The message will include a fund cite for travel and TDY.

g. Army Forensic Toxicology Drug Testing Laboratories and contract laboratories will—

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

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

(3) Test all urine specimens in accordance with the requirements of DOD Directive 1010.1, the requirements of OTSG, and the standard forensic toxicology drug testing laboratory operating procedures.

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

(5) Within 10 duty days after receipt of specimens, report results to the originating

unit by message. A copy of the message will be submitted to the Armed Forces Institute of Pathology. The completed DA Form 5180-R, (fig E-1), will also be dispatched at this time to the originating unit. If MINIMIZE is in effect, data will continue to be transmitted by electrical means. Reports will specify which specimens were confirmed positive and which were negative. No further information concerning negative specimens shall be reported to the originating unit.

(6) Establish and maintain direct technical liaison with other testing laboratories for purposes of standardization of methodology and the exchange of technical information which may be of mutual benefit.

(7) Develop and publish a standard operating procedure (SOP) manual as directed by OTSG. This manual shall be submitted to OTSG (DASG-PSC-L) for approval. Copies of this manual and all changes thereto will be provided to ASD (HA).

(8) Retain all documents or certified copies, pertaining to all positive test results at the FTDTL for at least 5 years from the date of the results report. At the end of 5 years, these records will be disposed of as prescribed by the Adjutant General for administrative records. These documents include all chain of custody documents, record of initial tests, confirmatory tests and retests for positive specimens.

(9) Provide data in format required, for the Drug and Alcohol Management Information System (DAMIS) for the purpose of tracking, comparison of trend data and accountability.

(10) Disposition of Specimens.

(a) All negative specimens will be discarded.

(b) Specimens confirmed positive and that are not used up in the testing process will be retained in a frozen state for period of 60 days following the issuance of the positive results report. Positive specimens will be retained for an additional 120 days when requested by the originating unit. (See para 10-4e.

## 10-5. Collection and transportation of urine specimens

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

b. All urine specimens must be handled by following a formal chain of custody. The chain of custody must account for each individual urine specimen in groups of 12 or less from the time of collection of the urine specimens until final analysis at the drug testing laboratory.

(1) The number of persons handling each specimen will be kept to a minimum to protect the integrity of the specimens.

(2) At the installation level, all urine specimens will be handled following the SOP set forth in appendix E.

(3) At the drug testing laboratories, all specimens will be handled following procedures established by OTSG

c. Collection of urine specimens will be accomplished in a manner and under circumstances conducive to the preservation of human dignity as much as possible.

(1) Specimens will be collected in Bottle, Urine Specimen, Shipping, 120s: U/I—Package, national stock number (NSN) 6640-00-165-5778. Optional use of the wider mouth nonsterile specimen container cup, NSN 6530-01-048-0855, is authorized for collection of urine specimens from female service members. (See para E-6.)

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

(3) DA Form 5180-R (RCS CSGPA 1687) will be used to account for all specimens and will be forwarded with the specimens as set forth in appendix E. DA Form 5180-R will be reproduced locally on 8½-by 11-inch paper.

d. Urine specimens will be shipped without preservatives or refrigeration to the appropriate drug testing laboratory. It is necessary to ensure delivery at the earliest date and, where possible, 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 U.S. Government bill of lading.

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

(a) Expedited surface transportation.

(b) U.S. Postal Service by first class mail; unless one or more specimens in the shipment were taken as a search or seizure under paragraph 10-3a(2), in which case registered mail will be used.

(c) The military Airlift Command transportation system: nonindustrially funded military organic aircraft.

(d) U.S. flag commercial air freight; air express, air freight forwarder.

(e) By foreign flag air carriers, when none of the transportation means above are available.

### 10-6. Alcohol breath measuring devices (ABMD)

a. *Equipment.* Two basic types of ABMD are authorized for use.

(1) *Portable (mobile) breath measuring devices.* Portable (mobile) breath testing devices may be used only for preliminary screening or educational purposes. The results of a portable ABMD may not be used in any disciplinary or administrative action

unless they are confirmed by a nonportable ABMD or a blood alcohol test, as described below. These devices must be listed on the National Highway Traffic Safety Administration (NHTSA) approved products list published in the Federal Register. This equipment will be operated, calibrated, and maintained in accord with manufacturer instructions.

(2) *Nonportable ABMD (nonmobile) breath testing devices.* Nonportable ABMDs must be on the NHTSA-approved products list. Breath tests using this equipment must be administered by law-enforcement personnel certified to operate equipment in accord with AR 190-5. Test results from this equipment can be used as a basis for administrative or disciplinary action.

b. *Procedures.* Commanders may use portable ABMDs for screening in one or more ways listed in paragraph 10-3a. Screening results are considered preliminary. Before screening results may be used in any administrative action, they must be confirmed by nonportable ABMD or a blood test administered by a medical treatment facility. A confirmatory test may only be administered if the soldier voluntarily consents to the second test (see Military Rule of Evidence 314) or the commander has sufficient evidence for probable cause under Military Rule of Evidence 315. A portable ABMD screening result which indicates impairment is not sufficient probable cause to serve as the basis for the confirmatory test.

c. *ABMD requisitioning.* Purchase authority and basis of issue for ABMD use for ADAPCP purposes is contained in CTA 50-909.

d. *ABMD maintenance.* ABMDs are commercial items of equipment and maintenance and calibration is the responsibility of the purchasing installation.

### 10-7. Urine drug prescreening (field testing)

a. *Overview.* The primary means of testing urine specimens is through a DOD certified laboratory. The use of DOD and DA approved portable and nonportable drug detection systems to prescreen urine specimens at the installation is an acceptable means for making a preliminary determination regarding the absence or presence of drug metabolite in a urine specimen. Expect for negative specimens submitted for internal quality control in accord with paragraph F-3a(4), negative specimens may be discarded. Positive specimens must be immediately forwarded to an FTDTL or Army contract laboratory for testing.

b. *Policy.*

(1) All prescreening must be accomplished under chain of custody as outlined in appendix E and follow operational procedures as outlined in appendix F.

(2) Installations and activities conducting prescreening must have trained and certified equipment operators and a quality control program at the installation. They also must

participate in a quality control (QC) program that is external to the installation. The external QC program will be managed by USADAOA and coordinated through the appropriate MACOM ADCO.

(3) Operator training and certification is an installation responsibility, to include arrangement for the training that has been approved by HQDA and programming for the cost of the training.

(4) Positive prescreening results are preliminary until confirmed as positive by an FTDTL or an Army contract drug testing laboratory or by admission of drug use by the service member.

(5) Prior to receipt of the confirmatory testing results from a drug testing laboratory, or by an admission by the service member, commanders may use positive prescreening results only for the following purposes:

(a) Referral to the ADAPCP Community Counseling Center for screening.

(b) Temporary transfer, removal, or suspension from duty of personnel serving in sensitive duty positions or in positions where drug abuse presents an immediate danger to the safety, health, or welfare of others.

(c) Temporary suspension of access to classified information.

(6) If the prescreened positive result is not confirmed as positive by an FTDTL or Army contract drug testing laboratory or an admission by the service member—

(a) The results may not be used to take further adverse administrative or disciplinary action.

(b) Any temporary action based upon the prescreening results shall be rescinded.

(7) To the extent an action is based upon evidence other than the prescreening result, nothing in b(1) through (6) above precludes continuation of temporary or other appropriate action.

### 10-8. Retesting of specimens

a. Urine specimens may be retested, providing a sufficient quantity of the specimen is available to permit retesting. All requests for a retest will be in writing. Retesting will be accomplished as follows:

(1) Upon request of the submitting installation/command, the soldier, or the attorney representing the service member. All requests must be forwarded through the submitting installation/command to the Army/Air Force laboratory performing the initial test, or through USADAOA in the case of contract laboratories.

(2) Upon request of an administrative board under rules applicable to the board.

(3) Upon order of a court-martial or rules applicable to the court-martial.

b. A soldier may obtain a retest at a forensic laboratory outside the DOD laboratory system at the service member's own expense when a sufficient quantity of the same specimen is available to permit retesting.

## 10-9. Requests for documents

a. FDTL or Army contract laboratory documents pertaining to a positive urinalysis results used in connection with adverse administrative or disciplinary action may be obtained by written request. All requests must identify the documents requested and must be submitted through the soldier's installation/command to the Army/Air Force or contract laboratory which performed the urinalysis. Documents will be furnished at no expense to the soldier as follows:

(1) Upon request of the installation/command, the soldier, or with soldier's consent, the attorney or other designated agent representing the soldier.

(2) Upon request of an administrative board under rules applicable to the board.

(3) Upon order of court-martial or rules applicable to the court-martial.

b. Documents which may be obtained from an FDTL or Army contract laboratory include, but are not limited to the following:

(1) Installation and laboratory chain of custody documents.

(2) The official report of a positive test result.

(3) A description of the analytical methodology.

(4) Results of the analysis of the soldier's sample and of other samples in the batch.

(5) Qualifications of laboratory personnel.

(6) A description of the quality assurance/quality control system.

c. The provision of this paragraph are not intended to, and do not, provide any rights or privileges as to the relevancy or admissibility of laboratory documents that are not otherwise afforded by the UCMJ, the Manual for Courts-Martial, or regulations governing adverse administrative and disciplinary actions. There is no requirement that any proceedings be delayed or postponed receipt of laboratory documents by the soldier concerned. However, such delay should normally be granted when the soldier presents a plausible showing that information in the laboratory documents would be favorable to the soldier. Such evidence may consist of testimony or documents indicating failure to comply with prescribed policies and procedures in the collection, transportation, or testing of urine specimen in question. The possibility that laboratory documents may be favorable to the soldier will ordinarily not be a basis for delay. If a delay is granted, consideration should be given, consistent with applicable rules of procedure, to accomplishing as much of the action (board hearings, etc.) as possible, then staying the proceedings pending receipt of the requested laboratory documentation. In no case will failure to comply with the provisions of this paragraph be used to invalidate an otherwise valid and legally sufficient adverse administrative or disciplinary action.

**Table 6-1.**  
**Use of mandatory urine or alcohol breath testing results**

WAYS a commander may direct urine or alcohol breath test	Referral to ADAPCP	Disciplinary action under UCMJ	Characterization of discharge	Other administrative action (See note 1)
To determine fitness for duty and the need for counseling, rehabilitation, or other medical treatment (See note 2)	Yes	No (See note 5)	No (See notes 5 and 6)	Yes
Participation in ADAPCP	Yes (See note 3)	No (See note 5)	No (See notes 5 and 6)	Yes (See note 4)
Search or seizure under Military Rules of Evidence 312, 314, 315 and 316	Yes	Yes	Yes	Yes
As part of a military inspection under Military Rule of Evidence 313	Yes	Yes	Yes	Yes
Ways a physician may direct urine or alcohol breath tests:				
Ascertain whether a soldier requires counseling, treatment, or rehabilitation for drug or alcohol abuse	Yes	No	No	Yes
Other valid medical purpose	Yes	Yes	Yes	Yes

**Notes:**

1. For example, withholding pass privileges (AR 630-5); admonition and (AR 600-37, chap 2); revocation of security clearances (AR 604-4, chap 10); bar to reenlistment (AR 600-80); and suspension of PRP certification (AR 50-5; AR 50-6); see generally FM 27-10.
2. This category refers to a soldier for whom the commander has a reasonable suspicion has ingested drugs or alcohol as opposed to probable cause that the soldier has ingested drugs or alcohol. See your local SJA if in doubt.
3. For soldiers enrolled in ADAPCP, can be used to determine whether further rehabilitation efforts are practical in accord with AR 635-200, chapter 9.
4. However, for soldiers enrolled in ADAPCP, discussion of ADAPCP participation in EERs and OERs must be in accordance with AR 623-105 or AR 623-205. In addition, the fact that a soldier is participating in ADAPCP should be revealed only to those with an official need to know, see paragraph 6-1b.
5. See paragraph 6-3e for an exception to this limitation.
6. See paragraph 6-5f for an exception to this limitation.

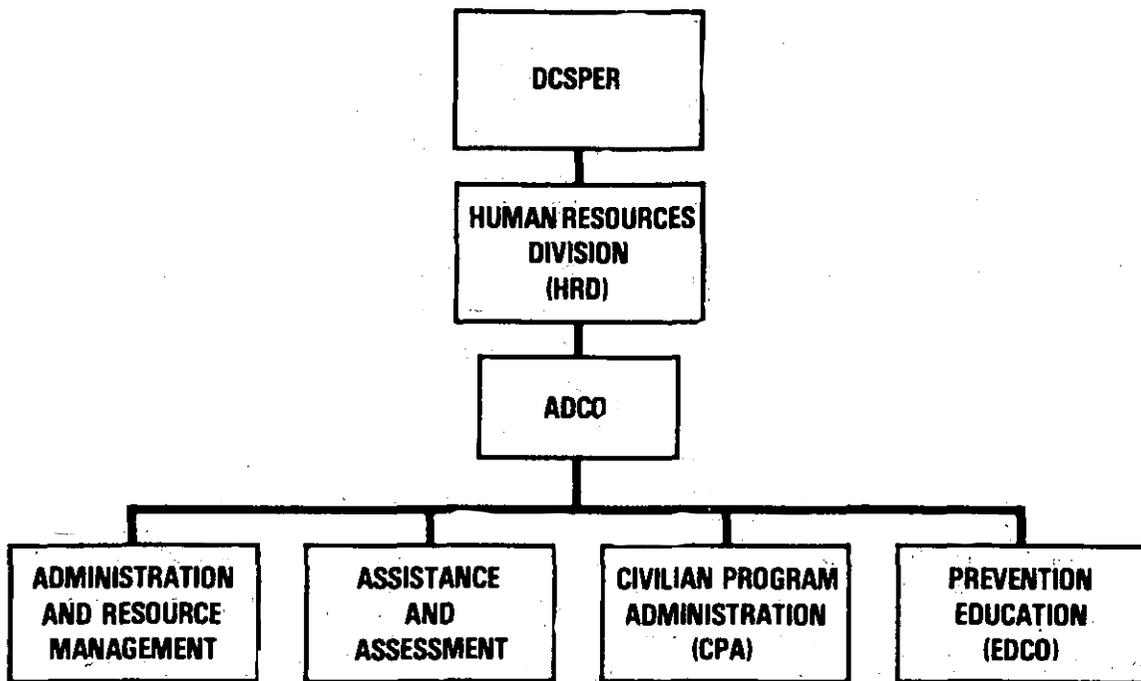


Figure 1-1. Typical MACOM headquarters organization chart for ADAPCP

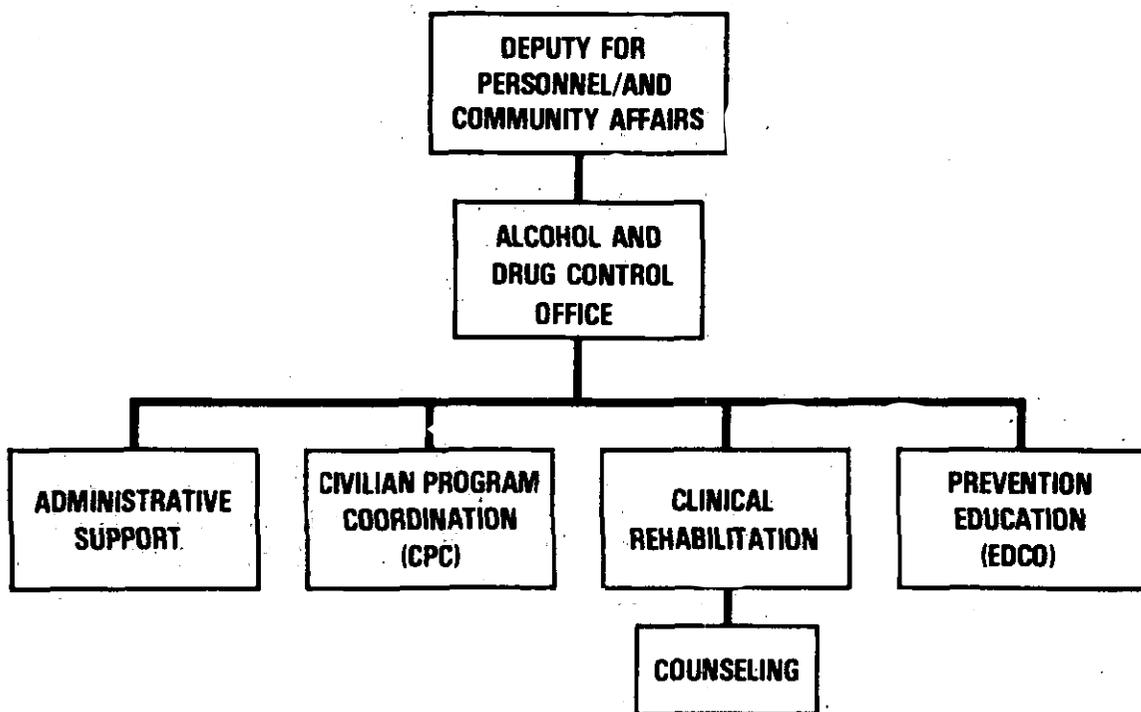


Figure 1-2. Typical installation/community organization chart for ADAPCP

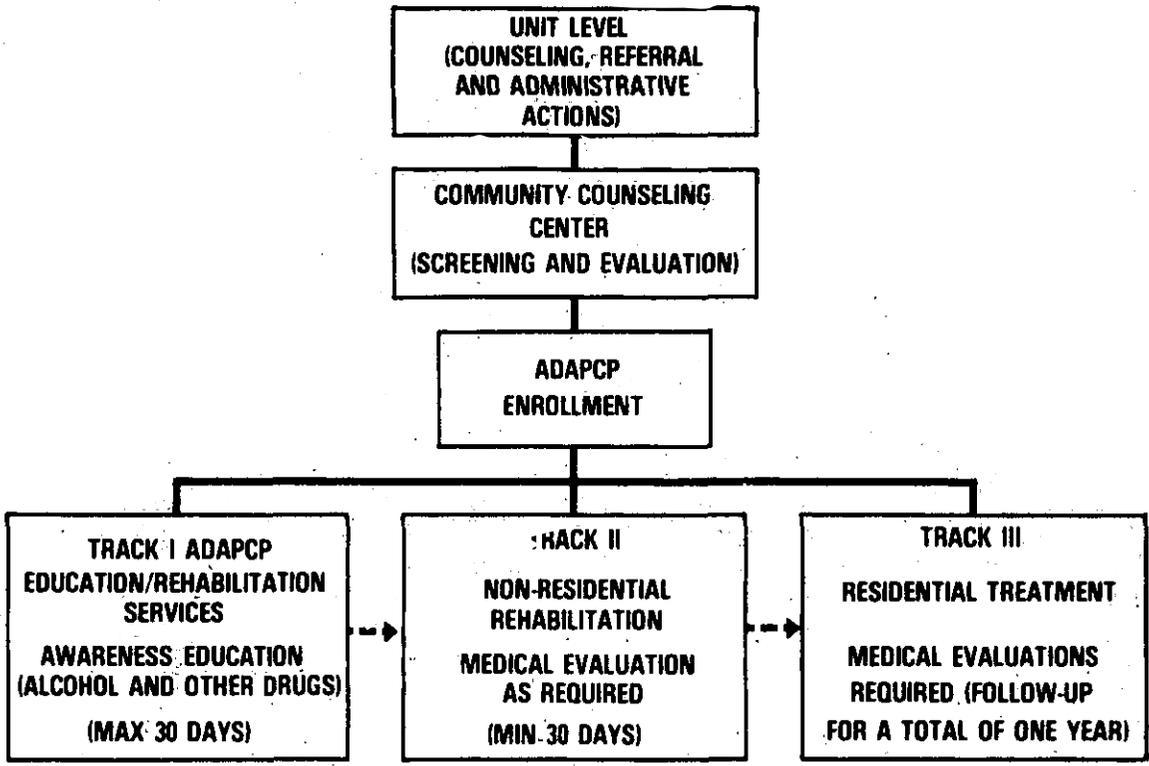
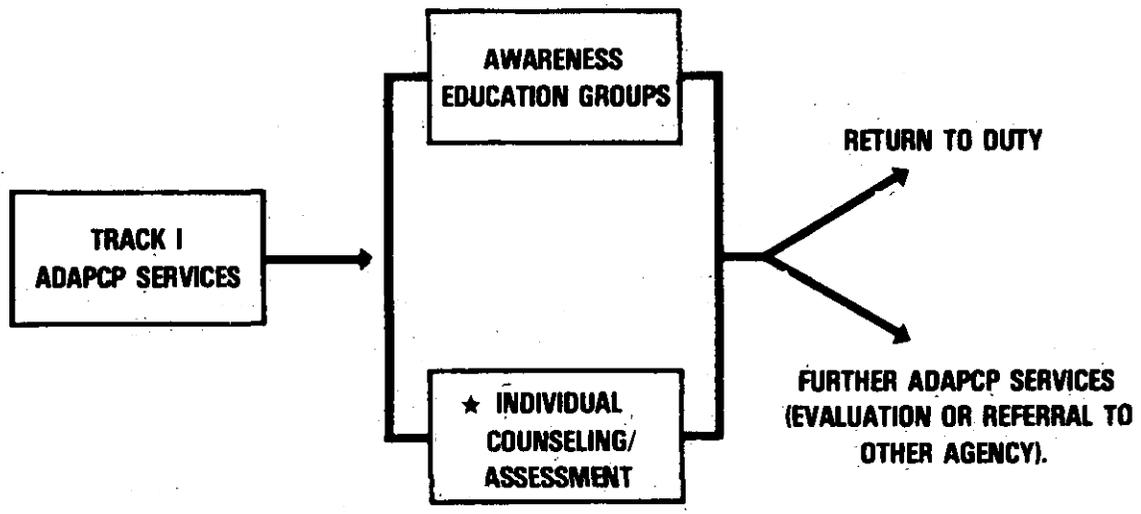


Figure 4-1. ADAPCP rehabilitation and treatment process



★ AS REQUIRED

Figure 4-2. Track I, ADAPCP education/rehabilitation services

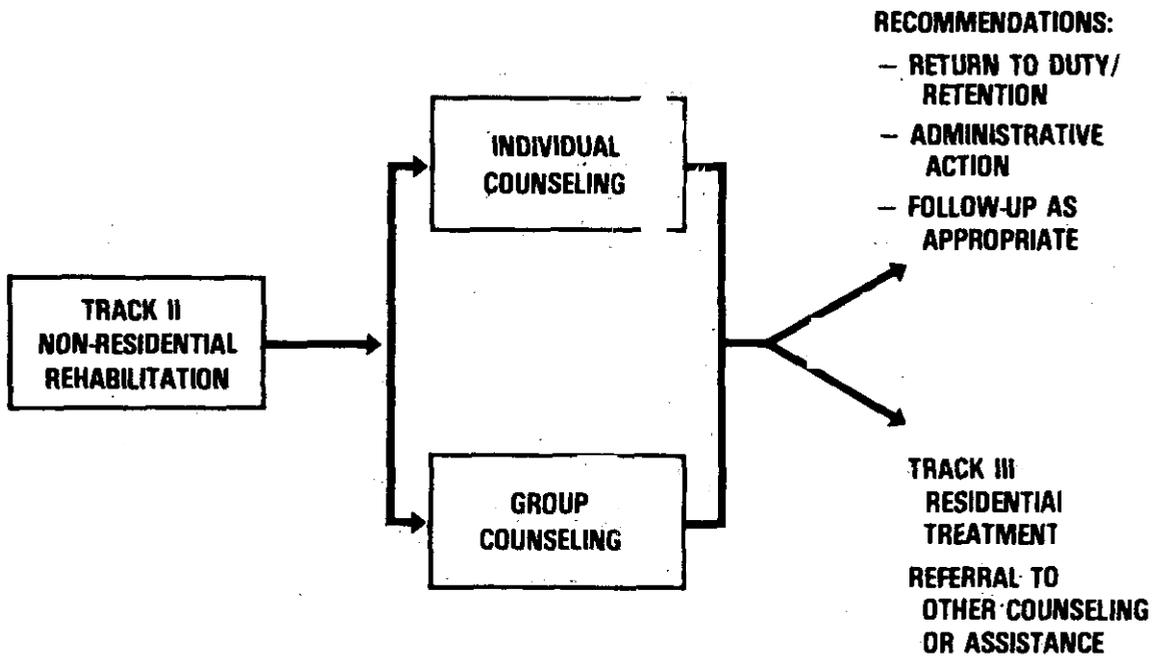


Figure 4-3. Track II nonresidential rehabilitation

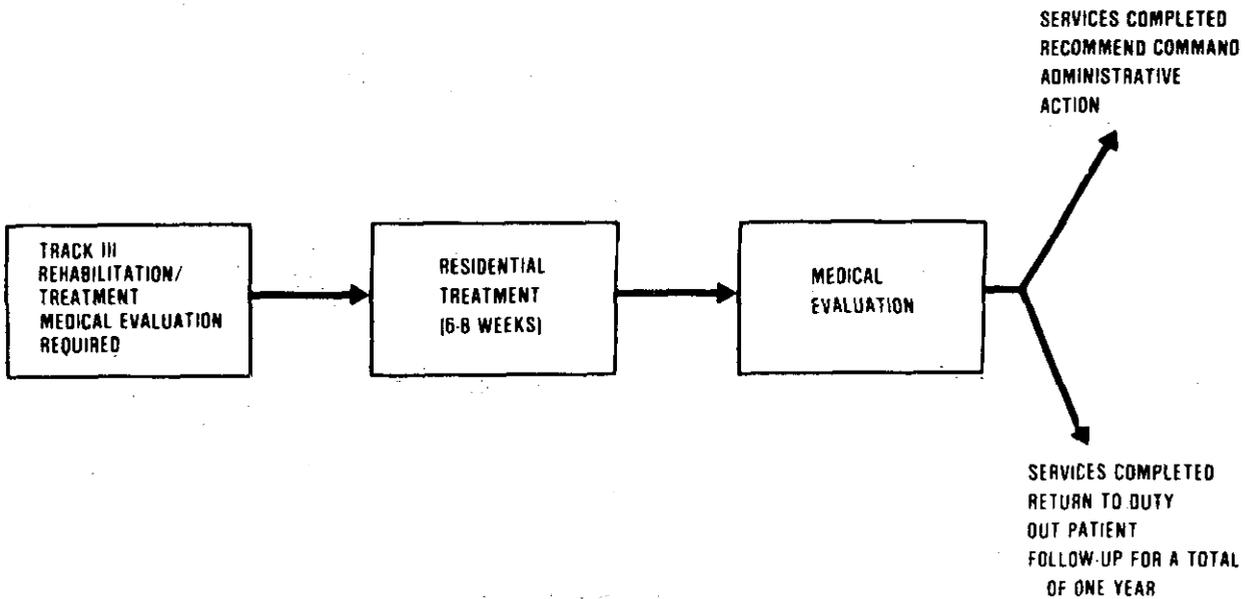
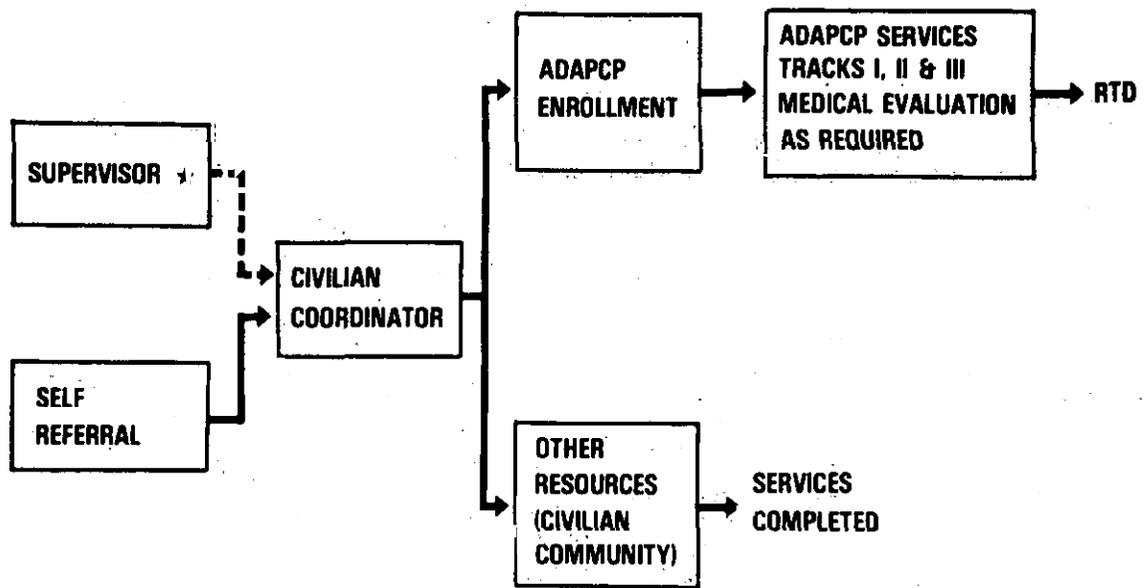


Figure 4-4. Track III residential rehabilitation/treatment.



★ WRITTEN PERMISSION FROM CLIENT REQUIRED FOR SUPERVISOR INVOLVEMENT

Figure 4-5. Civilian rehabilitation model (voluntary)

ATZM-PA-AD

7 November 1985

SUBJECT: Request for Confirmation of Reassignment and Enrollment of ADAPCP Client

Commander  
24th Inf Div and Fort Stewart  
ATTN: AFZP-PAP-AP (CCC)  
Fort Stewart, GA 31313

1. Request confirmation of assignment and enrollment in the ADAPCP of the following individual. Upon notification of enrollment in your program, the client's ADAPCP record will be forwarded per AR 600-85.

- a. Name/Rank/SSN: John D. Doe, PFC, 021-55-2495.
- b. Status in program: Track II, nonresidential rehabilitation.
- c. Program entry date: 29 September 1985.
- e. Date of PCS loss report to USADAOA (DAMIS): 30 October 1985.
- f. Physician diagnosis/basis for enrollment: alcohol abuse, episodic.
- g. Assignment instructions/reporting date: Headquarters Company, 24th Infantry Division, Fort Stewart, GA 31313. Reporting date, 10 November 1985.
- h. Counselor's name/telephone number: Mrs. Gayle Smith, AUTOVON 587-2804.

2. The above information has been released to you from official ADAPCP rehabilitation records, the confidentiality of which is protected by Federal law and Army regulation.

FOR THE COMMANDER:

LAWRENCE P. SMITH  
MAJ, IN  
Alcohol and Drug Control Officer

Figure 7-1. Sample request from ADCO to ADCO

AFUF-JFO-CCC

20 November 1985

SUBJECT: Request for ADAPCP Client Case File

Commander  
24th Inf Div and Fort Stewart  
ATTN: AFZP-PAP-AP (CCC)  
Fort Stewart, GA 31313

1. In accordance with AR 600-85, request that the following named soldier complete ADAPCP client case file be forwarded to this location for continuation in rehabilitation counseling. The following information is provided for confirmation of enrollment:
  - a. Name/Rank SSN: John D. Doe, PFC, 021-55-2495.
  - b. Date of enrollment at new assignment: 20 November 1985.
  - c. Date of PCS gain report to USADAOA (DAMIS): 20 November 1985.
  - d. Mailing address for gaining ADAPCP:

Community Commander  
Hanau Military Community  
ATTN: Hanau North CCC  
Francois Kaserne  
APO New York 09165

FOR THE COMMANDER:

FRANK T. DOBBS  
MAJ, AR  
Alcohol and Drug Control Officer

ATZM-PA-AD

7 November 1985

SUBJECT: Request for Confirmation of Reassignment and Enrollment of ADAPCP Client

Commander of:

PFC John D. Doe, 021-55-2495  
Company C, 793 Medical Company  
APO San Francisco 96334

1. The above named individual has been enrolled in the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) since 29 September 1985. Request that PFC John Doe be referred to your local Community Counseling Center (CCC) for further rehabilitative counseling services per AR 600-85.

2. In order for counseling service to continue, the following information is provided for your local CCC staff.

- a. Name/Rank/SSN: John D. Doe, PFC, 021-55-2495.
- b. Status in program: Track II, nonresidential rehabilitation.
- c. Program entry date: 29 September 1985.
- d. Rehabilitation progress: Progressing.
- e. Date of PCS loss report to USADAOA (DAMIS): 30 October 1985.
- f. Physician diagnosis/basis for enrollment: alcohol abuse, episodic.
- g. Assignment instructions/reporting date: Company C, 793 Medical Company, APO San Francisco 96334. Reporting date, 10 November 1985.
- h. Counselor's name/telephone number: Mrs. Gayle Smith, AUTOVON 687-2804.

3. The information in paragraph 2 of this correspondence has been released to you from official ADAPCP rehabilitation records, the confidentiality of which is protected by Federal law and Army regulation. It is requested that this correspondence be forwarded to the servicing CCC staff at the time of referral of the individual for enrollment.

FOR THE COMMANDER:

LAWRENCE P. SMITH  
MAJ, IN  
Alcohol and Drug Control Officer

Figure 7-3. Sample request from ADCO to unit commander

ATZM-PA-AD

7 November 1985

SUBJECT: Request for Confirmation of Reassignment and Enrollment of ADAPCP Client.

THRU: Commander  
21st (AG) Replacement Battalion  
APO New York 09057

TO: Commander  
PFC John D. Doe, 021-55-2495.

1. In accordance with AR 600-85, request this correspondence be immediately forwarded to the unit commander of PFC John D. Doe, 021-55-2495 for immediate action.
2. The above named individual has been enrolled in the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) since 29 September 1985. Request that PFC John Doe be referred to your local Community Counseling Center (CCC) for further rehabilitative counseling services.
3. In order for counseling service to continue, the following information is provided for your local CCC staff:
  - a. Name/Rank/SSN: John D. Doe, PFC, 021-55-2495.
  - b. Status in program: Track II, nonresidential rehabilitation.
  - c. Program entry date: 29 September 1985.
  - d. Rehabilitation progress: progressing.
  - e. Date of PCS loss report to USADAOA (DAMIS): 30 October 1985.
  - f. Physician diagnosis/basis for enrollment: alcohol abuse, episodic.
  - g. Assignment instructions/reporting date: 21st AG Replacement Battalion, APO New York 09057. Reporting date, 10 November 1985.
  - h. Counselor's name/telephone number: Mrs. Gayle Smith, AUTOVON 687-2804.
4. The information in paragraph 3 of this correspondence has been released to you from official ADAPCP rehabilitation records, the confidentiality of which is protected by Federal law and Army regulation. It is requested that this correspondence be forwarded to the servicing CCC staff at the time of referral of the individual for enrollment.

FOR THE COMMANDER:

LAWRENCE P. SMITH  
MAJ, IN.  
Alcohol and Drug Control Officer

Figure 7-4. Sample request from ADCO to replacement activity commander

ATZM-PA-AD

1 September 1985

SUBJECT: Letter of Transmittal

Director  
U.S. Army Drug and Alcohol  
Technical Activity  
ATTN: DAMIS  
5600 Columbia Pike  
Falls Church, VA 22041-5140

In accordance with AR 600-85, chapter 7, paragraph 7-11, the enclosed ADAPCP Client Intake Records (5), Client Progress Reports (11), PCS loss (2) and gain (1) reports are submitted for the period 1 August through 8 August 1985.

FOR THE COMMANDER:

19 Encl  
.as

LAWRENCE P. SMITH  
MAJ, IN  
Alcohol and Drug Control Officer

Figure 7-5. Sample letter of transmittal

## DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY. Title V, Public Law 92-129; section 413, Public Law 92-255

### PRINCIPAL PURPOSES.

- a. To provide necessary information to evaluate the existence of and, if appropriate, the nature and extent of the client's alcohol and other drug problem.
- b. To provide baseline information for monitoring the client's progress during rehabilitation in the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).
- c. To ensure continuity of care of client enrolled in ADAPCP rehabilitation.
- d. As part of the Active Army soldier's medical record, to provide information to military physicians in diagnosing other medical problems and in prescribing medication.
- e. To provide statistical information for program evaluation.

### ROUTINE USES

- a. Active Army soldiers. 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 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 client as an abuser of alcohol or other drugs is authorized within the Army Forces or to those components of the Veterans Administration furnishing health care to veterans. AR 600-85 further limits disclosure within the Armed Forces to those individuals having an official need to know (for example, the physician or the client's unit commander). All other disclosures require the written consent of the client except disclosures (1) to medical personnel outside the Armed Forces to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial competent jurisdiction.
- b. Civilian employees and other personnel. 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. All disclosures require the written consent of the client except disclosures (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation or (3) upon the order of a court of competent jurisdiction.
- c. Studies. Information from this form is forwarded to the U.S. Army Drug and Alcohol Operations Activity (USADAOA) for statistical analysis, Army-wide program evaluation, trend data, and gross data for research purposes.

### MANDATORY/VOLUNTARY DISCLOSURE AND EFFECT ON AN INDIVIDUAL NOT PROVIDING INFORMATION

- a. Disclosure is mandatory for Active Army soldiers. Failure to obey order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.
- b. Disclosure is voluntary for civilian employees and other personnel. The failure to disclose the information will result in a reduced capability of the program to provide treatment and services.

Figure 7-6. Sample Privacy Act statement

## Appendix A References

### Section I Required Publications

**AR 40-2**  
Army Medical Treatment Facilities General Administration. (Cited in para 2-1b.)

**AR 40-3**  
Medical, Dental, and Veterinary Care. (Cited in paras 4-6d and 4-17.)

**AR 40-61**  
Medical Logistics Policies and Procedures. (Cited in para 2-15a.)

**AR 40-66**  
Medical Record and Quality Assurance Administration. (Cited in paras 6-1, 7-7, 7-16, and 7-18.)

**AR 40-330**  
Rates Code and general policies for Army Medical Department Activities (Cited in para 4-6b.)

**AR 40-501**  
Standards of Medical Fitness. (Cited in para 1-14d.)

**AR 50-5**  
Nuclear Surety. (Cited in paras 1-10b and 1-15, and 10-3a.)

**AR 50-6**  
Chemical Surety Program. (Cited in paras 1-10b and 1-15.)

**AR 190-5**  
Motor Vehicle Traffic Supervision. (Cited in para 2-15c.)

**AR 190-22**  
Search, Seizure and Disposition of Property. (Cited in para 2-15.)

**AR 190-50**  
Physical Security for Storage of Controlled Medical Substances and Other Medically Sensitive Items. (Cited in para 2-15d.)

**AR 195-5**  
Evidence Procedures. (Cited in para 2-15.)

**AR 310-10**  
Military Orders. (Cited in para F-5b.)

**AR 310-49**  
The Army Authorization Document System (TADDS). (Cited in para 1-21b.)

**AR 340-1**  
Records Management Program. (Cited in para 6-10f.)

**AR 340-17**  
Release of Information and Records From Army Files. (Cited in para 6-10f.)

**AR 340-18-9**  
Maintenance and Disposition of Medical Functional Files. (Cited in paras 6-1d and 7-16a.)

**AR 340-21**  
The Army Privacy Program. (Cited in para 6-1b.)

**AR 360-5**  
Public Information. (Cited in para 6-12a.)

**AR 570-4**  
Manpower Management. (Cited in paras 1-19 and 1-21b.)

**AR 600-20**  
Army Command Policy and Procedures. (Cited in para 4-16.)

**AR 600-105**  
Aviation Service of Rated Army Officers. (Cited in para 1-14.)

**AR 604-5**  
Personnel Security Program (Cited in para 1-13.)

**AR 635-10**  
Processing Personnel for Separation. (Cited in para F-4c and F-5b.)

**AR 635-100**  
Officer Personnel. (Cited in paras 4-26a and 6-5d.)

**AR 635-200**  
Enlisted Personnel. (Cited in paras 4-26a, 6-5d, and D-2.)

**DA Pam 570-4**  
Manpower Procedures Handbook. (Cited in paras 1-19 and 1-21b.)

**DA Pam 570-551**  
Staffing Guide for US Army Garrisons. (Cited in paras 1-19 and 1-21b.)

**DA Pam 570-553**  
Staffing Guide for Headquarters Continental US Armies. (Cited in para 1-19.)

**DA Pam 570-557**  
Staffing Guide for US Army Medical Department Activities. (Cited in para 1-19.)

**DA Pam 570-566**  
Staffing Guide US Army Depots. (Cited in para 1-19.)

**DOD Directive 1010.1**  
DOD Drug Abuse Testing Program (Cited in paras 1-4b and D-2.)

**DOD Directive 1010.3**  
Drug and Alcohol Abuse Reports. (Cited in para 1-4b.)

**DOD Instruction 1010.6**  
Rehabilitation and Referral Services for Alcohol and Drug Abusers. (Cited in para 4b.)

**TB Med 290**  
Drug Abuse. (Cited in para 3-12.)

**TB Med 291**  
Guidance for Inventory, Control, and Accountability of Drugs and Injection Devices of Potential Abuse at Medical Treatment Facilities Worldwide. (Cited in para 2-15a.)

### Section II Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

**AR 10-78**  
United States Army Drug and Alcohol Technical Activity.

**AR 135-178**  
Separation of Enlisted Personnel.

**AR 190-30**  
Military Police Investigations.

**AR 190-41**  
Customs Law Enforcement.

**AR 195-2**  
Criminal Investigation Activities.

**AR 360-81**  
Command Information Program.

**AR 623-105**  
Officer Evaluation Reporting System.

**AR 623-205**  
Enlisted Evaluation Reporting System.

**AR 635-5**  
Separation Documents.

**AR 680-1**  
Unit Strength Accounting and Reporting.

**Civilian Personnel Regulation 302.2.**

**NGR 40-501**  
Standards of Medical Fitness.

### Section III Prescribed Forms

**DA Form 3711-R**  
Alcohol and Drug Abuse Prevention and Control Program. (Prescribed in para 7-3.)

**DA Form 4465**  
Client Intake Record. (Prescribed in para 3-10.)

**DA Form 4466**  
Client Progress Report. (Prescribed in para 7-8.)

**DA Form 5017-R**  
Civilian Employee Consent Form. (LRA)  
(Prescribed in para 4-4.)

**DA Form 5018-R**  
ADAPCP Client's Consent Statement for  
Release of Treatment Information. (LRA)  
(Prescribed in para 6-10i.)

**DA Form 5019-R**  
Condition of Employment for Certain Civilian  
Employee Positions Identified as Critical  
under the Drug Abuse Testing Program.  
(Prescribed in para 5-14c(2).)

**DA Form 5180-R**  
Urinalysis Custody and Report Record.  
(LRA) (Prescribed in para 10-5.)

**DD Form 2394**  
Report on Drug-Related Military Law En-  
forcement Activities. (Prescribed in para  
7-1g.)

**DD Form 2395**  
Report on Legal or Administrative Disposition  
of Drug Abuse Offenders. (Prescribed  
in para 7-1g.)

**DD Form 2396**  
Report on Urinalysis Testing for Drug  
Abuse. (Prescribed in para 7-1g.)

**DD Form 2397**  
Report on Service Members in Awareness  
Education or Rehabilitation Programs for  
Drug or Alcohol. (Prescribed in para 7-1g.)

**DD Form 2398**  
Report on Civilian Employee Alcohol and  
Drug Abuse. (Prescribed in paragraph  
7-1g.)

#### **Section IV** **Referenced Forms**

**DA Form 644**  
Servicemembers Statement Concerning Ap-  
plication for Compensation from the VA.

**DA Form 2496**  
Disposition Form (DF)

**DA Form 3881**  
Rights Warning/Waiver Certificate.

**DA Form 3997**  
Military Police Desk Blotter.

**Dd Form 214.**  
Certificate of Release or Discharge from  
Active Duty.

**DD Form 214 WS**  
Worksheet for Certificate of Release or Dis-  
charge from Active Duty.

**DD Form 1173**  
Uniformed Services Identification and Privi-  
lege Card.

**DD Form 1384**  
Transportation Control and Movement  
Document.

**DD Form 1407**  
Dependent Medical Care and DD Form  
1173 Statement.

**VA Form 21-526E**  
Veterans Application for Compensation of  
Pension at Separation from Service.

**DOL Form OVR-2**  
Reemployment Rights and Employment  
Data. (DOL Form OVR-2 is available  
from the Superintendent of Documents,  
U.S. Government Printing Office, Washing-  
ton, DC 20402.)

**SF 513**  
Medical Record—Consultation Sheet.

**SF 600**  
Health Record Chronological Record of  
Medical Care.

## Appendix B Client Oriented Drug Abuse Reporting Systems

### Section I Client Management Records and Reports

#### B-1. General

This appendix provides instructions, examples, and coding tables to be used when completing required client and management reports and forms. Chapter 7 prescribes their use and when they are submitted.

#### B-2. Forms

The following is a list of forms for reporting purposes. Samples of these forms and instructions for their completion are shown in the figures designated.

- a. DA Form 2496 (fig B-1).
- b. DA Form 4465 (fig B-2).
- c. DA Form 4465 (screened not enrolled) (fig B-3).
- d. DA Form 4466 (fig B-4).
- e. DA Form 3711-R (fig B-5).

#### B-3. Report instructions and coding

a. Diagnostic concepts, terminology, and the codes for use with the DA Forms 4465 and 4466 are contained in section II.

b. Data required by the Privacy Act of 1974 is on the reverse side of DA Forms 4465 and 4466.

c. ADAPCP service area codes for use with DA Forms 4465 and 4466 are contained in table B-1. This table lists official addresses and ADAPCP Service Area Codes required for completion of item 3 of DA Form 4465 and item 3 of DA Form 4466. Mailing address corrections for ADAPCPs listed will be sent directly to: Director, US Army Drug and Alcohol Technical Activity, ATTN: PEDADAMIS, 5600 Columbia Pike, Suite 300 Falls Church, VA 22041.

d. Civilian employee classification codes for use with DA Form 4465 are contained in table B-2.

e. Length of Service (LOS) codes for use with the DA Form 4465 are contained in table B-3.

f. Major command codes are shown in table B-4.

g. Specific unit codes are listed in table B-5.

h. Medical residential treatment facility codes are in table B-6. This table assigns specific codes for Army residential treatment facilities, general codes for residential treatment facilities of other services, and a code for other civilian residential treatment facilities. This table is to be used in completing item 8 of DA Form 4465 for all clients enrolled in Track III; and item 8b of DA Form 4466. Item 8b should be completed for all clients who are undergoing residential treatment or have completed residential treatment.

i. ADAPCP enrollment codes are listed in table B-7.

#### B-4. Privacy Act

A sample privacy Act statement is shown in figure B-6 for use with the ADAPCP log.

### Section II Diagnostic Concepts and Terminology

#### B-5. General

Individuals referred for medical evaluation will be diagnostically assessed utilizing terms, concepts, and criteria consistent with the DSM-III, American Psychiatric Association, 1980. It is to be emphasized that some individuals will use alcohol or other drug(s) in ways that do not meet the criteria required for specific DSM-III diagnosis of substance use disorder. Nevertheless, there may be evidence of problematical alcohol or other drug use that results in relatively ineffective psychological, social, or occupational functioning. In these instances, though a diagnosis of alcohol or other drug use disorder may not be rendered, awareness education or other rehabilitation or rehabilitative services may be warranted in order to interrupt the pattern of misuse at the earliest possible time.

#### B-6. Criteria

a. *Alcohol or other drug abuse.* This general category includes diagnosis that are essentially equivalent to "psychological dependence." The three criteria listed below must be met in order to diagnose alcohol or other drug abuse.

(1) There must be a pattern of pathological use. This may be manifested by the following:

- (a) Intoxication throughout the day.
- (b) Inability to decrease or stop use.
- (c) Repeated efforts to control use through periods of temporary abstinence or restriction of use to certain times of the day.
- (d) Continuance of use despite knowledge of the presence of a serious physical disorder aggravated by use of the substance.
- (e) Need for daily use for adequate functioning.
- (f) Episodes of complications of substance intoxication (for example, alcoholic blackouts, opioid overdose).

(2) There must be impairment in social or occupational functioning caused by the pattern of pathological use; for example, fights, loss of friends, absence from work, loss of job, legal difficulties, arguments with family or friends.

(3) There must be a minimal duration of disturbance of at least 1 month. Signs of the disturbance need not be continuously present throughout the month, but should be frequent enough for a pattern of pathological use causing interference with social or occupational functioning to be apparent.

b. *Alcohol or other drug dependence.* The only requirement is that there be evidence of tolerance or withdrawal, except for alcohol or cannabis, which, in addition, require

that criteria a(1) and/or (2) above also be met. Tolerance means that markedly increased amounts of the substance are required to achieve the desired effect or that there is a markedly diminished effect with regular use of the same dose. Withdrawal means that a substance-specific syndrome or symptom pattern follows cessation or reduction in the intake of the substance previously regularly used by the individual to induce a state of intoxication.

#### B-7. Recording specific diagnoses

a. In recording a specific diagnosis on the DA Forms 4465 or 4466, the physician will record the name of the specific substance(s) rather than the entire class of substance. In addition to writing the specific substance, the clinician must indicate the specific course of the diagnosis rendered. The physician will complete each diagnosis of abuse or dependence using the following terms:

(1) *Continuous.* This is more or less regular maladaptive use for over 6 months.

(2) *Episodic.* This is a fairly circumscribed period of maladaptive use with one or more similar periods in the past.

(3) *In remission.* This is previous maladaptive use but the client is not using the substance at present.

(4) *Unspecified.* This is a course of unknown nature or the first signs of illness with the course uncertain.

b. For example, the clinician should write—

(1) Amphetamine abuse, in remission (rather than amphetamine or sympathomimetic abuse).

(2) Valium dependence continuous (rather than barbiturate or similarly acting sedative or hypnotic dependence).

(3) Compazine abuse continuous (rather than other, mixed or unspecified substance abuse).

#### B-8. Specific diagnosis

a. The Physician will enter the name of the substance, the course, and the name of the specific substance(s) rather than the entire class of substance in item A-D on the DA Form 4465 or Item 5 A-D on the DA Form 4466. Each specific diagnosis should be completed with the course of abuse or dependence. The diagnosis code is not to be used by physicians when conducting medical evaluations. Record the written diagnosis and the code for each diagnosis on the DA Forms 4465 or 4466. When multiple substances are involved, the clinician should record the substance from top to bottom in decreasing order of clinical importance; for example, alcohol dependence continuous, valium dependence continuous, and barbiturate dependence continuous.

b. The following diagnostic categories will be used:

- (1) Alcohol abuse.
- (2) Alcohol dependence.
- (3) Barbiturate or similarly acting sedative or hypnotic abuse.

(4) Barbiturate or similarly acting sedative or hypnotic dependence.

(5) Opioid abuse.

(6) Opioid dependence.

(7) Cocaine abuse.

(8) Amphetamine or similarly acting sympathomimetic abuse.

(9) Amphetamine or similarly acting sympathomimetic with dependence.

(10) Phencyclidine (PCP) or similarly acting arycyclohexylamine abuse.

(11) Hallucinogen abuse.

(12) Cannabis abuse.

(13) Cannabis dependence.

(14) Other or mixed substance abuse.

(15) Other or mixed specified substance dependence.

(16) Dependence on a combination of opioid and other nonalcoholic substances.

(17) Dependence on a combination of substances, excluding opioids and alcohol.

### **B-9. No diagnosis apparent**

a. If during the diagnostic interview sufficient information suggests illegal, improper, or wrongful use of alcohol or other drugs which does not fully meet criteria for a formal diagnosis, the physician may enter "No Diagnosis Apparent" in item 5A of the DA Form 4465 or item 5A of the DA Form 4466. The physician will record the substance involved as shown below noting the specific substances within a category whenever possible.

(1) No diagnosis apparent, improper use of alcohol.

(2) No diagnosis apparent, improper use of amphetamines.

(3) No diagnosis apparent, improper use of barbiturates.

(4) No diagnosis apparent, improper use of cannabis.

(5) No diagnosis apparent, improper use of cocaine.

(6) No diagnosis apparent, improper use of hallucinogens.

(7) No diagnosis apparent, improper use of methaqualone.

(8) No diagnosis apparent, improper use of opioids.

(9) No diagnosis apparent, improper use of other tranquilizers.

(10) No diagnosis apparent, improper use of phencyclidine.

(11) No diagnosis apparent, improper use of (specify drug).

b. The "no diagnosis apparent" without an additional identifier of alcohol or other drugs may be used only when the physician cannot substantiate illegal, improper, or wrongful use. In these cases, the physician will confer with the rehabilitation team for proper disposition of the referral.

### **B-10. Enrollment in Tracks I or II without medical evaluation or no diagnosis apparent**

For those clients that are enrolled in either Tracks I or II without medical evaluation or with a physician's finding of no diagnosis apparent without an additional identifier of alcohol or other drugs (see para B-9b), the

ADAPCP counselor will indicate in item 5, DA Form 4465, the specific substance(s) rather than the entire class of substance in decreasing order of importance for which the client was enrolled for rehabilitation services, as follows:

a. Alcohol.

b. Amphetamines.

c. Barbiturates.

d. Cannabis.

e. Cocaine.

f. Hallucinogens. (Specify specific drug rather than "hallucinogens.")

g. Methaqualone.

h. Opioids.

i. Tranquilizers. (Specify specific drug rather than "tranquilizer.")

j. Phencyclidine.

k. Other. (Specify specific drug rather than "other.")

### **B-11. Screened not enrolled**

a. For the potential client who is referred for screening and/or medical evaluation and the decision was made not to enroll the client in the ADAPCP, the physician will enter the substance name and one or more of the following dispositions: (The primary final disposition should be listed first.)

(1) Medical Evaluation, Administrative Action.

(2) Medical Evaluation, Incomplete Evaluation.

(3) Medical Evaluation, Legal Action.

(4) Medical Evaluation, No Further Action.

(5) Medical Evaluation, Other Resources.

(6) Medical Evaluation, Separation.

(7) Medical Evaluation; Prescribed Medical/Authorized Use.

(8) Medical Evaluation, Nonalcohol/drug-related.

b. The potential client (regardless of client status) who is screened but not referred for medical evaluation, and the decision is made not to enroll, the final disposition is completed by the ADAPCP counselor or CPC (as appropriate) using one or more of the following final dispositions:

(1) Counselor Evaluation, Administrative Action.

(2) Counselor Evaluation, Incomplete Evaluation.

(3) Counselor Evaluation, Legal Action.

(4) Counselor Evaluation, No Further Action.

(5) Counselor Evaluation, Other Resources.

(6) Counselor Evaluation, Separation.

(7) Counselor Evaluation, Other No Further Action.

(8) Counselor Evaluation, Nonalcohol/drug related.

**Table B-1**  
**ADAPCP service area codes**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
<b>Oversea Areas</b>			
Commander U.S. Army Forces Command ATTN: AFPR-HR Fort McPherson, GA 30330		8. Community Commander Babenhausen Military Community ATTN: Babenhausen CCC APO New York 09455	E08
		9. Community Commander Bamberg Military Community ATTN: Bamberg CCC APO New York 09139	E09
<b>Alaska, Panama and Puerto Rico</b>			
1. Commander Fort Richardson ATTN: AFZT-P-AA (CCC) Fort Richardson, AD 99505	A03	10. Community Commander Baumholder Military Community ATTN: Baumholder CCC APO New York 09034	E10
2. Commander Fort Wainwright ATTN: AFZT-PA-WHA (CCC) Fort Wainwright, AK 99703	A04	11. Community Commander Berlin Military Community ATTN: Berlin CCC, McNair Bks APO New York 09742	E11
3. Commander Fort Greely ATTN: AFZT-PA-G-D (CCC) Fort Greely, AK 98733	A05	12. Community Commander Bindlach Military Community ATTN: Bindlach CCC Christensen Bks APO New York 09411	E12
4. Commander 193d Infantry Bde (Panama) ATTN: AFZU-PCD-CCC APO Miami 34004	C01	13. Community Commander Boeblingen Mil Sub Community ATTN: Boeblingen CCC APO New York 09046	E13
5. Commander U.S. Army Garrison (Puerto Rico) ATTN: AFZK-B-PA (CCC) Fort Buchanan, Puerto Rico 00934	F10	14. Community Commander Bremerhaven Mil Community ATTN: Bremerhaven CCC APO New York 09069	E14
<b>Europe</b>			
Commander in Chief U.S. Army Europe & 7th Army ATTN: AEAGA-HF APO New York 09403		15. Community Commander Hanau Military Community ATTN: Buedingen CCC APO New York 09076	E15
1. Community Commander Amberg Military Community ATTN: Amberg CCC, Pond Bks APO New York 09452	E01	16. Community Commander Giessen Military Community ATTN: Butzbach CCC APO New York 09045	E16
2. Community Commander Ansbach Military Community ATTN: Ansbach CCC APO New York 09326	E02	17. Community Commander Ansbach Military Community ATTN: Crailsheim CCC APO New York 09751	E17
3. Community Commander Aschaffenburg Mil Community ATTN: Ready CCC APO New York 09162	E03	18. Community Commander Darmstadt Military Community ATTN: Cambrai-Fritsch CCC APO New York 09175	E18
4. Community Commander Augsburg Military Community ATTN: Augsburg CCC APO New York 09178	E04	19. Community Commander Bad Kreuznach Mil Community ATTN: Dexheim CCC APO New York 09111	E19
5. Community Commander Fulda Military Community ATTN: Bad Hersfeld CCC McPheeters Bks APO New York 09141	E05	20. Community Commander Erlangen Mil Sub-Community ATTN: Erlangen CCC APO New York 09066	E20
6. Community Commander Bad Kissingen Mil Community ATTN: Bad Kissingen CCC APO New York 09330	E06	21. Community Commander Beuren Military Community ATTN: Beuren CCC (5th USAAG) APO New York 09171	E21
7. Community Commander Bad Kreuznach Mil Community ATTN: Bad Kreuznach CCC Rose Bks APO New York 09111	E07	22. Community Commander Hanau Military Community ATTN: Fliegerhorst CCC APO New York 09165	E22
		23. Community Commander Frankfurt Military Community ATTN: Betts CCC APO New York 09757	E23

**Table B-1**  
**ADAPCP service area codes—Continued**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
24. Community Commander Frankfurt Military Community ATTN: Eschborn CCC APO New York 09757	E24	39. Community Commander Heilbronn Military Community ATTN: Heilbronn CCC APO New York 09176	E39
25. Community Commander Frankfurt Military Community ATTN: Frankfurt North CCC Edwards Kaserne APO New York 09039	E25	40. Community Commander Nuernberg Military Community ATTN: Herzo Base CCC APO New York 09352	E40
26. Community Commander Giessen Military Community ATTN: Friedberg CCC APO New York 09074	E26	41. Community Commander Frankfurt Military Community ATTN: Hoechst CCC APO New York 09757	E41
27. Community Commander Fuerth Military Community ATTN: Fuerth CCC, Montieth Bks APO New York 09068	E27	42. Community Commander Hohenfels Military Community ATTN: Hohenfels CCC APO New York 09173	E42
28. Community Commander Fulda Military Community ATTN: Downs Kaserne CCC APO New York 09146	E28	43. Community Commander Baumholder Military Community ATTN: Idar Oberstein CCC APO New York 09322	E43
29. Community Commander Hanau Military Community ATTN: Gelnhhausen CCC APO New York 09165	E29	44. Community Commander Ansbach Military Community ATTN: Illesheim CCC APO New York 09140	E44
30. Community Commander Karlsruhe Military Community ATTN: Germersheim CCC APO New York 09095	E30	45. Community Commander Kaiserslautern Military Community ATTN: Daenner CCC APO New York 09227	E45
31. Community Commander Giessen Military Community ATTN: Giessen North CCC APO New York 09169	E31	46. Community Commander Kaiserslautern Military Community ATTN: Vogelweh CCC APO New York 09227	E46
32. Community Commander Wurzburg Military Community ATTN: Gibelstadt CCC APO New York 09036	E32	47. Community Commander Karlsruhe Military Community ATTN: Gerzewski CCC APO New York 09360	E47
33. Community Commander Goeppingen Military Community ATTN: Goeppingen CCC APO New York 09137	E33	48. Community Commander Kirchgoens Military Community ATTN: Kirchgoens CCC APO New York 09045	E49
34. Community Commander Grafenwoehr Military Community ATTN: Grafenwoehr CCC APO New York 09114	E34	49. Community Commander Kitzingen Military Community ATTN: Harvey Bks CCC APO New York 09031	E50
35. Community Commander Hanau Military Community ATTN: Hanau North CCC Francois Kaserne APO New York 09165	E35	50. Community Commander Kitzingen Military Community ATTN: Larson Bks CCC APO New York 09701	E51
36. Community Commander Hanau Military Community ATTN: Hanau South CCC Pioneer Kaserne APO New York 09165	E36	51. Community Commander Kaiserslautern Military Community ATTN: Landstuhl CCC C/O Daenner Kaserne APO New York 09227	E52
37. Community Commander Heidelberg Military Community ATTN: Patton Bks CCC APO New York 09102	E37	52. Community Commander Stuttgart Military Community ATTN: Ludwigsburg CCC APO New York 09154	E53
38. Community Commander Heidelberg Military Community ATTN: Tompkins Bks CCC APO New York 09102	E38	53. Community Commander Mainz Military Community ATTN: Mainz CCC APO New York 09185	E54
		54. Community Commander Mannheim Military Community ATTN: Coleman CCC APO New York 09086	E55

**Table B-1**  
**ADAPCP service area codes—Continued**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
55. Community Commander Mannheim Military Community ATTN: Sullivan CCC APO New York 09086	E56	71. Community Commander Camp Darby Military Community ATTN: Camp Darby CCC Livorno, Italy APO New York 09019	E73
56. Community Commander Saudi Arabia ATTN: Saudi Arabia CCC APO New York 09616	E57	72. Community Commander Caserna Ederle Military Community ATTN: Caserna Ederle CCC Vincenza, Italy APO New York 09221	E74
57. Community Commander Zweibrucken Military Community ATTN: Miesau CCC APO New York 09052	E58	73. Community Commander SHAPE Belgium ATTN: SHAPE Belgium CCC APO New York 09088	E75
58. Community Commander Munich Military Community ATTN: Munich CCC APO New York 09407	E59	74. Community Commander Sinai North Camp ATTN: Sinai North Camp CCC APO New York 09677	E76
59. Community Commander New Ulm Military Community ATTN: New Ulm CCC APO New York 09035	E60	75. Community Commander CHOCK, 528 USAAG ATTN: CHOCK CCC APO New York 09380	E77
60. Community Commander Stuttgart Military Community ATTN: Nellingen CCC APO New York 09160	E61	76. Community Commander Grafenwoehr Military Community ATTN: Vilsek CC APO New York 09144	E78
61. Community Commander Worms Military Community ATTN: Weirhof CCC APO New York 09058	E62	77. Community Commander Munich Military Community ATTN: Bad Aibling CCC APO New York 09098	E79
62. Community Commander Nuernberg Military Community ATTN: Merrel Bks CCC APO New York 09093	E63	78. Community Commander Mainz Military Community ATTN: Wackernheim CCC APO New York 09047	E80
63. Community Commander Nuernberg Military Community ATTN: Wm O'Darby Kaserne CCC APO New York 09696	E64	79. Community Commander Wurzburg Military Community ATTN: Peden Bks, Wertheim CCC APO New York 09047	E81
64. Community Commander Camp King Military Community ATTN: Camp King CCC APO New York 09451	E65	80. Community Commander Wiesbaden Military Community ATTN: Camp Pieri CCC APO New York 09457	E82
65. Community Commander Pirmasens Military Community ATTN: Pirmasens CCC APO New York 09696	E66	81. Community Commander Wildflecken Military Community ATTN: Wildflecken CCC APO New York 09026	E83
66. Community Commander Schwabach Military Community ATTN: O'Brien CCC APO New York 09142	E68	82. Community Commander Burtonwood AD ATTN: Burtonwood CCC APO New York 09075	E84
67. Community Commander Goepingen Military Community ATTN: Schwaebisch Gmeund CCC APO New York 09281	E69	83. Community Commander Worms Military Community ATTN: Worms CCC APO New York 09058	E85
68. Community Commander Heilbronn Military Community ATTN: Schwaebisch Hall CCC APO New York 09025	E70	84. Community Commander Wurzburg Military Community ATTN: Leighton Bks CCC APO New York 09801	E86
69. Community Commander Schweinfurt Military Community ATTN: Conn Bks CCC APO New York 09033	E71	85. Community Commander Zweibruecken Military Community ATTN: Zweibruecken CCC APO New York 09052	E87
70. Community Commander Schweinfurt Military Community ATTN: Ledward Bks CCC APO New York 09033	E72	86. Community Commander Bad Toelz Military Community ATTN: Bad Toelz CCC APO New York 09050	E88

**Table B-1**  
**ADAPCP service area codes—Continued**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
87. Community Commander Garistadt Military Community ATTN: Garistadt CCC APO New York 09355	E89	<b>Korea</b>	
88. Community Commander Mainz Military Community ATTN: McCully Bks CCC APO New York 09185	E90	USFK/EUSA, ACoFS, J-1 ATTN: AJ-HRD-D APO San Francisco 96301	
89. Community Commander Weisbaden Military Community ATTN: Wiesbaden CCC APO New York 09457	E91	1. 2D INF DIV'  Commander 2d Infantry Division ATTN: EAIDGP-DA APO San Francisco 96224	
90. Community Commander 54th Area Support Group ATTN: AERV-PD (CCC) APO New York 09712	E92	2. Camp Casey CCC	K02
91. Community Commander AFCENT SUPAC ATTN: AERAN-DA-CD (CCC) APO New York 09011	E93	3. Camp Howze CCC	K04
92. Community Commander Nuernberg Military Community ATTN: Pindar CCC APO New York 09070	E94	4. Camp Stanley CCC	K06
93. Community Commander Garmisch Military Community ATTN: Sheridan Kaserne CCC APO New York 09053	E95	5. Camp Hovey CCC	K10
94. Community Commander 558 USAAG ATTN: 558 USAAG (CCC) Athens, Greece APO New York 09253	E96	6. 19TH SPT CMD	
95. Community Commander Stuttgart Military Community ATTN: Patch Bks CCC APO New York 09131	E97	7. Commander USAG, Camp Humphreys ATTN: EANC-H-CCC APO San Francisco 96271	K01
		8. Commander USAG, Camp Page ATTN: EANC-CP-CCC APO San Francisco 96208	K03
		9. Commander USAG, Yongsan ATTN: EAGY-DPCA-CCC APO San Francisco 96301	K07
		10. Commander 34th SPT GP, Pusan ATTN: EANG-PG-CCC APO San Francisco 96259	K08
		11. Commander USAG, Taegu ATTN: EANC-T-CCC APO San Francisco 96218	K09
<b>Hawaii</b>		<b>CONUS</b>	
Commander U.S. Army Western Command ATTN: APPE-HR Fort Shafter, HI 96857		<b>U.S. Army Materiel Command (AMC)</b>	
Commander HQUSASCH ATTN: APZV-PAD Fort Shafter, HI 96857	W01	Commander U.S. Army Materiel Command ATTN: AMCAG-CS 5001 Eisenhower Avenue Alexandria, VA 22333	
<b>Japan and Okinawa</b>		1. Commander Aberdeen Proving Ground ATTN: STEAP-PH-D Aberdeen Proving Ground, MD 21005	G02
Commander US Army Japan ATTN: AJGA-HR-A APO San Francisco 96343		2. Commander Anniston Army Depot ATTN: SDSAN-DAS-PS Anniston, AL 36201	G03
1. Commander U.S. Army Garrison, Honshu ATTN: AJGH-PA-CAC APO San Francisco 96343	J01	3. Commander US Army Tank-Automotive Material Readiness Command TACOMSA-SANG ATTN: AMSTA-XY Mt Clemens, MI 48045	G10
2. Commander U.S. Army Garrison, Okinawa ATTN: AJGO-AHR APO San Francisco 96331	R01	4. Commander U.S. Army Tank-Automotive Command ATTN: AMSTA-XZ Warren, MI 48090	G11

**Table B-1**  
**ADAPCP service area codes—Continued**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
5. Commander Harry Diamond Laboratories ATTN: AMDEL-CA 2800 Powder Mill Road Adelphi, MD 20783	G12	20. Commander Sharpe Army Depot ATTN: SDSH-ADCO Lathrop, CA 95330	G51
6. Commander Dugway Proving Ground ATTN: STEDP-DA Dugway, UT 84022	G13	21. Commander Sierra Army Depot ATTN: SDSSI-ADA Herlong, CA 96113	G52
7. Commander Jefferson Proving Ground ATTN: STEJP-EE Madison, IN 47250	G19	22. Commander Tobyhanna Army Depot ATTN: SDSTO-CD Tobyhanna, PA 18466	G55
8. Commander Letterkenny Army Depot ATTN: SDSLE-SO Chambersburg, PA 17201	G23	23. Commander Toole Army Depot ATTN: SDSTE-PASO Toole, UT 84074	G56
9. Commander Lexington-Blue Grass Army Activity ATTN: SDSAN-LAB Lexington, KY 40507	G24	24. Commander Watervilliet Arsenal ATTN: SMCWV-VAPD Watervilliet, NY 12189	G60
10. Commander US Army Communications & Electronics Material command ATTN: AMSEL-PT-AD Fort Monmouth, NJ 07703	G30	25. Commander White Sands Missile Range ATTN: STEWS-DP-B White Sands Missile Range, NM 88002	G61
11. Commander New Cumberland Army Depot ATTN: SDSNC-APS New Cumberland, PA 17070	G33	26. Commander Yuma Proving Ground ATTN: STEXP-PT Yuma, AZ 85364	G63
12. Commander Armament Research and Development Command ATTN: SMCAR-PTB Dover, NJ 07801	G35	27. Commander U.S. Army Material Command ATTN: AMCAG-CS Alexandria, VA 22333	G65
13. Commander Pine Bluff Arsenal ATTN: SMCAPB-A1 Pine Bluff, AR 71601	G36	28. Commander U.S. Army Aviation Systems Command ATTN: AMSAV-U 4300 Goodfellow Blvd St. Louis, MO 63120	G67
14. Commander Pueblo Army Depot Activity ATTN: SDSTE-PUA-A Pueblo, Co 81001	G37	29. Commander Corpus Christi Army Depot ATTN: SDSCC-GL Corpus Christi, TX 78419	G68
15. Commander Red River Army Depot ATTN: SDSRR-AH Texarkana, TX 75501	G39	30. Commander McAlester Army Ammo Plant ATTN: SMCAC-ASD McAlester, OK 74501-5000	G69
16. Commander U.S. Army Missile Material Readiness Command ATTN: AMSMI-PS Redstone Arsenal, AL 35809	G40	31. Commander Chemical Research and Development Center Attn: SMCCR-AL Aberdeen Proving Ground, MD 21010	G70
17. Commander Rock Island Arsenal ATTN: SMCRI-EP Rock Island, IL 61201	G43	<b>Office of the Deputy Chief of Staff for Personnel</b>	
18. Commander Sacramento Army Depo ATTN: SDSSA-APD Sacramento, CA 95813	G45	1. Superintendent United States Military Academy ATTN: Chief, HRD (MAPS-G) West Point, NY 10996	D01
19. Commander Seneca Army Depot ATTN: SDSSE-THP Romulus, NY 14541	G50	2. Department of the Army Office of the Adjutant General U.S. Army Reserve Component Personnel and Administration Center St. Louis, MO 63132	D02

**Table B-1**  
**ADAPCP service area codes—Continued**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
<b>Defense Mapping Agency</b>		8. Commander Fort Indiantown Gap ATTN: AFQZ-PA-PS Annville, PA 17003	F13
1. Commander Army Topographical Station ATTN: ADAPCP 6500 Brooks Lane Washington, D.C. 20315	P01	9. Commander I Corps & Fort Lewis ATTN: AFZH-AD Fort Lewis, WA 98433	F14
<b>Defense Supply Agency (DSA)</b>		10. Commander Fort McCoy ATTN: AFZR-PAS-MSA Sparta, WI 54656	F16
1. Commander Defense Construction Supply Center ATTN: ADAPCP Columbus, OH 43215	L01	11. Commander Fort McPherson ATTN: AFZK-PA-PD Fort McPherson, Ga 30330	F17
2. Commander Defense General Supply Center ATTN: ADAPCP Richmond, Va 23219	L02	12. Commander Fort Meade ATTN: AFZI-PA-AD Fort Meade, MD 20755	F18
3. Commander Defense Personnel Support Center ATTN: ADAPCP 2800 S. 20th Street Philadelphia, PA 19101	L03	13. Commander 1st Inf Div & Fort Riley ATTN: AFZN-PA-HDA Fort Riley, KS 66442	F19
4. Commander Memphis Defense Depot ATTN: ADAPCP Airways Blvd Memphis, TN 38115	L04	14. Commander Presidio of San Francisco ATTN: AFZM-PA-HRDD Presidio of San Francisco, CA 94129	F20
5. Commander Ogden Defense Depot ATTN: ADAPCP Ogden, UT 84402	L05	15. Commander Fort Sheridan ATTN: AFZP-PA-D Fort Sheridan, IL 60037	F21
<b>U.S. Army Forces Command</b>		16. Commander 24th Inf Div & Fort Stewart ATTN: AFZ-PAP-AP Fort Stewart, GA 31313	F22
Commander U.S. Army Forces Command ATTN: AFPR-HR Fort McPherson, GA 30330		17. Commander 7th Inf Div & Fort Ord ATTN: AFZW-PA-GH Fort Ord, CA 93941	F26
1. Commander XVIII Airborne Corps & Fort Bragg ATTN: AFZA-MD-DA Fort Bragg, NC 28307	F03	18. Commander 5th Inf Div (Mech) & Fort Polk ATTN: AFZX-PA-HD Fort Polk, LA 71459	F27
2. Commander 101st Airborne Div (Air Assault) and Fort Campbell ATTN: AFZB-PA-AD Fort Campbell, KY 42223	F04	19. Commander Fort Irwin ATTN: AFZJ-PA-HD Fort Irwin, CA 92311	F28
3. Commander 4th Inf Div (Mech) & Fort Carson ATTN: AFZB-PA Fort Carson, CO 80913	F05	<b>Military District of Washington (MDW)</b>	
4. Commander Fort Devens ATTN: AFZD-PAH-AD Fort Devens, MA 01433	F07	Commander U.S. Military District of Washington ATTN: ANPE-AD Fort Meyer, VA 22211	
5. Commander Fort Drum ATTN: AFZS-PA-A Fort Drum, NY 13602	F08	1. Commander Fort Meyer ATTN: ANPE-AD/ADCO Fort Meyer, VA 22211	M03
6. Commander III Corps & Fort Hood ATTN: AFZF-HRD-AD-A Fort Hood, TX 76544	F11	<b>Military Traffic Management Command (MTMC)</b>	
7. Commander Fort Sam Houston ATTN: AFZG-PA-HDA Fort Sam Houston, TX 78234	F12	Commander Military Traffic Management Command ATTN: NT-PE (ADCO) 5611 Columbia Pike Falls Church, VA 22041	

**Table B-1**  
**ADAPCP service area codes—Continued**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
1. Commander Bayonne Military Ocean Terminal ATTN: CCC Bayonne, NJ 07002	X01	9. Commander Fort Jackson ATTN: ATZJ-PAPD Fort Jackson, SC 29207	B11
2. Commander Oakland Army Base ATTN: CCC Oakland, CA 96262	X02	10. Commander Fort Knox ATTN: ATZK-PA-PS-ADC Fort Knox, KY 40121	B12
<b>U.S. ARMY INFORMATION SYSTEMS COMMAND (USAISC)</b>		11. Commander Fort Leavenworth ATTN: ATZL-HR-AD Fort Leavenworth, KS 66027	B13
Commander U.S. Army Information Systems Command ATTN: AS-PER-HA Fort Huachuca, AZ 85613-5000		12. Commander Fort Lee ATTN: ATZM-PM-AD Fort Lee, VA 23801	B14
1. Commander Fort Huachuca ATTN: ASH-PCA-PSC Fort Huachuca, AZ 85613	Z01	13. Commander Fort McClellan ATTN: ATZN-PAC-A Fort McClellan, AL 36205	B15
2. Commander Fort Richie ATTN: ASNJ-DCA-PSD Fort Richie, MD 21719	Z02	14. Commander Fort Monroe ATTN: ATZG-PA-ADC Fort Monroe, VA 23651	B16
<b>U.S. ARMY TRAINING AND DOCTRINE COMMAND</b>		15. Commander Fort Rucker ATTN: ATZQ-PA-ADA Fort Rucker, AL 36362	B21
Commander U.S. Army Training and Doctrine Command ATTN: ATPL-HA Fort Monroe, VA 23651		16. Commander Fort Sill ATTN: ATZR-PA-HRD Fort Sill, OK 73503	B22
1. Commander Fort Belvoir ATTN: ATZA-PAH-A Fort Belvoir, VA 22060	B01	17. Commander Fort Leonard Wood ATTN: ATZT-PA-D Fort Leonard Wood, MO 65473	B24
2. Commander Fort Benning ATTN: ATZB-PA-ADCO Fort Benning, GA 31905	B02	18. Commander Fort Hamilton ATTN: ATZD-FH-PCA-AD Fort Hamilton, NY 11252	B25
3. Commander Fort Bliss ATTN: ATZC-PAHD Fort Bliss, Texas 79166	B03	<b>U.S. Army Intelligence and Security Command (INSCOM)</b>	
4. Commander Carlisle Barracks ATTN: ATZE-PA-HRD Carlisle Barracks, PA 17013	B04	Commander U.S. Army Intelligence and Security Command ATTN: IAPER-M Arlington Hall Station Arlington, VA 22212	
5. Commander Fort Dix ATTN: ATZD-GAS-ADCO Fort Dix, NJ 08640	B05	1. Commander Arlington Hall Station ATTN: CCC Arlington Hall Station, VA 22212	U01
6. Commander Fort Eustis ATTN: ATZF-PAPS-AD Fort Eustis, VA 23604	B06	2. Commander Vint Hill Farms Station ATTN: CCC Warrenton, Va 22186	U02
7. Commander Fort Gordon ATTN: ATZH-PAD Fort Gordon, GA 30905	B07	<b>U.S. Army Health Services Command</b>	
8. Commander Fort Benjamin Harrison ATTN: ATZI-PA-AD Fort Benjamin Harrison, IN 46216	B08	Commander U.S. Army Health Services Command ATTN: HSPE-HA Fort Sam Houston, TX 78234	

**Table B-1**  
**ADAPCP service area codes—Continued**

Organization/location	ADAPCP Service area code	Organization/location	ADAPCP Service area code
1. Commander Fort Detrick ATTN: FT Detrick HSD- PD Frederick, MD 21701	H01		
2. Commander Fitzsimmons Army Medical Center ATTN: HSF-DPC-HD Denver, CO 80045	H02		
3. Commander Walter Reed Army Medical Center ATTN: HSHL-RAD 6925 16th Street Washington, DC 20307	H03		

\*Note:  
 All correspondence to 2d ID should be addressed CDR, 2d ID, ATTN:  
 EAIDGP-DA, APO SF 96224, not to the individual counseling centers. Service  
 Area Codes are for USADAOA use only.

**Table B-2**  
Federal civilian employee categories and pay grades/  
equivalences.

Employee categories	Codes and pay grades
General service	GS 01-18
Wage grades	WG 01-15
Wage leaders	WL 01-15
Wage supervisors	WS 01-19
Nonsupervisory production schedulers	WD 01-11
Supervisory production schedulers	WN 01-09
General merit (eff 1-Oct 81)	GM 13-15
Senior executive service	ES 16-18
Local craft workers	NA 01-15
Local craft leaders	NL 01-15
Local craft supervisors	NS 01-19
Administrative services	AS 01-18
Universal annual	UA 01-18
Personnel services	PS 01-07
Contract workers	CW

**Table B-3**  
Length of Service Codes for use with DA Form 4465

Length of service	Dates codes
1 week or less	A1
Over 1 week to 1 month	A2
1 month, less than 2	A3
2 months, less than 3	A4
3 months, less than 4	B1
4 months, less than 5	B2
5 months, less than 6	B3
6 months, less than 7	C1
7 months, less than 8	C2
8 months, less than 9	C3
9 months, less than 10	D1
10 months, less than 11	D2
11 months, less than 12	D3
12 months, less than 16	E1
16 months, less than 19	F1
19 months, less than 22	G1
22 months, less than 24	H1
2 years, 3 years, etc.	02, 03 etc.

**Notes:**

- For item 16A of DA Form 4465, length of service will be indicated as follows:
  - For less than 2 years list service in months.
  - More than 2 years, list service in years. Round down, for example, 2 years 11 months will be coded as 02.
- For item 16B, length of service present unit, enter one of the above appropriate data codes for soldiers per instructions that follow:
  - For soldiers overseas, enter the appropriate data code for months or years assigned to the theater (that is, the time the soldier has been assigned to the theater, not the length of his tour).
  - For soldiers in CONUS, enter the appropriate data code for months or years assigned to the installation or activity.

**Table B-4**  
Major Command Codes

MACOM	CODE
U.S. Army Forces Command*	F
U.S. Army Europe & 7th Army (USAREUR)	E
U.S. Army Western Command (WESTCOM)	W
U.S. Army Japan (USARJ)	J
Eighth U.S. Army (Korea) (EUSA)	K
U.S. Army Materiel Command	G
Office of the Deputy Chief of Staff for Personnel (ODCSPER)	D
Defense Mapping Agency (DMA)	P
Defense Supply Agency	L
Military District of Washington	M
Military Traffic Management Command	X
U.S. Army Information Systems Command	Z
U.S. Army Training and Doctrine Command*	B
U.S. Army Intelligence and Security Command	U
U.S. Army Health Services Command	H
Office of the Chief of Army Reserve (formerly SAC DO2)	S
U.S. Army Corps of Engineers	C
U.S. Army Criminal Investigation Command	I
U.S. Army Recruiting Command	R
Other	O

\*National Guard clients will be carried under FORSCOM. U.S. Army Reserve clients may be carried under FORSCOM or TRADOC depending on their unit's mission.

**Table B-5**  
Specified unit codes

Use the following codes to identify types of units in item 26b, DA Form 4465:

**Parent**

- D—Divisional
- N—Nondivisional
- T—TDA

**Unit**

- A—Garrison Support
- B—Combat
- C—Combat Support
- D—Combat Services Support
- E—BCT
- F—AIT
- G—NCO/Officer Course
- H—Special (Ranger, Special Forces, etc.)
- I—Other

**Note:**

The parent unit code will be entered in the left box of item 26b. Enter the unit code in the right box of item 26b. Code I (other) should indicate TDA activities such as field operating agencies (FOAs), combat development activities, research and development activities, headquarters, and other types of activities which cannot be classified using codes A through H. Check the "COHORT" box if the unit is a designated COHORT organization.

**Table B-6**  
**Medical residential treatment facility codes**

Organization/Location	RTF Code
Commander MEDCOM-Korea ATTN: EAMC-ATF APO San Francisco 96301	R1
Commander William Beaumont Army Medical Center ATTN: ATF El Paso, TX 79920	W1
Commander Dwight David Eisenhower Medical Center ATTN: ATF Fort Gordon, GA 30905	W2
Commander Tripler Army Medical Center ATTN: HST-P Honolulu, HI 96859	W3
Commander Bad Cannstatt MEDDAC ATTN: ATF APO New York 09154	E1
Commander Berlin MEDDAC ATTN: Dept of Psychiatry RTF APO New York 09742	E2
Commander Frankfurt MEDDAC ATTN: Dept of Psychiatry RTF Box 4 APO New York 09757	E3
Commander Heidelberg MEDDAC ATTN: Dept of Psychiatry DARE Program APO New York 09102	E4
Commander Landstuhl MEDDAC ATTN: Dept of Psychiatry SHARE Program APO New York 09180	E5
Commander Nurnberg MEDDAC ATTN: Dept of Psychiatry RTF APO New York 09105	E6
Tri-Service Alcoholism Recovery Facility Bldg 12 National Naval Facility Bethesda, MD 20014	T1
Other residential treatment facilities (Air Force)	AF
Other residential treatment facilities (Navy)	NA
Other civilian residential treatment facilities	OT

**Table B-7**  
**ADAPCP enrollment codes—Section I**

Code	Description
ALCAC	Alcohol abuse continuous
ALCAE	Alcohol abuse episodic
ALCAR	Alcohol abuse in remission
ALCAU	Alcohol abuse unspecified
ALCCF	Alcohol, counselor evaluation, family member/spouse of abuser
ALCCG	Alcohol, counselor evaluation, gain/enrolled
ALCDC	Alcohol dependence continuous
ALCDE	Alcohol dependence episodic
ALCDR	Alcohol dependence in remission
ALCDU	Alcohol dependence unspecified
ALCIG	Alcohol no diagnosis apparent improper use, gain/enrolled
ALCMG	Alcohol, medical evaluation, gain/enrolled
AMPAC	Amphetamine abuse continuous
AMPAE	Amphetamine abuse episodic
AMPAR	Amphetamine abuse in remission
AMPAU	Amphetamine abuse unspecified
AMPCF	Amphetamines, counselor evaluation, family member/spouse of abuser
AMPCG	Amphetamines, counselor evaluation, gain/enrolled
AMPDC	Amphetamines dependence continuous
AMPDE	Amphetamine dependence episodic
AMPDR	Amphetamine dependence in remission
AMPDU	Amphetamine dependence unspecified
AMPIG	Amphetamine no diagnosis apparent improper use, gain/enrolled
AMPMG	Amphetamine, medical evaluation, gain/enrolled
BARAC	Barbiturate abuse continuous
BARAE	Barbiturate abuse episodic
BARAR	Barbiturate abuse in remission
BARAU	Barbiturate abuse unspecified
BARCF	Barbiturates, counselor evaluation, family member/spouse of abuser
BARCG	barbiturates, counselor evaluation, gain/enrolled
BARDC	Barbiturate dependence continuous
BARDE	Barbiturate dependence episodic
BARDR	Barbiturate dependence in remission
BARDU	Barbiturate dependence unspecified
BARIG	Barbiturate no diagnosis apparent improper use, gain/enrolled
BARMG	Barbiturate, medical evaluation, gain/enrolled
CANAC	Cannabis abuse continuous
CANAE	Cannabis abuse episodic
CANAR	Cannabis abuse in remission
CANAU	Cannabis abuse unspecified
CANCF	Cannabis, counselor evaluation, family member/spouse of abuser

**Table B-7  
ADAPCP enrollment codes—Section I—Continued**

Code	Description
CANCG	Cannabis, counselor evaluation, gain/enrolled
CANDC	Cannabis dependence continuous
CANDE	Cannabis dependence episodic
CANDR	Cannabis dependence in remission
CANDU	Cannabis dependence unspecified
CANIG	Cannabis improper use, gain/enrolled
CANMG	Cannabis, medical evaluation, gain/enrolled
COCAC	Cocaine abuse continuous
COCAE	Cocaine abuse episodic
COCAR	Cocaine abuse in remission
COCAU	Cocaine abuse unspecified
COCCF	Cocaine, counselor evaluation, family member/spouse of abuser
COCCG	Cocaine, counselor evaluation, gain/enrolled
COCIG	Cocaine no diagnosis apparent improper use, gain/enrolled
COCMG	Cocaine, medical evaluation, gain/enrolled
HALAC	Hallucinogen abuse continuous
HALAE	Hallucinogen abuse episodic
HALAR	Hallucinogen abuse in remission
HALAU	Hallucinogen abuse unspecified
HALCF	Hallucinogen, counselor evaluation, family member/spouse of abuser
HALCG	Hallucinogen, counselor evaluation, gain/enrolled
HALIG	Hallucinogen no diagnosis apparent improper use, gain/enrolled
HALMG	Hallucinogen, medical evaluation, gain/enrolled
METCF	Methaqualone, counselor evaluation, family member/spouse of abuser
METCG	Methaqualone, counselor evaluation, gain/enrolled
METIG	Methaqualone no diagnosis apparent improper use, gain/enrolled
METMG	Methaqualone, medical evaluation, gain/enrolled
OMSAC	Other mixed substance abuse continuous
OMSAE	Other mixed substance abuse episodic
OMSAR	Other mixed substance abuse in remission
OMSAU	Other mixed substance abuse unspecified
OMSDC	Other mixed substance dependence continuous
OMSDE	Other mixed substance dependence episodic
OMSDR	Other mixed substance dependence in remission
OMSDU	Other mixed substance dependence unspecified
OPIAC	Opiate abuse continuous
OPIAE	Opiate abuse episodic
OPIAR	Opiate abuse in remission
OPIAU	Opiate abuse unspecified
OPICF	Opiate, counselor evaluation, family member/spouse of abuser
OPICG	Opiate, counselor evaluation, gain/enrolled
OPIDC	Opiate dependence continuous
OPIDE	Opiate dependence episodic
OPIDR	Opiate dependence in remission
OPIDU	Opiate dependence unspecified
OPIIG	Opiate no diagnosis apparent improper use, gain/enrolled
OPIMG	Opiate, medical evaluation, gain/enrolled
OTHCF	Other substance, counselor evaluation, family member/spouse of abuser
OTHCG	Other substance, counselor evaluation, gain/enrolled

OTHIG	Other substance no diagnosis apparent improper use, gain/enrolled
OTHMG	Other substance, medical evaluation, gain/enrolled
PHEAC	Phencyclidine abuse continuous
PHEAE	Phencyclidine abuse episodic
PHEAR	Phencyclidine abuse in remission
PHEAU	Phencyclidine abuse unspecified
PHECF	Phencyclidine, counselor evaluation, family member/spouse of abuser
PHECG	Phencyclidine, counselor evaluation, gain/enrolled
PHEIG	Phencyclidine no diagnosis apparent improper use, gain/enrolled
PHEMG	Phencyclidine, medical evaluation, gain/enrolled
TRACF	Tranquilizer, counselor evaluation, family member/spouse of abuser
TRACG	Tranquilizer, counselor evaluation, gain/enrolled
TRAIG	Tranquilizer no diagnosis apparent improper use, gain/enrolled
TRAMG	Tranquilizer, medical evaluation, gain/enrolled

**Table B-7  
Screened-not-enrolled—final disposition codes—Section II**

Code	Description
ALCCA	Alcohol, counselor evaluation, administrative action
ALCCI	Alcohol, counselor evaluation, incomplete evaluation
ALCCL	Alcohol, counselor evaluation, legal action
ALCCN	Alcohol, counselor evaluation, no further action
ALCCO	Alcohol, counselor evaluation, other resources
ALCCS	Alcohol, counselor evaluation, separation
ALCMA	Alcohol, medical evaluation, administrative action
ALCMI	Alcohol, medical evaluation, incomplete evaluation
ALCML	Alcohol, medical evaluation, legal action
ALCMN	Alcohol, medical evaluation, no further action
ALCMO	Alcohol, medical evaluation, other resources
ALCMS	Alcohol, medical evaluation, separation
ALCFN	Alcohol, family member, no further action
ALCFO	Alcohol, family member, other resources
AMPCA	Amphetamines, counselor evaluation, administrative action
AMPCL	Amphetamines, counselor evaluation, incomplete evaluation
AMPCL	Amphetamines, counselor evaluation, legal action
AMPCL	Amphetamines, counselor evaluation, no further action
AMPCO	Amphetamines, counselor evaluation, other resources
AMPCS	Amphetamines, counselor evaluation, separation
AMPMA	Amphetamines, medical evaluation, administrative action
AMPMI	Amphetamines, medical evaluation, incomplete evaluation
AMPML	Amphetamines, medical evaluation, legal action
AMPML	Amphetamines, medical evaluation, no further action
AMPMN	Amphetamines, medical evaluation, other resources
AMPNO	Amphetamines, medical evaluation, other resources
AMPMP	Amphetamines, medical evaluation, prescribed medication/authorized use

**Table B-7**  
**Screened-not-enrolled—final disposition codes—Section**  
**II—Continued**

Code	Description
AMPMS	Amphetamines, medical evaluation, separation
AMPFN	Amphetamines, family member, no further action
AMPFO	Amphetamines, family member, other resources
BARCA	Barbiturates, counselor evaluation, administrative action
BARCI	Barbiturates, counselor evaluation, incomplete evaluation
BARCL	Barbiturates, counselor evaluation, legal action
BARCN	Barbiturates, counselor evaluation, no further action
BARCO	Barbiturates, counselor evaluation, other resources
BARCS	Barbiturates, counselor evaluation, separation
BARMA	Barbiturates, medical evaluation, administrative action
BARMI	Barbiturates, medical evaluation, incomplete evaluation
BARML	Barbiturates, medical evaluation, legal action
BARMN	Barbiturates, medical evaluation, no further action
BARMO	Barbiturates, medical evaluation, other resources
BARMP	Barbiturates, medical evaluation, prescribed medication/ authorized use
BARMS	Barbiturates, medical evaluation, separation
BARFN	Barbiturates, family member, no further action
BARFO	Barbiturates, family member, other resources
CANCA	Cannabis, counselor evaluation, administrative action
CANCI	Cannabis, counselor evaluation, incomplete evaluation
CANCL	Cannabis, counselor evaluation, legal action
CANCN	Cannabis, counselor evaluation, no further action
CANCO	Cannabis, counselor evaluation, other resources
CANCS	Cannabis, counselor evaluation, separation
CANMA	Cannabis, medical evaluation, administrative action
CANMI	Cannabis, medical evaluation, incomplete evaluation
CANML	Cannabis, medical evaluation, legal action
CANMN	Cannabis, medical evaluation, no further action
CANMO	Cannabis, medical evaluation, other resources
CANMS	Cannabis, medical evaluation, separation
CANFN	Cannabis, family member, no further action
CANFO	Cannabis, family member, other resources
COCCI	Cocaine, counselor evaluation, incomplete evaluation
COCCL	Cocaine, counselor evaluation, legal action
COCCN	Cocaine, counselor evaluation, no further action
COCCO	Cocaine, counselor evaluation, other resources
COCCS	Cocaine, counselor evaluation, separation
COCMA	Cocaine, medical evaluation, administrative action
COCMI	Cocaine, medical evaluation, incomplete evaluation
COCML	Cocaine, medical evaluation, legal action
COCMN	Cocaine, medical evaluation, no further action
COCMO	Cocaine, medical evaluation, other resources
COCMP	Cocaine, medical evaluation, prescribed medication/ authorized use
COCMS	Cocaine, medical evaluation, separation
COCFN	Cocaine, family member, no further action
COCFO	Cocaine, family member, other resources
HALCA	Hallucinogen, counselor evaluation, administrative action
HALCI	Hallucinogen, counselor evaluation, incomplete evaluation
HALCL	Hallucinogen, counselor evaluation, legal action
HALCN	Hallucinogen, counselor evaluation, no further action
HALCO	Hallucinogen, counselor evaluation, other resources
HALCS	Hallucinogen, counselor evaluation, separation
HALMA	Hallucinogen, medical evaluation, administrative action
HALMI	Hallucinogen, medical evaluation, incomplete evaluation
HALML	Hallucinogen, medical evaluation, legal action
HALMN	Hallucinogen, medical evaluation, no further action
HALMO	Hallucinogen, medical evaluation, other resources
HALMS	Hallucinogen, medical evaluation, separation
HALFN	Hallucinogen, family member, no further action
HALFO	Hallucinogen, family member, other resources
METCA	Methaqualone, counselor evaluation, administrative action
METCI	Methaqualone, counselor evaluation, incomplete evaluation
METCL	Methaqualone, counselor evaluation, legal action
METCN	Methaqualone, counselor evaluation, no further action
METCO	Methaqualone, counselor evaluation, other resources
METCS	Methaqualone, counselor evaluation, separation
METMA	Methaqualone, medical evaluation, administrative action
METMI	Methaqualone, medical evaluation, incomplete evaluation
METML	Methaqualone, medical evaluation, legal action
METMN	Methaqualone, medical evaluation, no further action
METMO	Methaqualone, medical evaluation, other resources
METMS	Methaqualone, medical evaluation, separation
METFN	Methaqualone, family member, no further action
METFO	Methaqualone, family member, other resources
NADCA	Non alcohol or drug, counselor evaluation, admin. action
NADCI	Non alcohol or drug, counselor evaluation, incomplete eval.
NADCL	Non alcohol or drug, counselor evaluation, legal action
NADCN	Non alcohol or drug, counselor evaluation, no further action
NADCO	Non alcohol or drug, counselor evaluation, other resources
NADCS	Non alcohol or drug, separation
NADMA	Non alcohol or drug, medical evaluation, administrative action
NADMI	Non alcohol or drug, medical evaluation, incomplete evaluation
NADML	Non alcohol or drug, medical evaluation, legal action
NADMN	Non alcohol or drug, medical evaluation, no further action
NADMO	Non alcohol or drug, medical evaluation, other resources
NADMS	Non alcohol or drug, medical evaluation, separation
NADFN	Non alcohol or drug, family member, no further action
NADFO	Non alcohol or drug, family member, other resources
OPICA	Opiates, counselor evaluation, administrative action
OPICI	Opiates, counselor evaluation, incomplete evaluation
OPICL	Opiates, counselor evaluation, legal action
OPICN	Opiates, counselor evaluation, no further action
OPICO	Opiates, counselor evaluation, other resources
OPICS	Opiates, counselor evaluation, separation
OPIMA	Opiates, medical evaluation, administrative action
OPIMI	Opiates, medical evaluation, incomplete evaluation
OPIML	Opiates, medical evaluation, legal action
OPIMN	Opiates, medical evaluation, no further action
OPIMO	Opiates, medical evaluation, other resources

**Table B-7**  
**Screened-not-enrolled—final disposition codes—Section**  
**II—Continued**

Code	Description
OPIMP	Opiates, medical evaluation, prescribed medication/authorized use
OPIMS	Opiates, medical evaluation, separation
OPIFN	Opiates, family member, no further action
OPIFO	Opiates, family member, other resources
OTHCA	Other substance, counselor evaluation, administrative action
OTHCI	Other substance, counselor evaluation, incomplete evaluation
OTHCL	Other substance, counselor evaluation, legal action
OTHCN	Other substance, counselor evaluation, no further action
OTHCO	Other substance, counselor evaluation, other resources
OTHCS	Other substance, counselor evaluation, separation
OTHMA	Other substance, medical evaluation, administrative action
OTHMI	Other substance, medical evaluation, incomplete evaluation
OTHML	Other substance, medical evaluation, legal action
OTHMN	Other substance, medical evaluation, no further action
OTHMO	Other substance, medical evaluation, other resources
OTHMP	Other substance, medical evaluation, prescribed medication/authorized use
OTHMS	Other substance, medical evaluation, separation
OTHFN	Other substance, family member, no further action
OTHFO	Other substance, family member, other resources
PHECA	Phencyclidine, counselor evaluation, administrative action
PHECI	Phencyclidine, counselor evaluation, incomplete evaluation
PHECL	Phencyclidine, counselor evaluation, legal action
PHECN	Phencyclidine, counselor evaluation, no further action
PHECO	Phencyclidine, counselor evaluation, other resources
PHECS	Phencyclidine, counselor evaluation, separation
PHEMA	Phencyclidine, medical evaluation, administrative action
PHEMI	Phencyclidine, Medical Evaluation, Incomplete Evaluation
PHEML	Phencyclidine, medical evaluation, legal action
PHEMN	Phencyclidine, medical evaluation, no further action
PHEMO	Phencyclidine, medical evaluation, other resources
PHEMS	Phencyclidine, medical evaluation, separation
PHEFN	Phencyclidine, family member, no further action
PHEFO	Phencyclidine, family member, other resources
TRACA	Tranquilizer, counselor evaluation, administrative action
TRACI	Tranquilizer, counselor evaluation, incomplete evaluation
TRACL	Tranquilizer, counselor evaluation, legal action
TRACN	Tranquilizer, counselor evaluation, no further action
TRACO	Tranquilizer, counselor evaluation, other resources
TRACS	Tranquilizer, counselor evaluation, separation
TRAMA	Tranquilizer, medical evaluation, administrative action
TRAMI	Tranquilizer, medical evaluation, incomplete evaluation
TRAML	Tranquilizer, medical evaluation, legal action
TRAMN	Tranquilizer, medical evaluation, no further action
TRAMO	Tranquilizer, medical evaluation, other resources
TRAMP	Tranquilizer, medical evaluation, prescribed medication/authorized use
TRAMS	Tranquilizer, medical evaluation, separation
TRAFN	Tranquilizer, family member, no further action
TRAF0	Tranquilizer, family member, other resources

**RESERVED**

**Figure B-1. Sample completed DA Form 2496**

**CMT 1**

**Item 1.** Enter the rank and full name fo Army soldier being referred.

**Item 2.** Enter the reason for referral; that is one of the following:

(a) Laboratory positive test following commander directed or other biochemical urine testing.

(b) Self-referral.

(c) Commander referral.

(d) Investigation/apprehension referral (includes DWI arrest and court ordered referral)

(e) Medical referral.

**Item 3.** Check whether a medical evaluation is requested as a part of the screening process. The commander may request a medical evaluation for any soldier referred to the CCC. (A laboratory positive biochemical urine test, for other than THC alone, requires a medical evaluation of the positive result.)

**CMT 2**

**Item 1.** Check the box which corresponds to the recommendation. (In some instances more than one box may be checked; for example, enrollment in Track I and unit counseling by the commander.)

**Item 2.** Indicate the mutually agreed upon time for the rehabilitation team meeting to further discuss the case and the rehabilitation plan for the soldier.

**CMT 3**

Indicated approval or disapproval of the recommendation(s) for the soldier after the scheduled meeting.

# DISPOSITION FORM

For use of this form, see AR 340-15, the proponent agency is TAGO.

REFERENCE OR OFFICE SYMBOL	SUBJECT
AFUF-JFO	ADAPCP Military Client Referral and Screening Record

TO Fort Stewart Counseling Center FROM MMC, USA Gar FORSCOM DATE 20 Mar 85 CMT 1  
CPT Lancaster AV 228-8201

1. Effective this date PFC John C. Doe is referred for CCC screening.
2. Reason for referral PFC Doe was apprehended by Military Police while driving under the influence of alcohol on March 85.
3. Request medical evaluation  Yes  No

  
JOHN T. LANCASTER  
CPT, INF  
Commanding

DPCA-ADCO-CCC  
TO CDR, HHC, USA Gar FROM Ft Stewart Counseling Center DATE 21 Mar 85 CMT 2  
Mrs. Sperling AV 228-8309

1. The above named individual has been screened and the following is recommended:
  - a. Enrollment  
(1)  Track I  
(2)  Track II  
(3)  Track III
  - b.  Unit counseling by Commander or designated representative
  - c.  Other (specify)  
\_\_\_\_\_
  - d.  No ADAPCP services required at the present time.

2. Rehabilitation team meeting is scheduled for the following date 21 MARCH, 85 to discuss results of initial screening interview and recommendation(s).

JANE T. SPERLING  
Clinical Director  
CCC

AFUF-JFC  
TO Ft Stewart Counseling Center FROM HHC, USA Gar DATE 22 Mar 85 CMT 3  
CPT Lancaster AV 228-8201

Approve  Disapprove recommendation

  
JOHN T. LANCASTER  
CPT, INF  
Commanding

DA FORM 2496  
AUG 80

PREVIOUS EDITIONS WILL BE USED

U.S. GOVERNMENT PRINTING OFFICE: 1982-372-711

Figure B-1. Sample completed DA Form 2496

**Figure B-2-Sample-DA Form 4465 (CIR)**

**Item.** Client's Name. For local use only.

**Item.** Client's unit/office. Include only on health record and ADAPCP client record copies. Information not to be forwarded to USADAOA (DAMIS).1 Enter office where civilian employee works.

**Item 1.** Date of enrollment-Year, month, day.  
**Remarks.** For soldiers, enter calendar date of CMT 3 on the ADAPCP Military Client Referral and Screening Record. For civilian employees and other clients, enter the date the client was enrolled by the ADAPCP staff.

**Item 2.** Client's ID code.2 Active duty/ADT military client.  
**Remarks.** Enter social security number (SSN) for all military service members.

Nonmilitary client code  
**Remarks.** Enter the first three digits of the client's SSN plus date of birth by year, month, and day; for example, 253450215 (15 Feb 45). For foreign nationals and other clients who do not have an SSN, enter 000 plus date of birth as above.

**Item 3.** ADAPCP service area code.  
**Remarks.** Enter current ADAPCP service area code from table B-1

**Item 4.** Client's status.  
**Remarks.** Check one box only. When block 4B is checked, use table B-9 for codes of other Military services. Retired military or family members currently working in Federal service will be reported as a Federal service employee.

**Item 5A.** Physician diagnosis/basis for enrollment  
**Remarks.** See paragraph B-9. ADCO will ensure that physicians performing medical evaluation have access to information in paragraph B-9.

**Item 5B.** Name of MTF  
**Remarks.** Enter name of MTF.

**Item 5C.** Name and grade of physician  
**Remarks.** Complete items 5C, and D only when item 5A (Physician's diagnosis/basis for enrollment) is completed by a physician. Enter typed or printed name and grade of physician. Items 5C and 5D will not be completed unless a specific diagnosis or no diagnosis apparent is rendered during medical evaluation by a physician.

**Item 5D.** Signature of physician  
**Remarks.** Signed by physician.

**Item 5E.** Date  
**Remarks.** Self-explanatory.

**Item 6.** Diagnostic code(s)  
**Remarks.** Enter appropriate codes. (See table B-7).

**Item 7.** Case finding method  
**Remarks.** Check appropriate box which indicates the reason for referral by the commander on the ADAPCP Military Client Referral and Screening Record. For civilian employees and

other clients, check the box which best reflects how the client's problem was initially discovered.

**Item 8.** Enrollment disposition  
**Remarks.** Check appropriate box for disposition of client at time of program entry.

**Item 9.** Civilian employee grade.  
**Remarks.** For the first two digits-alpha character indicating GS, WG, etc, see table B-2. For the second two digits, enter the pay grade level.

**Item 9A.** Grade Code  
**Remarks.** For all service members, enter the pay grade designation; for example, E6, O3. Leave left two boxes blank for military.

**Item 10.** Client's present residence  
**Remarks.** Check appropriate box.

**Item 11.** Client's year of birth  
**Remarks.** Enter the year, month, and day of the client's year of birth. Enter number only.

**Item 12.** Race  
**Remarks.** Check appropriate box.

**Item 13.** Sex  
**Remarks.** Check appropriate box.

**Item 14.** Education  
**Remarks.** Check appropriate box.

**Item 15.** Marital status  
**Remarks.** Check appropriate box.

**Item 16.** Length of service  
**Remarks.** Self-explanatory

**Item 16A.** Length of service (LOS) data code  
**Remarks.** For LOS data code, see table B-3. Enter length of service for all military service members and civilian employees.

**Item 16B.** Length of service present unit  
**Remarks.** For LOS data code, see table B-3. Enter length of service in present unit for all military service members.

**Item 17.** Primary military occupational speciality (PMOS) of soldier  
**Remarks.** Self-explanatory.

**Item 17A.** PMOS Code/Civilian Series  
**Remarks.** Enter Army service member's PMOS code or civilian series. Leave blank for members of other services.

**Item 17B.** Performing in PMOS/civilian series  
**Remarks.** Check appropriate box.

**Item 18.** Previous alcohol or drug client  
**Remarks.** Check appropriate box. "Other" rehabilitation programs include rehabilitation programs of other Services, civilian programs, Alcoholics Anonymous and other counseling that was alcohol or drug related.

**Item 19.** Consent of civilian employee to release information to supervisor.  
**Remarks.** Check "yes" if civilian employee consented to release of rehabilitation information to supervisor. Otherwise, check "no."

**Item 20.** Client's disciplinary record (alcohol or drug related)

**Remarks.** Enter numbers appropriate to specific disciplinary record items for all clients. For any entry that exceeds "9," enter "9"

**Item 21.** Soldier's record for AWOL  
**Remarks.** Enter total number of AWOL episodes for all military service members. For any entry that exceeds "9," enter "9."

**Item 22.** Soldier's expiration term of service (ETS) date.  
**Remarks.** Year, month, day. Enter calendar date of all military service member's ETS date; that is, 850516.

**Item 23.** Inpatient detoxification  
**Remarks.** Check appropriate box.

**Item 24.** Utilization of civilian treatment/Rehabilitation facilities  
**Remarks.** Check appropriate box.

**Item 25.** Drug/alcohol usage profile  
**Remarks.** Show history of client's drug/alcohol usage by completing in accord with instructions on the form.

**Item 26A.** Major command  
**Remarks.** Enter Major command code. (See table B-4.)

**Item 26B.** Specific unit code  
**Remarks.** Enter specific unit code. (See table B-5.)

**Item 27A.** Typed name of counselor  
**Remarks.** Self-explanatory.

**Item 27B.** Signature of counselor.  
**Remarks.** Must be signed by counselor. Unsigned forms will be returned.

**Item 28.** Military mailing address of Community Counseling Center.  
**Remarks.** Enter the complete mailing address of community counseling center.

**Item 29A.** Typed name of clinical director  
**Remarks.** Self-explanatory.

**Item 29B.** Signature of clinical director  
**Remarks.** Must be authenticated by the clinical director. Unsigned forms will be returned.

**Notes:**

1. Incomplete records will be returned to the submitting ADAPCP for completion.
2. To assist in the compilation of accurate data and to ensure the matching of the ADAPCP client intake records (CIRs) (DA Form 4465) with subsequent ADAPCP client progress reports (CPRs) (DA Form 4466), it is important that entries in items 2 and 3 of the CIR be identical to items 2 and 3 on all subsequent CPRs submitted on the same client. Once a CIR has been submitted to USADAOA, the codes in items 2 or 3 of the CIR and items 2 and 3 of CPRs must not be changed unless specifically requested by USADAOA. Any errors discovered after submission of a CIR or CPR will be immediately reported by the ADCO to USADAOA (DAMIS).

Client's Name:

Unit Office:

ADAPCP CLIENT INTAKE/SCREENING RECORD (CIR)

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

REQUIREMENT CONTROL SYMBOL  
CSGPA-1400(R2)

SEE REVERSE SIDE FOR PRIVACY ACT STATEMENT

1. DATE OF ENROLLMENT OR FINAL DISPOSITION 8 5 1 2 2 0 Year Month Day		2. CLIENT'S ID CODE 9 9 9 2 2 8 9 9 9		3. ADAPCP SERVICE AREA CODE: F 1 2		4. CLIENT'S STATUS (Check one box only) A. <input checked="" type="checkbox"/> Army/ADT B. <input type="checkbox"/> Other Mil Svc: (Enter Code) C. <input type="checkbox"/> ARNG D. <input type="checkbox"/> USAR E. <input type="checkbox"/> DA/NAF Civ Empl F. <input type="checkbox"/> Other DOD Civ Empl G. <input type="checkbox"/> DEP AD MIL H. <input type="checkbox"/> Dep Ret/Dec Mil I. <input type="checkbox"/> Dep DA/NAF Civ Empl J. <input type="checkbox"/> Dep DOD Civ Empl K. <input type="checkbox"/> Ret Mil L. <input type="checkbox"/> Foreign National																																																													
5A. DIAGNOSIS/BASIS FOR ENROLLMENT OR FINAL DISPOSITION: A. Cannabis - Imp Use B. _____ C. _____ D. _____ E. _____			6. ENROLLMENT OR FINAL DISPOSITION CODE(S) A. C.A.N.I.6 B. _____ C. _____ D. _____ E. _____			7. INITIAL CASE FINDING METHOD (Check one box only) BIO-CHEMICAL: A. <input checked="" type="checkbox"/> CDR Dir. Indiv B. <input type="checkbox"/> CDR Dir Unit C. <input type="checkbox"/> CDR Dir Breathalizer D. <input type="checkbox"/> Physician Directed E. <input type="checkbox"/> Rehab. Staff F. <input type="checkbox"/> Other Local Test NON-BIO-CHEMICAL: G. <input type="checkbox"/> Self Ref H. <input type="checkbox"/> CDR Ref I. <input type="checkbox"/> Supv Ref J. <input type="checkbox"/> Inves/APP K. <input type="checkbox"/> Med Ref L. <input type="checkbox"/> Parental Ref																																																													
5B. NAME OF MEDICAL TREATMENT FACILITY: Brooks Army Med CTR.				5C. NAME AND GRADE OF PHYSICIAN: John E. Doe MAJ		5D. SIGNATURE OF PHYSICIAN <i>John E. Doe</i>																																																													
5E. DATE OF MED EVAL 10 Dec 85		8. ENROLLMENT DISPOSITION A. <input type="checkbox"/> Track I B. <input checked="" type="checkbox"/> Track II C. <input type="checkbox"/> Track III RTF Code		9. MIL/AV GRADE: E 4		10. CLIENT'S PRESENT RESIDENCE: A. <input checked="" type="checkbox"/> Army Barrack B. <input type="checkbox"/> BEQ C. <input type="checkbox"/> BOQ D. <input type="checkbox"/> On-Post Housing E. <input type="checkbox"/> Off-Post Housing with Dependents F. <input type="checkbox"/> Off-Post Housing without Dependents																																																													
11. DATE OF BIRTH: 3 0 0 6 1 3 Year Month Day		12. RACE: A. <input checked="" type="checkbox"/> White B. <input type="checkbox"/> Black C. <input type="checkbox"/> Asian/Pacific Islander D. <input type="checkbox"/> Alaskan Native/American Indian E. <input type="checkbox"/> Hispanic F. <input type="checkbox"/> Other/Unknown		14. Education: A. <input type="checkbox"/> College Grad. B. <input type="checkbox"/> Some College C. <input type="checkbox"/> High School Grad D. <input checked="" type="checkbox"/> Some High School/GED E. <input type="checkbox"/> 1st-8th Grade		13. SEX: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female																																																													
15. MARITAL STATUS: A. <input checked="" type="checkbox"/> Never Married B. <input type="checkbox"/> Now Married C. <input type="checkbox"/> Divorced D. <input type="checkbox"/> Separated E. <input type="checkbox"/> Widowed		16. LENGTH OF SERVICE(LOS): A. 0 2 LOS Data Code B. F 1 1 LOS Present Unit		17. PMOS/SPECIALTY A. 1 1 1 B 1 PMOS/Civilian Series Code B. Performing in PMOS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		18. Previous Alcohol or Drug Counseling/Rehabilitation: A. <input type="checkbox"/> Army B. <input checked="" type="checkbox"/> None C. <input type="checkbox"/> Other: (Specify)																																																													
19. CONSENT OF CIVILIAN EMPLOYEE TO RELEASE INFORMATION TO SUPERVISOR: <input type="checkbox"/> Yes <input type="checkbox"/> No				20. CLIENT'S DISCIPLINARY RECORD (Alcohol or Drug Related):		21. TOTAL NUMBER OF AWOL EPISODES:																																																													
CIVILIAN		MILITARY		CIVILIAN EMPLOYEE		22. SVC MEMBER'S ETS DATE 8 7 1 1 3 0 Year Month Day																																																													
A. Arrests		C. Article 15		E. Letters of Reprimand																																																															
B. Convictions		D. Court Martial		F. Suspensions																																																															
23. INPATIENT DETOXIFICATION A. <input type="checkbox"/> Necessary B. <input checked="" type="checkbox"/> Unnecessary C. <input type="checkbox"/> Completed				24. UTILIZATION OF CIVILIAN TREATMENT REHAB. FACILITIES: <input type="checkbox"/> Yes <input type="checkbox"/> No																																																															
25. DRUG/ALCOHOL USAGE PROFILE (Complete items below according to instructions provided):																																																																			
<table border="1"> <tr> <th></th> <th>Last Time Used</th> <th>How Often Used</th> <th>How Taken</th> <th>Use Prior To Fed. SVC.</th> </tr> <tr> <td>A. Alcohol</td> <td>2</td> <td>3</td> <td>2</td> <td>Y</td> </tr> <tr> <td>B. Amphetamines</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>C. Barbituates</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>D. Cannabis Product</td> <td>3</td> <td>2</td> <td>2</td> <td>Y</td> </tr> <tr> <td>E. Cocaine</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>F. Hallucinogens</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>G. Methaqualone</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>H. Opiates</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>I. Other Tranquilizer</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>J. Phencyclidine</td> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>K. Other (Specify)</td> <td>1</td> <td></td> <td></td> <td></td> </tr> </table>					Last Time Used	How Often Used	How Taken	Use Prior To Fed. SVC.	A. Alcohol	2	3	2	Y	B. Amphetamines	1				C. Barbituates	1				D. Cannabis Product	3	2	2	Y	E. Cocaine	1				F. Hallucinogens	1				G. Methaqualone	1				H. Opiates	1				I. Other Tranquilizer	1				J. Phencyclidine	1				K. Other (Specify)	1				<p>INSTRUCTIONS: Complete the following profile for each substance listed. Place the appropriate number(s)/letter(s) from the table below into the appropriate block(s) at left.</p> <p>If 1 (never used) is entered in the "last time used" block, the remaining three blocks will be left blank. Otherwise all four blocks must be completed.</p> <p>Each substance that the client is enrolled for must reflect usage profile.</p> <p>Complete the blocks as follows:</p> <p>Last time used.....  1 = Never used  2 = Within 48 hours  3 = 2 to 7 days ago  4 = 1 to 4 weeks ago  5 = 1 to 6 months ago  6 = Over 6 months ago</p> <p>How often used.....  1 = Daily  2 = 2 to 6 times a week  3 = Once a week  4 = 2 to 3 times a month  5 = Once a month  6 = Less than once a month</p> <p>How taken.....  1 = By needle  2 = Not by needle</p> <p>Use prior to Federal SVC.....  Y = Yes  N = No</p>			
	Last Time Used	How Often Used	How Taken	Use Prior To Fed. SVC.																																																															
A. Alcohol	2	3	2	Y																																																															
B. Amphetamines	1																																																																		
C. Barbituates	1																																																																		
D. Cannabis Product	3	2	2	Y																																																															
E. Cocaine	1																																																																		
F. Hallucinogens	1																																																																		
G. Methaqualone	1																																																																		
H. Opiates	1																																																																		
I. Other Tranquilizer	1																																																																		
J. Phencyclidine	1																																																																		
K. Other (Specify)	1																																																																		
26A. MAJOR COMMAND CODE: E		27A. TYPED NAME OF COUNSELOR D.P. Dailey		28. MILITARY MAILING ADDRESS OF COMMUNITY COUNSELING CENTER Commander Fort Sam Houston - ATN: AF26-PA-HDA Fort Sam Houston TX 78234																																																															
26B. SPECIFIC UNIT CODE: Cohort B		27B. COUNSELOR'S SIGNATURE <i>D.P. Dailey</i>		29B. SIGNATURE OF CLINICAL DIRECTOR <i>Tom T. Hall</i>																																																															
29A. TYPED NAME OF CLINICAL DIRECTOR Tom T. Hall																																																																			

Figure B-2. Sample completed DA Form 4465

**Figure B-3. Sample completed DA Form 4465 (screened not enrolled (CIR))**

The DA Form 4465, (Screened Not Enrolled (CIR)); is completed in similar fashion to the DA Form 4465, except for the following changes:

- a. **Item 1.** Enter date of final disposition instead of date of enrollment.
- b. **Item 5A.** Enter diagnosis/basis for final disposition instead of diagnosis for enrollment.
- c. **Item 6.** For diagnostic code, enter appropriate screened not enrolled codes from table B-7, Section II.
- d. Items 8 through 25 will not be filled out.
- e. Items 26A through 29B will be filled out exactly as in the enrollment CIR.

Client's Name.

Unit Office.

<b>ADAPCP CLIENT INTAKE/SCREENING RECORD (CIR)</b> For use of this form, see AR 600.85; the proponent agency is DCSPER.				<b>REQUIREMENT CONTROL SYMBOL</b> CSGPA-1400(R2)																																																													
<b>SEE REVERSE SIDE FOR PRIVACY ACT STATEMENT</b>																																																																	
1. DATE OF ENROLLMENT OR FINAL DISPOSITION <b>86 03 09</b> Year Month Day		2. CLIENT'S ID CODE <b>235819784</b>		3. ADAPCP SERVICE AREA CODE: <b>F22</b>																																																													
5A. DIAGNOSIS/BASIS FOR ENROLLMENT OR FINAL DISPOSITION: A. <b>Alcohol, No further Action</b>			6. ENROLLMENT OR FINAL DISPOSITION CODE(S) A. <b>A.L.C.C.N</b>																																																														
5B. NAME OF MEDICAL TREATMENT FACILITY:			7. INITIAL CASE FINDING METHOD (Check one box only)																																																														
5C. NAME AND GRADE OF PHYSICIAN:			8. ENROLLMENT DISPOSITION																																																														
5D. SIGNATURE OF PHYSICIAN			5E. DATE OF MED EVAL																																																														
9. MIL/CIV GRADE:		10. CLIENT'S PRESENT RESIDENCE: A. <input type="checkbox"/> Army Barrack B. <input type="checkbox"/> BEQ C. <input type="checkbox"/> BOQ D. <input type="checkbox"/> On-Post Housing E. <input type="checkbox"/> Off-Post Housing with Dependents F. <input type="checkbox"/> Off-Post Housing without Dependents																																																															
11. DATE OF BIRTH:		12. RACE: A. <input type="checkbox"/> White B. <input type="checkbox"/> Black C. <input type="checkbox"/> Asian/Pacific Islander D. <input type="checkbox"/> Alaskan Native/American Indian E. <input type="checkbox"/> Hispanic F. <input type="checkbox"/> Other/Unknown																																																															
13. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		14. Education: A. <input type="checkbox"/> College Grad. B. <input type="checkbox"/> Some College C. <input type="checkbox"/> High School Grad D. <input type="checkbox"/> Some High School/GED E. <input type="checkbox"/> 1st-8th Grade																																																															
15. MARITAL STATUS: A. <input type="checkbox"/> Never Married B. <input type="checkbox"/> Now Married C. <input type="checkbox"/> Divorced D. <input type="checkbox"/> Separated E. <input type="checkbox"/> Widowed			16. LENGTH OF SERVICE(LOS): A. <input type="checkbox"/> B. <input type="checkbox"/> LOS Data Code LOS Present Unit																																																														
17. PMOS/SPECIALTY A. <input type="checkbox"/> B. Performing in PMOS PMOS/Civilian Series Code <input type="checkbox"/> Yes <input type="checkbox"/> No			18. Previous Alcohol or Drug Counseling/Rehabilitation: A. <input type="checkbox"/> Army B. <input type="checkbox"/> None C. <input type="checkbox"/> Other: _____ (Specify!)																																																														
20. CLIENT'S DISCIPLINARY RECORD (Alcohol or Drug Related):					21. TOTAL NUMBER OF AWOL EPISODES: _____																																																												
CIVILIAN		NO.		MILITARY																																																													
A. Arrests		C. Article 15		E. Letters of Reprimand																																																													
B. Convictions		D. Court Martial		F. Suspensions																																																													
23. INPATIENT DETOXIFICATION A. <input type="checkbox"/> Necessary B. <input type="checkbox"/> Unnecessary C. <input type="checkbox"/> Completed					24. UTILIZATION OF CIVILIAN TREATMENT REHAB FACILITIES: <input type="checkbox"/> Yes <input type="checkbox"/> No																																																												
25. DRUG/ALCOHOL USAGE PROFILE (Complete items below according to instructions provided):																																																																	
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Last Time Used</th> <th>How Often Used</th> <th>How Taken</th> <th>Use Prior to Fed. SVC.</th> </tr> </thead> <tbody> <tr><td>A. Alcohol</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>B. Amphetamines</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>C. Barbiturates</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>D. Cannabis Product</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>E. Cocaine</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>F. Hallucinogens</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>G. Methamphetamine</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>H. Opiates</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>I. Other Tranquillizer</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>J. Phencyclidine</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>K. Other (Specify)</td><td>_____</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>					Last Time Used	How Often Used	How Taken	Use Prior to Fed. SVC.	A. Alcohol	_____	_____	_____	_____	B. Amphetamines	_____	_____	_____	_____	C. Barbiturates	_____	_____	_____	_____	D. Cannabis Product	_____	_____	_____	_____	E. Cocaine	_____	_____	_____	_____	F. Hallucinogens	_____	_____	_____	_____	G. Methamphetamine	_____	_____	_____	_____	H. Opiates	_____	_____	_____	_____	I. Other Tranquillizer	_____	_____	_____	_____	J. Phencyclidine	_____	_____	_____	_____	K. Other (Specify)	_____	_____	_____	_____	<p>INSTRUCTIONS: Complete the following profile for each substance listed. Place the appropriate number(s)/letter(s) from the table below into the appropriate block(s) at left.</p> <p>If 1 (never used) is entered in the "last time used" block, the remaining three blocks will be left blank. Otherwise all four blocks must be completed.</p> <p>Each substance that the client is enrolled for must reflect usage profile.</p> <p>Complete the blocks as follows:</p> <p>Last time used: 1 = Never used 2 = Within 48 hours 3 = 2 to 7 days ago 4 = 1 to 4 weeks ago 5 = 1 to 6 months ago 6 = Over 6 months ago</p> <p>How often used: 1 = Daily 2 = 2 to 6 times a week 3 = Once a week 4 = 2 to 3 times a month 5 = Once a month 6 = Less than once a month</p> <p>How taken: 1 = By needle 2 = Not by needle</p> <p>Use prior to Federal SVC: Y = Yes N = No</p>	
	Last Time Used	How Often Used	How Taken	Use Prior to Fed. SVC.																																																													
A. Alcohol	_____	_____	_____	_____																																																													
B. Amphetamines	_____	_____	_____	_____																																																													
C. Barbiturates	_____	_____	_____	_____																																																													
D. Cannabis Product	_____	_____	_____	_____																																																													
E. Cocaine	_____	_____	_____	_____																																																													
F. Hallucinogens	_____	_____	_____	_____																																																													
G. Methamphetamine	_____	_____	_____	_____																																																													
H. Opiates	_____	_____	_____	_____																																																													
I. Other Tranquillizer	_____	_____	_____	_____																																																													
J. Phencyclidine	_____	_____	_____	_____																																																													
K. Other (Specify)	_____	_____	_____	_____																																																													
26A. MAJOR COMMAND CODE: <b>E</b>		27A. TYPED NAME OF COUNSELOR <b>John L. BARKES</b>		28. MILITARY MAILING ADDRESS OF COMMUNITY COUNSELING CENTER <b>Commander - 24th Inf Div + Fort Stewart ATTN: AD2P-PAP-AP Fort Stewart, GA 31313</b>																																																													
26B. SPECIFIC UNIT CODE: <b>B</b> <input type="checkbox"/> Cohort <input type="checkbox"/> B		27B. COUNSELOR'S SIGNATURE <i>John L. Barkes</i>		29B. SIGNATURE OF CLINICAL DIRECTOR <i>Mary Jones</i>																																																													
29A. TYPED NAME OF CLINICAL DIRECTOR <b>MARY JONES</b>																																																																	

DA FORM 4465, Oct 85

EDITION OF NOV 81 IS OBSOLETE

Figure B-3. Sample completed DA Form 4465 (screened not enrolled (CIR))

**Figure B-4. Sample completed DA Form 4466 (Client Progress Report (CPR))**

**Item.** Client's name.

**Remarks.** For local use only. Include only on health record and ADAPCP client record copies. Information not to be forwarded to USADAOA (DAMIS).<sup>1</sup>

**Item.** Client's unit/office

**Remarks.** Enter office where civilian employee works.

**Item 1.** Date report is due. Year, month, day.

**Remarks.** Enter the date on which the CPR is actually due for the 1st, 2d, 3d, or 4th CPR reports. Program release reports will reflect the actual date the client is released from the program. PCS loss or gain reports will reflect the actual date a soldier is a PCS loss or gain to an installation.

**Item 2.** Client's ID code.<sup>2</sup>

**Item 2A.** Active duty/ADT military client.

**Remarks.** Enter SSN for all military personnel as reported in item 2 of the initial CIR.

**Item 2B.** Nonmilitary client code.

**Remarks.** Enter the same client code as reported in item 2 of the initial CIR

**Item 3.** Current ADAPCP service area code.

**Remarks.** Enter current ADAPCP service area code from table B-1.

**Item 4.** Reason for report.

**Remarks.** Check the entry which reflects the reason for report. A final CPR will be submitted immediately when a client is released from the ADAPCP or when the client reaches the 360th day of a rehabilitation program. A CPR is required for each of the 90, 180, 270, or 360th day anniversary dates of enrollment in the ADAPCP. Clients that are entered into Track I will receive a release from program CPR at the end of Track I services. Clients needing more intense service may be transferred to tracks II or III through immediate submission of a change of Track CPR. Item 4h of the CPR will be completed and item 7a will show the client's new status. Item 16 will be completed showing the client's change of Track. Use a 1st, 2d, or 3d CPR as appropriate, for clients brought out of the RTF and placed into follow-up status. A CPR is required when a soldier is a PCS loss or gain to an installation ADAPCP. The CPR for loss must be completed in its entirety. The PCS gain record will only contain the information requested in items 1, 2, 3, 4, 16, and 17A through 18B.

**Item 5A.** Additional diagnosis.

**Remarks.** Enter additional diagnosis. (See paragraph B-8.)

**Item 5B.** Additional diagnostic code(s).

**Remarks.** Enter additional diagnostic code(s). (See table B-7.)

**Item 6.** Rehabilitation methods used since initial CIR or last CPR.

**Remarks.** 1st CPR: check all entries applicable to client since entry into the ADAPCP through submission of the CIR. Subsequent

CPRs: Check only those methods used in rehabilitation since submission of the last CPR.

**Item 7A.** Client's ADAPCP status as of report date.

**Remarks.** Check the client's status in the program as of the date of submission of the CPR. Check item 7A(D) for clients who are Track III followups.

**Item 7B.** Client status as report date.

**Remarks.** Check the client's status as appropriate.

**Item 8.** Rehabilitation facilities used since initial CIR/last CPR.

**Remarks.** 1st CPR: check all entries applicable to client status since the client entered the ADAPCP through submission of a CIR. Subsequent CPRs: Check only those facilities used in rehabilitation since submission of the last CPR.

**Item 9.** Reasons for program release.

**Remarks.** Check appropriate box A-J for Army AD/ADT soldiers, and box K-S for civilian employees and other clients being released from the program. Check one box only.

**Item 10.** Counselor's assessment of progress during rehabilitation.

**Remarks.** Check appropriate box.

**Item 11.** Commander's appraisal of progress and military effectiveness.

**Remarks.** The ADAPCP staff will complete the efficiency and conduct rating after consulting with the commander on the soldier's efficiency and conduct during rehabilitation. Item 11 will be completed on each CPR submitted for soldiers.

**Item 12.** ADAPCP recommendation to commander.

**Remarks.** The ADAPCP staff will complete item 12 for each soldier released from the program.

**Item 13.** Commander's action.

**Remarks.** Commander will check the appropriate box based upon planned action in each soldier's case upon release from the ADAPCP. Item 13 will be completed only when a soldier is being released from the program.

**Item 14A.** Typed name of commander.

**Remarks.** Self-explanatory.

**Item 14B.** Signature of commander.

**Remarks.** The commander will authenticate the planned action for each soldier upon release of the service member from the program. The commander will authenticate the planned action by signing item 14B.

**Item 15A.** Major command code.

**Remarks.** See table B-4

**Item 15B.** Specific unit code

**Remarks.** See table B-5.

**Item 16.** Remarks.

**Remarks.** Complete if additional remarks will help to clarify the report. Physicians will enter additional diagnosis in accordance with paragraph B-8.

**Item 17A.** Typed name of counselor.

**Remarks.** Self-explanatory.

**Item 17B.** Signature of counselor.

**Remarks.** Must be signed by counselor. Unsigned forms will be returned.

**Item 18.** Military mailing address of Community Counseling Center.

**Remarks.** Enter the complete mailing address of the Community Counseling Center.

**Item 18A.** Typed name of Clinical Director.

**Remarks.** Self-explanatory.

**Item 18B.** Signature of Clinical Director.

**Remarks.** Must be signed by clinical director. Unsigned forms will be returned.

**Notes:**

1. Incomplete records will be returned to the submitting ADAPCP staff for completion.

2. Items 2 and 3 on the CPR must be identical to item 2 and 3 on the CIR submitted for the same client. These items will not be changed for any client unless specifically requested by USADAOA (DAMIS).

CLIENT'S NAME		UNIT OFFICE	
<b>ADAPCP CLIENT PROGRESS REPORT (CPR)</b>			REQUIREMENT CONTROL
For use of this form, see AR 600-85; the proponent agency is the DCSPER			SYMBOL CSGPA-1400(R2)
<b>SEE REVERSE SIDE FOR PRIVACY ACT STATEMENT</b>			
1 DATE OF REPORT <b>8 05 12 06</b> <small>Year Month Day</small>	2 CLIENT'S ID CODE <b>9999999999</b>	3 ADAPCP SERVICE AREA CODE <b>F 1 2</b>	4 REASON FOR REPORT (Check one box only): A <input checked="" type="checkbox"/> Released from Program B <input type="checkbox"/> 1st CPR C <input type="checkbox"/> 2nd CPR D <input type="checkbox"/> 3rd CPR E <input type="checkbox"/> 4th CPR (Reporting Completed) F <input type="checkbox"/> PCS Loss Report: <input type="checkbox"/> Gaining Area Code G <input type="checkbox"/> PCS Gain Report: <input type="checkbox"/> Losing Area Code H <input type="checkbox"/> Change of Track CPR
5A ADDITIONAL DIAGNOSIS BASIS FOR ENROLLMENT A _____ B _____ C _____ D _____		5B ADDITIONAL ADAPCP ENROLLMENT CODES A _____ B _____ C _____ D _____	
<b>SECTION A - CLIENT'S PROGRESS REPORT</b>			
6 REHABILITATION METHODS USED SINCE INITIAL CIR OR LAST CPR (Check as many boxes as appropriate and enter the primary method into Item 1): A <input type="checkbox"/> Awareness Education B <input checked="" type="checkbox"/> Individual Counseling C <input checked="" type="checkbox"/> Group Counseling D <input type="checkbox"/> Antabuse E <input type="checkbox"/> Other Prescribed Medication F <input checked="" type="checkbox"/> Alcoholics Anonymous G <input type="checkbox"/> Family Treatment H <input type="checkbox"/> Other (Specify): _____ 1 Primary Rehabilitation Method (Enter A-H as appropriate): _____			
7A CLIENT'S ADAPCP STATUS AS OF REPORT DATE (Check one box only): A <input type="checkbox"/> Track I B <input type="checkbox"/> Track II C <input type="checkbox"/> Track III D <input checked="" type="checkbox"/> Follow-up Treatment		7B CLIENT'S STATUS AS OF REPORT DATE (Check as many boxes as are appropriate): A <input checked="" type="checkbox"/> Duty B <input type="checkbox"/> School C <input type="checkbox"/> In Confinement (Military or Civilian) D <input type="checkbox"/> AWOL 30 Days or Less (Service Member) E <input type="checkbox"/> Other Hospitalization F <input type="checkbox"/> Other (Specify): _____	
8 REHABILITATION FACILITIES USED SINCE INITIAL CIR/LAST CPR (Check as many boxes as appropriate): A <input type="checkbox"/> Military Inpatient Detoxification B <input type="checkbox"/> Residential Treatment Facility (Enter RTF Code) _____ C <input checked="" type="checkbox"/> ADAPCP Facility D <input type="checkbox"/> Other Civilian Facility (Non Residential)			
9 REASONS FOR PROGRAM RELEASE (Complete only if client is released from program -- Check only one box unless indicated below): <b>ACTIVE DUTY/ADT ARMY SERVICE MEMBER</b> A <input checked="" type="checkbox"/> Program Completed B <input type="checkbox"/> Expiration of Term of Service (ETS) C <input type="checkbox"/> Other Honorable Discharge D <input type="checkbox"/> Administrative Discharge (Alcohol or Drug Related) E <input type="checkbox"/> Less than Honorable Discharge F <input type="checkbox"/> AWOL 31 Days or More (DFR Dropped from Roll) G <input type="checkbox"/> Retired H <input type="checkbox"/> Death I <input type="checkbox"/> USAR/ARNG ADT Completed J <input type="checkbox"/> Transferred to VA (Also check box B, C, D, or E to reflect type of discharge as appropriate) <b>CIVILIAN EMPLOYEE OR OTHER CLIENT</b> K <input type="checkbox"/> Program Completed L <input type="checkbox"/> Leaving Federal Service M <input type="checkbox"/> Terminated from Federal Service (Alcohol or drug related) N <input type="checkbox"/> Transferring to Another Federal Agency O <input type="checkbox"/> Refuses Further Treatment Services P <input type="checkbox"/> Leaving ADAPCP Service Area Q <input type="checkbox"/> Retired R <input type="checkbox"/> Death S <input type="checkbox"/> Other (Specify) _____			
10 COUNSELOR'S ASSESSMENT OF PROGRESS DURING REHABILITATION: A <input checked="" type="checkbox"/> Excellent B <input type="checkbox"/> Good C <input type="checkbox"/> Fair D <input type="checkbox"/> Unsatisfactory		11 COMMANDER'S APPRAISAL OF PROGRESS AND MILITARY EFFECTIVENESS: A Efficiency <input checked="" type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory B Conduct <input checked="" type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory	
12 ADAPCP RECOMMENDATION TO COMMANDER (Complete only if client is released from program): A <input checked="" type="checkbox"/> Retention on Active Duty B <input type="checkbox"/> Separation			
<b>SECTION B - MILITARY CLIENT'S DISPOSITION</b>			
13 COMMANDER'S ACTION A <input checked="" type="checkbox"/> Retention on Active Duty B <input type="checkbox"/> Separation			
14A TYPED NAME OF COMMANDER <b>Joseph P. Dokes</b>	14B COMMANDER'S SIGNATURE <i>Joseph P. Dokes</i>	14C DATE <b>29 Nov 85</b>	
15A MAJOR COMMAND CODE (See instructions and enter required code): <b>F</b>		15B SPECIFIC UNIT CODE (See instructions; enter code if required) <b>D B</b>	
16 REMARKS			
17A TYPED NAME OF COUNSELOR <b>Sheila Wilson</b>		17B COUNSELOR'S SIGNATURE <i>Sheila Wilson</i>	17C DATE <b>30 Dec 85</b>
18 MILITARY MAILING ADDRESS OF COMMUNITY COUNSELING CENTER (ICCC) (ATTN: AF26-PA-1) <b>Ft. SAM HOUSTON, TX</b>		18A TYPED NAME OF CLINICAL DIRECTOR <b>Tom T. Hall</b>	18B CLINICAL DIRECTOR'S SIGNATURE <i>Tom T. Hall</i>

Figure B-4. Completed sample of DA Form 4466

**Figure B-5: Sample completed DA Form 3711-R**

Instructions for completing DA Form 3711-R (Alcohol and Drug Abuse Prevention and Control Program Summary) (RCS CSGPA 1291-R4) are as follows:

**Section A. Installation/MACOM Identifying Data**

**Line 1-** Enter the full mailing address of the CCC (including the "ATTN" line).

**Line 2-** Enter the year, month, and day of the report period ending date. (The report period ending date will be the last calendar day of each month. The report period begins on the first day of each month and ends on the last day of the month.)

**Line 3-** Enter the individual CCC ADAPCP service area code listed in table B-3.

**Line 4-** Enter the name, title, and AUTOVON number of the person preparing the report.

**Line 5-** Enter the name, grade and title of the person authenticating the report. (Normally, the report will be authenticated by the ADCO.)

**Line 6-** Signature of the report authenticator.

**Section B. ADAPCP Rehabilitation Facilities and Staff**

(Complete Section B at the end of the first report period for each month.)

**Line 7- Type of Facilities.** Check the block(s) indicating the type of rehabilitation facilities available on the installation where the CCC resides.

**Line 8- Type of Treatment Provided.** Check the block(s) indicating the type(s) of clients treated by the installation facilities checked in line 7. Block "C" should be checked for the CCC (provides treatment for both alcohol and drug clients). If a residential treatment facility is operated by the installation MEDDAC, check the appropriate block to indicate the type(s) of clients treated (if different from the CCC).

**Line 9- Administration.** Report the number of CCC personnel authorized and assigned to administration in the CCC. This line should include only administrative staff (that is, clerical staff and personnel responsible for urine collection). Do not report persons assigned to a nonadministrative slot but working in administration.

**Line 10- Counseling Services.** Report the number of CCC personnel authorized and assigned to counseling services in the CCC. This line should include only counseling service staff authorized/assigned (both garrison and medical TDA), to include supervisory counselors. Do not report persons assigned to a noncounseling services slot but working in a counseling position.

**Line 11- Clinical Director.** Report the authorization and assignment of the clinical director. Do not report supervisory counselor acting as clinical director. Report only a clinical director who is authorized/assigned to the CCC submitting the report.

**Line 12- ADCO.** Report the authorization and assignment of the ADCO. Do not report supervisory counselors or clinical directors, even if no ADCO is assigned to the CCC. Report only an ADCO authorized/assigned to the CCC submitting the report (that is, an ADCO assigned to a central CCC may supervise several other CCCs, but would be reported as an authorized/assigned ADCO only by the CCC to which he/she is slotted/assigned).

**Line 13- EDCO.** Report the authorization and assignment of the EDCO. Do not report other personnel providing education services, even if no EDCO is assigned to the CCC. Report only an EDCO authorized and assigned to the CCC submitting the report (that is, an EDCO assigned to a central CCC may coordinate and provide education services to several other CCCs, but should be reported as an authorized/assigned EDCO only by the CCC to which he/she is slotted/assigned).

**Line 14- CPC.** Report the authorization and assignment of the Civilian Program Coordinator (CPC). Do not report other personnel providing civilian coordination services, even if no CPC is assigned to the CCC. Report only a CPC authorized and assigned to the CCC submitting the report (that is, a CPC assigned to a central CCC may provide civilian coordination services to several CCCs, but would be reported as an authorized and assigned CPC only by the CCC to which he/she is slotted/assigned).

**Line 15- Prevention Education/Training.** Report the number of personnel authorized and assigned to prevention education/training services in the CCC. This line should include only prevention education/training staff authorized/assigned (both garrison and medical TDA) to a prevention education/training slot during the report period.

**Section C. ADAPCP Functions, Activities, Services-Manhours and Workload.**

This section describes the personnel effort (manhours expended and workload) required to the accomplish the ADAPCP mission. Where manhours are required, report only whole hours, even if the data are collected in less than 1-hour increments.

**Column a. Time expended.** This column lists major ADAPCP functional activities.

**Column b. Man-hours.** Enter the total hours expended by ADAPCP staff members in the reported activity, including preparation time. If total time expended exceeds or is less than the working time available during the report period, explain the difference in the Remarks section.

**Column c. Number of courses/sessions.** Enter the number of education/training courses or counseling sessions (as appropriate) that were conducted by ADAPCP

staff members. When a course consisted of several sessions spread over one or more days, report only one course. Number of sessions reflects the actual number of counseling sessions conducted by the ADAPCP staff members. Data for courses will include courses provided to units, schools, community centers, or at other locations outside the ADAPCP facilities.

**Column d. Number of students/clients.** Enter the total number of students attending each course (lines 21 through 27) or the total number of clients attending each session (for lines 28 through 30 and line 32) as appropriate.

**Column e. Number of visits.** Enter the number of visits during the report period (lines 28-32). The key to reporting visits is the documentation of the event in the appropriate records such as the client case file or the ADAPCP log of contacts for screening.

(1) A visit will be counted each time a client or potential client is seen by a counselor or other care provider for screening, rehabilitation, counseling, consultation, or medical advice. This is counted as a visit as long as a signed entry is made in a client file, other record or log for such treatment or contact.

(2) Other examples of visits are as follows:

(a) Each time a potential client is screened even if the individual is referred to another agency for counseling/assistance.

(b) Each time a previous client is seen for crisis intervention or other rehabilitation service.

(c) Each time medical advice or consultation (i.e., crisis intervention) is provided by telephone, if properly documented in an appropriate record or log.

(d) Each time a commander or supervisor consultation is provided, if properly documented in appropriate record or log.

(3) For group or family counseling sessions, count each patient attending as one visit, regardless of the length of the session or the number of counselors involved, as long as the requirements for proper documentation are satisfied.

**Line 17. Man-hours expended in administrative support.** Enter the total number of man-hours spent in administrative support of the ADAPCP during the report month. This will include, but not be limited to, the following functions: personnel, supply, reports preparation, and administrative control of the urinalysis testing program. (This line should not include time expended in clinical record keeping or writing case notes.)

**Line 18. Man-hours expended in clinical record keeping.** Enter the total number of man-hours expended in clinical record keeping for the ADAPCP during the report period. This includes writing case notes, social history preparation/collection, etc.

**Line 19. Man-hours expended in planning and evaluation.** Enter the total number of man-hours expended in planning and evaluation of ADAPCP activities.

**Line 20. Man-hours expended in other ADAPCP-related functions.** Enter the total number of man-hours expended in those administrative support activities not reported in this section.

**Line 21. Commander and Staff Education.** Enter the required data concerning commanders and training of the commanders' staff members.

**Line 22. Unit Education.** Enter the required data concerning training provided to the military and civilian work force. Commanders and staff should be counted in the student body.

**Line 23. Dependent Youth/Family Member Education.** Enter the required data concerning education provided to youth groups, directors of youth activities, family member groups, etc.

**Line 24. Civilian Employee Supervisory Education.** Enter the required data concerning education provided to civilian or military supervisors of civilian employees.

**Line 25. ADAPCP Staff Education/Training.** Enter the required data concerning ADAPCP staff training. USADAOA and USADART and other Army-sponsored training will be included on this line.

**Line 26. Alcohol/Drug Awareness Training.** Enter the required data for personnel participating in alcohol/drug awareness education/training programs.

**Line 27. Other Education and Training.** Enter the required data concerning outreach programs, including education provided to schools, PTAs, and other interested groups.

**Line 28. Screening Interviews.** Enter the required data (man-hours, sessions, and number of clients and visits) for the total number of ADAPCP screening interviews conducted during the report period.

**Line 29. Individual Counseling.** Enter the number of man-hours expended in counseling sessions, number of clients, and total visits for individual counseling during the report period. These may include other counseling contacts outside of the normal office visits.

**Line 30. Group Counseling.** Enter the total number of man-hours, counseling sessions, number of clients, and total visits for group counseling during the report period. These may include other counseling contacts in addition to the normal office visits.

**Line 31. Command Consultation.** Enter the total number of man-hours and visits in the functions of command consultation including documented telephone contacts.

**Line 32. Other Rehabilitation Services.** Enter the total number of man-hours expended, number of sessions, number of clients, and total visits for alcohol or drug related crisis intervention or other rehabilitation services provided to previous ADAPCP clients.

**RESERVED**

**ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM TRANSMITTAL SUMMARY**

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

REQUIREMENT CONTROL  
SYMBOL CSGPA-1291(R4)

**SECTION A--INSTALLATION/MACOM IDENTIFYING DATA**

1. INSTALLATION AND MAILING ADDRESS OF COMMUNITY COUNSELING CENTER (CCC) <i>Commander, Fort Meade, AHN: AFZ I-PA-AD, Ft. Meade, Md 20735</i>	2. REPORT PERIOD ENDING: <i>85-12-31</i>	3. ADAPCP SERVICE AREA CODE: <i>F 18</i>
4. NAME, TITLE, AUTOVON TELEPHONE NUMBER OF PERSON PREPARING REPORT <i>James B. Doe, SFC, NCOIC, Admin, AV 293-4569</i>	5. NAME, GRADE, AND TITLE OF ADCO/ CLINICAL DIRECTOR/CPC <i>CARL Swenson-MAJ-ADCO</i>	6. SIGNATURE <i>Carl Swenson</i>

**SECTION B--ADAPCP REHABILITATION FACILITIES AND STAFF**

7. TYPE OF FACILITIES				8. TYPE OF TREATMENT PROVIDED									
A. <input type="checkbox"/> OUT-PATIENT				B. <input type="checkbox"/> IN-PATIENT				A. <input type="checkbox"/> ALCOHOL		B. <input type="checkbox"/> DRUG		C. <input type="checkbox"/> COMBINED	
LINE	STAFF	OFFICER		ENLISTED				CIVILIAN		SPECIAL DUTY			
		AUTHORIZED <i>b</i>	ASSIGNED <i>c</i>	91G		OTHER		AUTHORIZED <i>h</i>	ASSIGNED <i>i</i>	MILITARY <i>j</i>	CIVILIAN <i>k</i>		
				AUTHORIZED <i>d</i>	ASSIGNED <i>e</i>	AUTHORIZED <i>f</i>	ASSIGNED <i>g</i>						
9	Administration			1	1	3	3	2	2	1			
10	Counseling Services			4	3			4	4				
11	Clinical Director							1	1				
12	ADCO	1	1										
13	EDCO			1	1								
14	CPC							1	1				
15	Prevention Ed/Trng					3	3						
16	TOTAL	1	1	6	5	6	6	8	8	1			

**SECTION C--ADAPCP FUNCTIONS, ACTIVITIES, AND SERVICES--MANHOURS AND WORKLOAD**

	TIME EXPENDED <i>a</i>	MANHOURS <i>b</i>	NUMBER OF COURSES <i>c</i>	NUMBER OF STUDENTS <i>d</i>	NUMBER OF VISITS <i>e</i>
17	Administrative Support	1456			
18	Clinical Recordkeeping	139			
19	Planning and Evaluation	65			
20	Other ADAPCP Related Functions	298			
<b>PREVENTION EDUCATION AND TRAINING</b>					
21	Commander and Staff Education	10	5	36	
22	Unit Education	25	3	450	
23	Dependent Youth Education	48	2	130	
24	Civilian Employee Supervisor Education	7	3	28	
25	ADAPCP Staff Education Training	62	1	2	
26	Alcohol Drug Awareness Education	60	11	9	
27	Other Education and Training	35	3	121	
<b>SCREENING, REHABILITATION, AND TREATMENT</b>					
			NUMBER OF SESSIONS	NUMBER OF CLIENTS	
28	Screening Interviews	70	2	40	80
29	Individual Counseling	60	67	21	54
30	Group Counseling	54	3	50	150
31	Command Consultation	110			85
32	Other Rehabilitation Services	80	12	17	62

DA FORM 3711-R, AUG 86

EDITION OF NOV 81 IS OBSOLETE. ADAPCP SUMMARY (DA Form 3711-R)--Page 1 of 2

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Figure B-5. Sample completed DA Form 3711-R

**Figure B-5. Sample completed DA Form 3711-R—Continued**

**Section D. Pending Cases by Referral Method**

This section describes the pending work load by referral method.

Column a. Pending Cases are defined as the number of persons requiring disposition.

Columns b and c. The heading Biochemical comprises columns b. and c. These columns describe the number of individuals identified as pending cases through urinalysis testing.

Column d. Self referred describes the number of individuals presenting themselves to the ADAPCP or CCC of their own volition.

Column e. Commander Referred includes those individuals who are referred for screening at the direction of a commander or a supervisor for suspected alcohol or other drug abuse.

Column f. Investigation/Apprehension includes those individuals who are referred by civilian court order or as a result of law enforcement activities; for example, individuals referred by civilian or military law enforcement officials.

Column g. Medically Referred includes individuals evaluated during annual or other routine medical examination or during observation or treatment, for a condition which was recognized by a physician as related to alcohol or other drug abuse.

**Line 33. Total beginning of this period.** Enter the total number, for each of the referral methods, of the pending cases from the prior reporting period which had at the beginning of this report period not yet been screened.

**Line 34. Total screened this period.** Enter the total number, for each of the referral methods, of persons from line 33 screened.

**Line 35. Total gained this period.** Enter the total number, for each of the referral methods, of new referrals during this period which still remain to be screened at the end of the report period.

**Line 36. Total end of this period.** Enter the total number, for each of the referral methods, of pending cases which have not been screened and remained to be seen at the end of this reporting period.

**Section E. Biochemical Testing of Urine Specimens for Drug Abuse**

This section describes the work load and results of the testing of urine specimens for drug abuse by the types of testing programs used by the Army.

**Column b. Commander-Directed testing, individual.** The testing of an individual soldier upon the order of his commander to produce a urine specimen for analysis. Laboratory results of such testing will not be purged of multiple specimens collected from the same individual.

**Column c. Commander-Directed testing, unit sweep.** The testing of a unit upon the order of the commander of that unit. The laboratory results of such testing will not be purged of multiple specimens collected from the same individual.

**Column d. Physician-Directed testing.** The testing of an individual soldier upon the direction of a physician. Laboratory results of such testing will not be purged of multiple specimens collected from the same individual.

**Column e. Rehabilitation Client Testing.** The testing of clients during the rehabilitation process. The test results must be purged of multiple test results from the same individual in the same report period. A single positive in a series will be the basis for reporting a laboratory positive for that individual for that report period. The results returned for an individual client during a report period will be considered a series for that report period, regardless of when the test specimens were taken.

**Column f. Entry on Active Duty Testing.** Make no entries in this column.

**Column g. Treatment/Rehabilitation Staff Testing.** The testing of treatment/rehabilitation staff is done on a regular basis. The results of testing must be purged of multiple test results for the same individual, using the rule that a single positive result will make the entire series positive for the report period. The results returned for a staff member will be considered a series for that report period.

**Line 37. Total specimens Submitted to Laboratory.** Enter the total number of urine specimens collected and sent to the drug testing laboratory during the report period.

**Line 38. Total Persons Tested.** Enter the total number of personnel from whom urine specimens were collected.

**Line 39. Total Prescreening Specimens Collected.** For each category of specimen collected, enter the total number of prescreening specimens taken during the report month. This will include total positive and negative specimens collected.

**Line 40. Total Prescreening Specimens Positive.** For each category of specimens, enter the total number of prescreening specimens that were positive.

**Line 41. Total Prescreening Persons Positive.** For each category of specimens, enter the total number of persons positive at prescreening.

**Line 42. Total Prescreening Specimens Submitted to Lab.** Enter the total number of urine specimens collected and sent to the drug testing laboratory during the report period.

**Line 43. Total Specimens Returned Negative.** Enter the total number of negative urine results received from the laboratory during the report period.

**Line 44. Total Persons Negative.** Enter total number of persons for whom negative results were received from the laboratory during the report period.

**Line 45. Total Specimens Returned Positive.** Enter the total number of positive urine results received from the laboratory during the report period.

**Line 46. Total Persons Positive.** Enter the number of personnel for whom laboratory positive specimen results have been received.

**Line 47. Total Prescreening Specimens Lab Confirmed.** Enter the total number of prescreening positives confirmed positive. Total positives will not be purged of multiple specimens for the same individual.

**Section F. Installation demographic information:**

**Line 48. Assigned/Attached/MOU.** Enter the total number of personnel, by category, served by the installation/community. Report this only on the first report of each quarter.

**Remarks.** Enter in the Remarks section each month the number of biochemical (urine) quotas received and the number used.

**ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM TRANSMITTAL SUMMARY**

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

REQUIREMENT CONTROL  
SYMBOL CSGPA-1291(R4)

**SECTION D—PENDING CASES BY REFERRAL METHOD**

PENDING CASES <i>a</i> Number of Persons Requiring Disposition	PRESCREENED		SELF-REFERRED <i>d</i>	COMMANDER REFERRED <i>e</i>	INVESTIGATION APPREHENSION <i>f</i>	MEDICALLY REFERRED <i>g</i>
	<i>b</i>	CONFIRMED <i>c</i>				
33 Total Beginning of This Period	53	21	3	7	10	2
34 Total Screened/Dispositioned This Period	41	11	3	7	9	2
35 Total Gained This Period	15	13	-	6	10	-
36 Total End of This Period	27	23	-	6	11	-

**SECTION E—BIOCHEMICAL TESTING OF URINE SPECIMENS FOR DRUG ABUSE**

**ADAPCP SERVICE AREA CODE:**

ITEMS <i>a</i>	COMMANDER DIRECTED		PHYSICIAN DIRECTED <i>d</i>	REHAB CLIENTS <i>e</i>	ENTRY ON ACTIVE DUTY <i>f</i>	TREATMENT REHAB STAFF <i>g</i>
	INDIVIDUAL <i>b</i>	UNIT SWEEP <i>c</i>				
<i>Data This Period</i>						
37 Total Specimens Submitted to Lab	62	375	3	10		8
38 Total Persons Tested	55	315	3	10		8
<b>Field Tests This Period</b>						
39 Total Prescreening Specimens Collected	250	1235				
40 Total Prescreening Specimens Positive	30	160				
41 Total Prescreening Persons Positive	20	145				
42 Total Prescreening Specimens Submitted to Lab	45	225				
<b>Lab Results Received This Period</b>						
43 Total Specimens Returned Negative	57	150	2	7		7
44 Total Persons Negative	53	125	2	7		7
45 Total Specimens Returned Positive	35	165	3			
46 Total Persons Positive	33	158	3			
47 Total Prescreening Specimens Lab Confirmed	35	135	3			

**SECTION F—INSTALLATION DEMOGRAPHIC INFORMATION**

POPULATION SERVED	PERMANENT PARTY SOLDIERS	CIVILIAN EMPLOYEES	DEPENDENTS AND RETIREES	TRAINEES	OTHER SERVICES	USAR ADI
48 Assigned/Attached/MOU	4750	2035	15,775	250	750	150

Remarks

COMMAND/INSTALLATION MAILING ADDRESS

Commander - Fort Meade  
AHN: AFZ I - PA - AD, Fort Meade, MD 20955

DATE (month and year)

JANUARY 86

Figure B-5. Sample completed DA Form 3711-R—Continued

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**AUTHORITY.**

Title V, Public Law 92-129 Section 413, Public Law 92,255

**PRINCIPAL PURPOSES.**

- a. To provide statistical information for program evaluation.
- b. To document ADAPCP initial screening interview workload.
- c. To provide a ready reference for the ADAPCP staff of clients and potential clients who received an initial interview and the disposition of each client.

**ROUTINE USES.**

a. Active Army soldiers. Release of any information from the ADAPCP is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137; 42 USC 4582 as amended by 88 Stat 131; and Chapter 1, Title 42, Code of Federal Regulations. Under these statutes and regulations, disclosure is authorized within the Armed Forces or to those components of the Veterans Administration furnishing health care to veterans. AR 600-85 further limits disclosure within the Armed Forces to those individuals having an official need to know (for example, the physician or the client's unit commander). All other disclosures require the written consent of the client except disclosures (1) to medical personnel outside the Armed Forces to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation; or, (3) upon the order of a court of competent jurisdiction.

b. Civilian employees and other personnel. Release of any information from the ADAPCP Log is subject to the restrictions of 21 USC 1175 as amended by 88 Stat 137, 42 USC 4582 as amended by 88 Stat 131, and Chapter 1, Title 42, Code of Federal Regulations. All disclosures require the written consent of the client except disclosures (1) to medical personnel to the extent necessary to meet a bona fide medical emergency; (2) to qualified personnel conducting scientific research, management, or financial audits or program evaluation; or, (3) upon the order of a court of competent jurisdiction.

c. Studies. Information contained in the ADAPCP Log is an internal record of contacts. The log is maintained in the ADAPCP facility and is maintained in the same manner as an ADAPCP client case file.

**MANDATORY/VOLUNTARY DISCLOSURE AND EFFECT ON AN INDIVIDUAL NOT PROVIDING INFORMATION**

a. Disclosure is mandatory for Active Army soldiers. Failure to obey an order from competent authority to provide required information may be subject to appropriate disciplinary action under the UCMJ.

b. Disclosure is voluntary for civilian employees and other personnel. Failure to disclose the information will result in a reduced capability of the program to provide proper treatment and services.

**Figure B-6. Privacy Act statement for ADAPCP Log**

## Appendix C Training and Education Standards and Guidelines

### C-1. General

This appendix contains the following:

a. Minimum standards for Track I, Alcohol and other drug awareness education.

b. Guidelines for ADAPCP education and training.

### C-2. Minimum standards for Track I, alcohol and other drug awareness education

a. Track I, alcohol and other drug awareness education will be instituted at all Army installations and military communities where a formal ADAPCP exists. The ADCO is responsible to the commander for instituting and evaluating the program in his or her installation or community. The EDCO is responsible for design and coordination of the program and, where qualified, will assist in instruction. The clinical director and the rehabilitation staff will assist the EDCO by providing instructors for technical and clinical instruction and any clinical assessment of a client that may be required. Other resources within the community include the safety officer, provost marshal, Staff Judge Advocate, chaplain, Army Community Service (ACS), organizational effectiveness staff officer, and qualified volunteers. Such personnel may be called upon to assist in the development, conduct, and evaluation of awareness education.

b. The goals of Track I awareness education include the following areas:

(1) Alcohol and other drug awareness; emphasis is upon the entire spectrum of drinking and drug behavior, not solely on alcoholism and drug dependency.

(2) Participant self-evaluation of personal drinking habits and patterns, attitudes toward use and abuse of other drugs.

(3) Impact of alcohol and other drug abuse upon career, health, family, and other social relationships.

(4) Resources available within the community/command for support in any decision to change abusive drinking or other drug taking behavior.

(5) Strategies, opportunity, and support for those who wish to change drinking and drug taking behavior.

c. Track I awareness education is an education approach to behavior change and is not designed to be treatment for alcoholism or drug dependency. Nor is it designed for individual or group counseling. Individuals who are found to be or who discover themselves to be in a serious situation with regard to abuse or dependency of alcohol or other drugs must be referred to other tracks.

d. The minimum standards for Track I awareness education are as follows:

(1) Awareness education will consist of at least 12 hours, but may be longer. Any

brief individual or group counseling of a client or assessment will not be counted as part of the minimum 12 hours.

(2) Size of the group should not exceed 15 persons so that group participation can be maximized.

(3) Family participation is encouraged, but not required.

(4) Timing and sequencing is not prescribed here. However, the following subject areas will be covered for either alcohol, other drugs, or both as the design dictates:

(a) Self-measurement, self-evaluation instruments that measure knowledge and attitudes about alcohol or other drugs and that impact on the awareness of individual drinking or drug taking behavior.

(b) Appropriate and applicable command policies, Army regulations, and State laws governing the use of illegal drugs, driving while intoxicated and other violations commonly committed under the influence of alcohol or other drugs.

(c) Applicable provisions of Army regulations such as AR 635-200, AR 50-5, and this regulation.

(d) Information on definitions and the nature of alcohol and/or other drugs. This includes how they affect the human body, mind, and overall health.

(e) Information about the impact of alcohol and/or other drugs on career, family, and other social relationships.

(f) Causes and conditions which lead to the abuse of alcohol and/or other drugs to include stress, peer pressure, alienation, and loneliness.

(g) Resources available for support and assistance in overcoming problems with alcohol and other drugs.

(h) Support systems available within the community and family and means to obtain that support.

(i) Development of goals, strategies, and individual "action plans" for each participant wishing to change drinking or drug taking behavior.

### C-3. Guidelines for ADAPCP education and training

a. All films and videotapes must conform to guidelines established by the Education and Training Subcommittee of the DOD Drug and Alcohol Advisory Committee before purchase or use by an Army program. To obtain review of any film or videotape by the DOD Education and Training Subcommittee, contact, through channels, the Alcohol and Drug Policy Office, HQDA (DAPE-HRL), WASH DC 20310.

b. Films and videotapes intended for use only with professional and paraprofessional audiences do not require review by the DOD Education and Training Subcommittee. Such audiences include physicians, chaplains, counselors, law enforcement personnel, alcohol, and drug abuse program staff.

c. All alcohol and other drug abuse education materials which do not comply with

the guidelines in this chapter will be modified or removed from circulation as soon possible.

d. The following guidelines will govern all prevention education training conducted for DA audiences:

(1) The kinds of instructional technique and strategies listed below generally have proven to be either ineffective or counterproductive. Thus, education employing the following techniques will not be used:

(a) Exaggerating risks and making fear the main deterrent to future use.

(b) Relying on "preaching" or "sermonizing" to convince the audience not to abuse alcohol or other drugs.

(c) Using stereotypes for characters and settings, such as only minorities are abusers and pushers, drug abusers are hippies, the alcoholic is a skid row bum, only young people abuse drugs, or only illegal drugs are abused.

(d) Demonstrating the use of illegal drugs.

(2) As with other manifestations of human behavior, alcohol and other drug abuse have a variety of causes. Educational solutions for prevention require a variety of approaches taking into consideration all aspects of the problem from the obvious indicators to the more obscure variations. Instruction which presents the following concepts is encouraged:

(a) The nature of chemicals, medicines, alcohol and other drugs and their psychological, sociological, and pharmacological effects.

(b) The harmful effects of the abuse of alcohol and other drugs upon one's physical and mental well-being, interpersonal relations, and short- and long-range personal goals.

(c) The legal implications and consequences of the use and abuse of alcohol and other drugs.

(d) How alcohol and other drug abuse is related to accidents, absenteeism, degradation of work effectiveness, and family problems.

(e) Conditions that help to solve the problem of abuse of alcohol and other drugs are—

1. Better communications.

2. People who have a feeling of control over their own lives and a purpose in living.

3. Value structures which emphasize long-range personal goal setting.

4. A better understanding of leadership, decision-making, attitudes, and values.

## Appendix D Procedures for Medical Evacuation for Transfer to the Veterans Administration

### D-1. Overview

This appendix provides guidance on the separation processing for those alcohol or other drug dependent AD or ADT soldiers being transferred by medical evacuation to VA medical facility prior to separation.

### D-2. Objectives

The objectives of these procedures are—

a. To ensure completion of separation processing for those soldiers being transferred to the VA.

b. To process those soldiers for separation who do not desire transfer to a VA medical facility, in the normal manner.

### D-3. Concept

For those soldiers being transferred to the VA, discharge from the Army will occur subsequent to the soldier's arrival at the VA medical facility. This will require the completion of some steps of separation processing before the soldiers depart for the VA. Additional steps will be completed after the soldier's arrival at the VA. The expeditious processing of soldiers being transferred to the VA will reduce opportunities for further alcohol or other drug involvement. It will facilitate continuity of the rehabilitation effort and result in the efficient transfer to civilian life.

### D-4. Procedures for soldiers assigned to CONUS units

a. The commander of a soldier designated for transfer to a VA medical facility prior to discharge from the Army will, in the order below—

(1) Initiate and complete administrative discharge proceedings. This will include asking a soldier in writing if he or she desires to be transferred to a VA medical facility.

(2) Request that the supporting MEDCEN/MEDDAC obtain a VA bed designation from the Armed Services Medical Regulating Office (ASMRO).

(3) Request the Military Personnel Office (MILPO) publish orders reassigning the soldier to the separation transfer point (STP) listed in the ASMRO message. This request will be deferred until notification that a VA bed designation has been received and administrative discharge proceedings, including medical examination, have been completed.

(4) Furnish copies of the ASMRO message designating a VA bed to the MILPO and the STP listed in the ASMRO message.

b. Upon notification by the soldier's commander, the losing MILPO will issue discharge orders (AR 310-10, Format 501, app A).

(1) The MILPO will prepare and distribute the orders as follows:

(a) Assign the soldier to the U.S. ARMY separation transfer point shown in the ASMRO message.

(b) Enter a reporting date that coincides with the date that the soldier will physically complete separation processing.

(c) Enter a date of discharge that is exactly 15 days from the expected arrival date of the soldier at the VA medical facility.

(2) The additional instructions portion of the order will include the authority for the soldier and family members (by name and relationship) to receive the same benefits and entitlements as authorized by their identification cards. This will be valid for a period of 30 days from the date the order is issued. (Example: You and your family members are authorized medical care, exchange privileges, and admission to military theaters until 31 May 1986 (Mary S., wife; Samuel U., son).)

(3) The additional instructions portion of the order will also include the statement, "You will be admitted to the (enter MEDCEN/MEDDAC shown in the ASMRO message) for medical evaluation direct to (enter VA medical facility shown in the ASMRO message).

(4) Distribution will include one copy of the VA medical facility to which the soldier will be evacuated, addressed to the attention of Chief, Medical Administration Service No. 136 and one copy for the CONUS MEDCEN/MEDDAC shown in the ASMRO message.

c. Prior to being medically evacuated to the VA, the soldier will physically report to and complete separation processing at the STP. The responsible STP commander or chief will accomplish separation processing actions as outlined in AR 635-10, paragraph 3-7, except for final pay and the departure ceremony. These actions will include—

(1) Collecting identification cards of the soldier and of any family members.

(2) Preparing DD Form 214 (Certificate of Release or Discharge from Active Duty) under AR 635-5.

(3) Obtaining from the soldier the address to which the final paycheck, copies and 4 of DD Form 214, and discharge certificate will be mailed.

d. The MEDCEN/MEDDAC which obtains the VA bed designation will ensure that the clinical and health record accompanies the soldier to the VA.

e. For strength accountability purposes at the STP, the soldier will be carried as present for duty (PDY) until the effective date of discharge. (See AR 680-1.)

f. If, after evacuation of the VA, the soldier is not returned to military control and is not reported by the VA as either AWOL or deceased, the responsible finance and accounting officer (FAO) and STP commander or chief will—

(1) Distribute DD Form 214 under AR 635-5

(2) Mail the final paycheck, copies 1 and 4 of DD Form 214, and discharge certificate to the soldier on the next day following the effective date of discharge.

(3) Dispose of the Military Personnel Records Jacket (MPRJ) and accompanying documents under AR 635-10, appendix E.

(4) Submit the Standard Installation/Division Personnel System (SIDPERS) separating transaction on the next duty day following the effective date of discharge

### D-5. Procedures for soldiers to OCONUS units

a. The commander of a soldier designated for transfer to a VA medical facility prior to discharge from the Army will, in the order below—

(1) Initiate and complete administrative discharge proceedings. This will include asking a soldier in writing if he or she desires to be transferred to a VA medical facility.

(2) Request that supporting OCONUS MEDCEN/MEDDAC obtain a VA bed designation from the ASMRO.

(3) Request that the MILPO publish orders assigning the soldier to the STP listed in ASMRO message and start separation processing. This will be done after notification that a VA bed designation has been received and administrative discharge proceedings (including medical examination) have been completed.

(4) Furnish a copy of the ASMRO message designating a VA bed to the MILPO.

b. Upon notification by the commander, the MILPO having custody of the soldier's MPRJ will accomplish separation processing actions listed below: (This will not include final pay, preparation of DD Form 214, and discharge certificate which will be accomplished by the CONUS STP. (See d below).)

(1) Issue discharge orders (AR 310-10, Format 501, app A) Prepare and distribute orders as follows:

(a) Assign the soldier to the U.S. Army STP shown in the ASMRO message. (This will be for records processing only.)

(b) Enter a reporting date that is exactly 15 days after the expected arrival date of the soldier at the VA.

(c) Enter a date of discharge that is exactly 15 days after the expected arrival date of the soldier at the VA.

(2) The additional instructions portion of the order will include the authority for the soldier and family members (by name and relationship) to receive the same benefits and entitlements as authorized by their identification cards. This will be valid for a period of 30 days from the date the order is issued. (Example: You and your dependents are authorized medical care exchange privileges, and admission to military theaters until 31 May 1986. (Mary S., wife; Samuel U., son).)

(3) The additional instructions portion of the order will also include the statement, "You will be admitted to the (enter

MEDCEN/MEDDAC shown in the ASMRO message) for medical evacuation direct to (enter VA medical facility shown in the ASMRO message)."

(4) Distribution will include one copy of the VA medical facility to which the soldier will be evacuated, addressed to the attention of Chief, Medical Administration Service No. 136, and one copy for the OCONUS MEDCEN/MEDDAC shown in the ASMRO message.

(5) Prepare DD Form 214 WS (Worksheet for Certificate of Release or Discharge from Active Duty) and insert it in the soldier's MPRJ.

(6) Conduct the separation orientation (AR 635-10).

(7) Collect the identification cards of the soldier and of any family members.

(8) Obtain from the soldier the address to which the soldier desires the final paycheck, copies 1 and 4 of DD Form 214, and discharge certificate to be mailed by the CONUS STP.

(9) Have the soldier complete an OVR-2 (Reemployment Rights and Employment Data), DD Form 1407 (Dependent Medical Care and DD Form 1173 Statement), and DA Form 664 (soldier's statement concerning application for compensation from the Veterans Administration (VA Form 21-526E)). Include these forms in the MPRJ.

(10) Forward to the CONUS STP named in the discharge orders, on the day of the soldier's medical evacuation, the following: (This in most cases will require expeditious telephonic communication with the OCONUS MEDCEN/MEDDAC.)

(a) The soldier's MPRJ, to include sufficient copies of discharge orders, an original copy of approved administrative discharge proceedings, and a copy of the separation medical examination.

(b) The soldier's personal financial record (PFR).

(c) One copy of the ASMRO message.

(d) Notification that the health record has accompanied the soldier to the VA.

c. Upon transfer, the OCONUS MEDCEN/MEDDAC will—

(1) Ensure that the inpatient treatment record and health record accompanies the soldier to the VA.

(2) Transport the soldier to the VA medical facility only after the unit commander advises that—

(a) The original copy of the approved administrative discharge proceedings and a copy of separation medical examination is in MPRJ.

(b) The original separation medical examination is in health records.

d. The CONUS FAO and STP commander or chief, upon receipt of the soldier's MPRJ, PFR, discharge orders, and ASMRO message will—

(1) Contact the VA medical facility listed in the discharge orders (and also listed in the ASMRO message) to determine the date of the soldier's arrival at the VA.

(OCONUS soldiers will not physically report to the CONUS STP.)

(2) Indorse the discharge order to show the correct effective date of discharge if the soldier arrived at the VA more than 15 days before the scheduled date of discharge shown in the order.

(3) Rescind the unexecuted portion (AR 310-1, Format 705, app A) of the discharge order and issue AR 310-1, Format 500, appendix A, if the soldier arrived at the VA before the scheduled date of discharge, but less than 15 days before the scheduled date of discharge shown in the order.

(4) Indorse the discharge order to show the actual effective date of discharge if the soldier reports to VA and his or her discharge from the Army is delayed due to lack of documentation. (Example: No approved administrative discharge proceedings, no separation medical examination, or discharge orders not received at CONUS FAO/STP.)

(5) Prepare DD Form 214 under AR 635-5.

(6) Compute the soldier's final pay.

(7) Distribute DD Form 214 under AR 635-5.

(8) Mail final pay check, copies 1 and 4 of DD Form 214, and discharge certificate to the soldier at the address furnished by the soldier (para D-5b(5)) on the next duty day following the effective date of discharge. (This will not be done if the soldier was returned to military control by the VA, or was reported as either AWOL or deceased by the VA prior to the effective date of discharge.)

(9) Dispose of the MPRJ and accompanying documents under AR 635-10, appendix E.

(10) Submit the SIDPERS separation transaction on the next duty day following the effective date of discharge.

## Appendix E Standard Operating Procedures for Chain of Custody for Commander-Directed Urinalysis

**E-1.** The unit commander directs that a urine test be conducted and identifies individual soldier, parts of unit, and/or entire unit for testing. (See para 10-3b.)

**E-2.** UADC receives urine specimen bottles and labels them as follows:

- a. Attaches gum label on body of bottle.
- b. Records the following on the label: (See fig E-1, sample completed label.)

- (1) Julian date.
- (2) Specimen number as assigned by the installation ADCO. (See para E-15.)
- (3) Individual's social security number.

**E-3.** UADC initiates and records appropriate information on one DA Form 5180-R for each observer. If an observer is to observe more than 12 soldiers urinate, additional 5180-Rs will be used for that particular observer. The 5180-R must reflect only one observer (para E-5) for the specimens. If less than 12 soldiers are to be observed by an observer, do not add more specimens to the 5180-R and do not have different observers sign the same 5180-R in order to obtain a complete form of 12 specimens. (See sample completed DA Form 5180-R, at fig E-2 if the urine specimen is not prescreened and fig E-3 if the urine specimen is prescreened at the installation.) If a clerical mistake is made while filling out entries on the 5180-R or on a bottle label, prior to the discrepancy inspection required by paragraph E-17, the mistake may be corrected by its maker by lining through the mistake, initialing and dating the correction, and adding the correct entry. No other method of correction is authorized except by certificate of correction as described in paragraph E-17c.

**E-4.** UADC maintains a urinalysis ledger documenting all individuals submitting test samples with the following information:

- a. Julian date.
- b. Specimen number.
- c. Individual's social security number.
- d. Name of observer who observed the soldier urinating. (See para E-5.)

**E-5.** UADC distributes urine specimen bottle to the soldier in the presence of the observer. The UADC directs the soldier to verify the information on the label by signing his or her payroll signature in the urinalysis ledger and initialing the gum label. The observer will also verify the information on the label and sign the urinalysis ledger.

**E-6.** Observer (E-5 or above, same sex) has the duty to ensure that the specimens provided are not contaminated or altered in

any way. The observer directly observes the soldier urinating into specimen bottle and placing the cap on the bottle. Observer ensures that at least 60 milliliters of urine are provided by the soldier. Observer will take custody of bottles from the soldiers directly observed and retain custody until the bottles are turned over to UADC. Observer also ensures that bottles are not reopened while bottles are in the custody of the soldier or the observer. When the optional wider-mouth specimen collection container is used by a female soldier (immediately after collection, and while still under direct observation of the observer), the urine must be poured into the currently approved urine specimen bottle and tightly capped by the soldier providing the specimen.

**E-7.** Observer takes urine specimen bottles from soldier, returns them to the UADC, and signs the prepared chain of custody document, DA Form 5180-R, releasing up to 12 bottles for each 5180-R UADC and authenticating that he or she performed actions specified in paragraph E-6. The observer also initials the label on each specimen bottle as verification of receipt from the soldier.

**E-8.** UADC initials the labels on all bottles received and signs the chain-of-custody section of DA Form 5180-R receiving up to 12 urine specimen bottles for each DA Form 5180-R from the observer.

**E-9.** UADC then places the DA Form 5180-R for that specimen container (box or mailer) in an envelope, and places the envelope, unsealed, inside the specimen container. The UADC then secures the specimen container(s), ensuring they are not opened or tampered with, and transports them unsealed to the installation biochemical collection point (IBCP) within 24 hours after collection.

**E-10.** At the IBCP, the unsealed specimen containers will be opened by the IBTC or the IBTC's designated representative. The actions of the IBTC outlined below may be performed by the IBTC's designated representative. The IBTC will review the 5180-R for completeness, and accuracy of information (see para E-17). Also, the IBTC will ensure that all information recorded on the specimen bottles matches the information recorded on DA Form 5180-R and urinalysis ledger for that specimen and that at least 60 milliliters of urine is contained in each bottle. If no discrepancies are noted, the IBTC will direct the UADC to sign the "Released By" column of the DA Form 5180-R, releasing custody of the specimen to the IBTC, and the IBTC signs the "Received By" column verifying receipt of the specimen. If discrepancies are found, the procedure in paragraphs E-17b and c will be followed concerning the discrepancy.

**E-11.** The IBTC then directs the UADC to seal each specimen container, in the presence of the IBTC, with adhesive paper tape over all sides, edges, and flaps of the container. The UADC then signs his or her payroll signature across the tape on the top and bottom of each container, and secures the envelope, with DA Form 5180-R enclosed, unsealed, to the outside of the specimen container.

**E-12.** The IBTC signs each DA Form 5180-R releasing it to one of the authorized modes of transportation. Examples include—

- a. "Released to First Class Mail," or, if one or more specimens were taken as a commander-directed search or seizure (para 10-3a(2)), "Released to Registered Mail, Reg No. 12697."
- b. "Released to SP4 Smith to hand-carry to Drug Testing Lab." (SP4 Smith must sign DA Form 5180-R receiving specimens.)
- c. "Released to Military Airlift Command Bill of Lading No. XXXX."
- d. "Released to United Airlines Flight 554, Bill of Lading No. XXXX."
- e. "Released to Swiss Air Freight 52, Bill of Lading No. XXX."

**E-13.** IBTC secures containers ensuring they are not opened or tampered with in any way and packages them as required for shipment. All packages will be wrapped with brown mailing paper ensuring that each DA Form 5180-R remains inside the wrapper, affixed in its envelope to the specimen container. IBTC ships containers to the drug testing laboratory by transportation priority one with a required delivery date NLT 3 days after specimens were taken. One of the following transportation modes will be used:

- a. U.S. Postal Service by First Class Mail, or, if one or more specimens were taken as a commander-directed search or seizure (para 10-3a(2)), by registered mail.
- b. Hand-carried by surface transportation.
- c. Military Airlift Command transportation system.
- d. U.S. flag commercial air freight, air express, air freight, air express, air freight forwarder.
- e. When none of the above can satisfy the movement required, by foreign flag air carrier.

**E-14.** If the urine specimens are to be prescreened, the following procedures apply:

- a. The IBTC will release under chain of custody, by signing the "Released By" column of the DA Form 5180-R, a small amount of urine (referred to as an aliquot) to the screening equipment operator. Necessary action will be taken to ensure that the urine specimen and aliquot are not contaminated in any manner or by any other urine.

The operator will enter "aliquots of specimen number ( ) through ( ) removed for screening" in the "Purpose of Change/Remarks" column of the DA Form 5180-R and then sign in the "Received By" column. The IBTC retains custody of the primary urine specimen in the bottle during prescreening.

b. Upon completion of prescreening, the equipment operator will indicate in the "Installation Prescreening Results" column the appropriate alphabetical code from line 8 of special instructions on the DA Form 5180-R which indicates that the specimen was prescreened at the installation level and the results.

c. Upon completion of screening, the IBTC will again sign the "Released By" column of the DA Form 5180-R on all forms upon which there are positive-screened specimens indicated. Positive screened specimens with appropriate DA Form 5180-R may be consolidated for shipment to the appropriate DTL. However, if specimen bottles are consolidated into a specimen container, all DA Forms 5180-R accounting for specimens in the container will be affixed in the envelope attached to the outside of the container (paras E-11 and E-13). Specimens will be shipped as described in paragraphs E-11 through E-13, except that the IBTC will sign the seal on the container.

d. As a quality control measure, the IBTC will randomly submit a minimum of 2 percent (not to exceed 10 percent) of prescreened negative specimens to the drug testing laboratory for quality control testing.

e. Other prescreened negatives may be discarded.

**E-15.** Specimen numbers will be developed in a manner to provide maximum compatibility for use in the U.S. Army Drug and Alcohol Management Information System. Specimen numbers will consist of the following elements of information:

a. ADAPCP service area code for the installation (for example, A02, Fort Richardson, Alaska).

b. A 3-digit numerical code (001-999) assigned by the installation ADCO to identify the specific unit submitting the specimen (for example, 003 is assigned HHC, 1st Bn/14th Armor, 33rd Inf Div (MECH)).

c. The next 4 digits will consist of the Julian date of the day on which the specimen is collected (for example, 5365 representing 30 Dec 85).

d. The next 3 digits will represent the number of the specimen assigned by the unit from 001 or 999 (for example, 034 represents the thirty-fourth specimen collected for that unit on that day).

e. (5) A complete unit specimen number will consist of 13 alpha numeric characters. A completed specimen number for this example would be: A020035365034.

**E-16. Supplies for command-directed urinalysis**

a. Book, Memorandum-Record ruled, 14- by 8½-inch, not indexed NSN 7530-00-286-8363.

b. Bottle, Urine Specimen, Shipping 120's NSN 6640-00-165-5778.

c. Cup, Nonsterile, specimen container, NSN 6530-01-0480-0855.

d. Envelope, Mailing, Plain white—4¼- by 9½-inch NSN 7530-00-286-6970.

e. Label, Pressure sensitive NSN 7530-00-082-2662.

f. Paper, Kraft-Untreated, Wrapping NSN 813-00-290-3407 (24-inch), NSN 8135-00-160-7764 (36").

g. Sack, Shipping-Water Resistant, cushioned, double wall, kraft NSN 8105-00-281-1169 (14½- by 20-inch), NSN 8105-00-281-1168 (9½- by 14½-inch), NSN 8105-00-281-1167 (12½- by 9-inch).

h. Tape, Gummed Kraft—3-inch wide medium weight NSN 8135-00-270-8717.

i. Tape, Gummed Kraft—3-inch wide NSN 8135-00-598-6097.

**E-17. Installation Biochemical Collection Point (IBCP) Inspection Items**

a. The installation biochemical testing coordinator (IBTC) will ensure that no urine specimens are forwarded to a drug testing laboratory (DTL) unless the specimen and accompanying chain of custody documentation are free from discrepancies or discrepancies are corrected as specified in paragraph E-17c. The items listed below at a minimum, will be inspected.

(1) Is the following information contained on the front side of the DA Form 5180-R, where applicable, and does it match the information required to be on the label on the specimen bottle:

- (a) Complete address of submitting unit.
- (b) Specimen number (in accord with para E-15).
- (c) Social Security Account Number.
- (d) Correct code for the type of urinalysis (for example, command directed, fitness for duty, medical).
- (e) Testing category code entered.
- (f) Prescreening results, if any (in accord with para E-14).
- (g) Initials of UADC, observer, and soldier.

(2) When the specimen container is ready for shipment, are all sides sealed with tape, and is the signature of the UADC across the seal? (IBTC if specimens were prescreened).

(3) On the chain of custody portion of the DA Form 5180-R:

- (a) Are signatures accounting for each change of custody properly annotated to include comparing signature in the urinalysis ledger.
- (b) Are dates correct?
- (c) Does the "Purpose of change/remarks" column clearly explain each change of custody?
- (d) If prescreening was accomplished, are entries as required by E-14 correct?

b. If a discrepancy is found during the check, the IBTC shall initiate appropriate action, to correct the discrepancy or error, if possible.

c. All discrepancies that can be corrected must be explained in a certificate of correction which explains the discrepancy, the circumstances and the corrective action taken. This certificate must be signed by all personnel involved including the person(s) who made the error and the IBTC. If the error is a missed entry or an incorrect entry either on the bottle label or on the DA 5180-R, correction will not be made on the label or on the form. The evidence that correction was made will be the certificate of correction. The certificate of correction will be appended to the original and all copies of the DA Form 5180-R, and a copy will also be filed at the IBCP for a period of 5 years.

**E-18. Aviation specialties**

Aviation Specialties for officer, warrant officer, and enlisted personnel are shown below. These specialties require annual testing.

- a. *Officer.*
  - (1) 15 Specialties.
  - (2) 71 Specialties.
  - (3) 67J Specialty.
- b. *Warrant officer.*
  - (1) 100A Multi-engine Utility Helicopter Pilot.
  - (2) 100B Utility/Observation Helicopter Pilot.
  - (3) 100C Cargo Helicopter Pilot.
  - (4) 100E Attack Helicopter Pilot.
  - (5) 100K Multi-engine Attack Helicopter Pilot.
  - (6) 100Q Combat Services/Support Fixed Wing Pilot.
  - (7) 100R Combat Surveillance Fixed Wing Pilot.
  - (8) 150A Air Traffic Control Technician.
  - (9) 150A Aviation Maintenance Technician.
- c. *Enlisted.* Enlisted soldiers from career management fields (CMFs) 28, 67, and 93, are considered aviation personnel.

**Table E-1  
Forensic Toxicology Drug Testing Laboratory (FTDTL) codes and addresses.**

**Laboratory:** Wiesbaden, FRG  
**LAB code:** L02  
**Address:** Forensic Toxicology Drug Testing Lab  
Wiesbaden, FRG  
APO NY 09457

**Laboratory:** Ft. Meade, MD  
**LAB code:** L01  
**Address:** Forensic Toxicology Drug Testing Lab  
Fort Meade, MD 20755-5235

**Laboratory:** Schofield Barracks, HI  
**LAB code:** L03  
**Address:** Forensic Toxicology Drug Testing Lab  
Building 673  
Schofield Barracks, HI 96857

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**Laboratory:** Commercial Contract Lab  
**LAB code:** L05  
**Address:** (Presently)  
COMPUCHEM Laboratories, Inc  
3308 East Chapel Hill/Nelson Highway  
Research Triangle Park, NC 27709

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**Laboratory:** Air Force Testing Lab  
**LAB code:** L04  
**Address:** Air Force Drug Testing Lab (AFSC)  
Brooks AFB, Texas 78235-5000

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**Note:**  
For purposes of FTDTL identification and completion  
of the DA Form 5180-R, the above laboratory codes  
are assigned.

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**Table E-2**  
**Area responsibilities of supporting**  
**Forensic Toxicology Drug Testing**  
**Laboratories**

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**CONUS**

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**Laboratory Code:** L01  
**Laboratory:** Forensic Toxicology Drug  
Testing Laboratory  
Dept. of Pathology (WRAMC)  
Ft. Meade, MD 20755  
Autovon: 923-4076/6075  
**Area Supported:** CT, DE, IN, KY, ME, MD,  
MA, MDW, NH, NJ, NY, NC, OH, PA, RI, TN,  
VT, VA, WVA, AL, FL, GA, SC, PANAMA,  
PUERTO RICO

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**Laboratory Code:** L04  
**Laboratory:** Air Force Drug Testing  
Laboratory (AFSC)  
Brooks AFB, TX 78253  
Autovon: 240-2604/3188  
**Area Supported:** AZ, AR, CO, ID, IL, IA, KN,  
LA, MI, MN, MS, MO, MT, NE, NM, ND, OK,  
SK, TX, UT, WI, WY

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**OCONUS**

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**Laboratory Code:** L02  
**Laboratory:** Forensic Toxicology Drug  
Testing Laboratory  
Wiesbaden Air Base  
APO NY 09457  
Autovon: Mainz Military 5562/5625  
**Area Supported:** European Cmd.

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**Laboratory Code:** L03  
**Laboratory:** Forensic Toxicology Drug  
Testing Laboratory  
Tripler Army Med. Center  
Schofield Barracks HI 96857  
Autovon: 655-9253/9133  
**Area Supported:** AK, CA, HI, NV, WA, KOR,  
JAPAN, OKIN, TAIWAN, PHILLIPPINES,  
GUAM OR

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**Contract Lab**

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**Laboratory Code:** L05  
**Laboratory:** Commercial Contract Drug  
Testing Laboratory  
**Area Supported:** As announced in DA/  
MACOM quota allocation messages

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**Notes:**  
1. Although geographical proximity of supporting  
laboratory will be a primary consideration, urinalysis  
quotas will be allocated by DA and MACOMs on the  
basis of laboratory capabilities and installation  
testing requirements.  
2. Appropriate laboratory code will be entered in  
block 9 of DA Form 5180-R.

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Julian Date	Installation Specimen Number
ADC's Initials (Verifying receipt of specimen)	Soldier's Initials (Verifying information)
Soldier's Social Security Number	Observer's Initials

4365	A020034365034
SSP	EEM
000-12-3456	IAW

Figure E-1. Sample completed bottle label

**URINALYSIS CUSTODY AND REPORT RECORD**

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

REQUIREMENT CONTROL  
SYMBOL CSGPA-1687

SUBMITTING UNIT: **HHC 1st BN 14th ARMOR**  
33rd Inf Div. (Mech)  
Ft. Richardson, AK 99505

1 **A 0 2** ADAPCP Service Area Code  
2 **0 0 3** Unit Code  
3 **4 3 6 5** Julian Date Specimens Collected

SHIPPED TO: **Drug Testing Laboratory**  
Bldg 673  
Schofield Barracks, HI 96857-5460

9 **2 0 3** Forensic Toxicology Drug Testing Laboratory (FTDTL)  
10 **5 0 0 4** Julian Date Specimens Received

4 Specimen Number	5 Complete SSAN	6 Type Test	7 Testing Category	8 Installation Prescreening Results	11 Laboratory Accession Number	12 Laboratory Results
037	0000000001	U	A	X		
038	0000000002	U	B	X		
039	0000000003	U	B	X		
040	0000000004	U	B	X		
041	0000000005	U	A	X		
042	0000000006	U	B	X		
043	0000000007	U	A	X		
044	0000000008	U	A	X		
045	0000000009	U	A	X		
046	0000000010	U	A	X		
047	0000000011	U	A	X		
048	0000000012	U	A	X		

**13 CERTIFICATION OF LABORATORY OFFICIAL RECORDS CUSTODIAN**

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

Date \_\_\_\_\_ (Signature) \_\_\_\_\_  
(Name and Grade/Title) \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

- The submitting unit will:
- \*1, 2, 3. Enter the complete unit address, the ADAPCP service area code of the ADAPCP servicing the unit, the 3-digit numeric code assigned to the unit by the ADCO, and the julian date the specimens were collected.
  - \*4. Enter the specimen numbers of persons tested (beginning with 001 each testing day and numbering consecutively).
  - 5. Enter the full social security account number of each person tested.
  - 6. Enter the code for the type of test as follows:
    - I = Commander directed individual
    - U = Commander directed unit inspection
    - R = Rehab client
    - S = ADAPCP staff
    - P = Physician directed
    - O = Other local test
  - 7. Enter the testing category grade identifier as follows: A (E-1 to E-4); B (E-5 to O-10); C (Civilian).
  - 8. Enter the results of installation prescreening (field testing) as follows (enter all positive results):
    - A = Amphetamine positive
    - B = Barbiturate positive
    - C = Cocaine positive
    - M = Methaqualone positive
    - N = Negative test
    - O = Opiate positive
    - P = Phencyclidine (PCP) positive
    - T = Marijuana (THC) positive
    - X = Not locally prescreened
  - 9. Enter the mailing address of the FTDTL and the FTDTL code (See AR 600-85).
- The Forensic Toxicology Drug Testing Laboratory will:
- 10. Enter the julian date the specimens were received.
  - 11. Enter the laboratory accession number.
  - 12. Enter the laboratory results (may be stamped, typed, or legibly printed "POS" or "POSITIVE" followed by abbreviation of drug(s) identified).
  - 13. Certifying official will line through inappropriate language in certification statement, sign, and stamp, type or legibly print name and grade/title.
- \*Items 1, 2, 3, and 4 constitute complete specimen number.

Figure E-2. Sample completed DA Form 5180-R (not prescreened)

CHAIN OF CUSTODY			
DATE	RELEASED BY	RECEIVED BY	PURPOSE OF CHANGE/REMARKS
30 Dec 84	SIGNATURE <i>I. A. Watcher (Observer)</i> TYPED NAME I. A. Watcher	SIGNATURE <i>Susan S. Public (ADC)</i> TYPED NAME Susan S. Public	ADC received urine specimen from observer
30 Dec 84	SIGNATURE <i>Susan S. Public</i> TYPED NAME Susan S. Public	SIGNATURE <i>Joe C. Officer (IBTC)</i> TYPED NAME Joe C. Officer	IBTC received urine specimens from ADC.
30 Dec 84	SIGNATURE <i>Joe C. Officer</i> TYPED NAME Joe C. Officer	SIGNATURE <i>Postal Service</i> TYPED NAME Postal Service	Box of urine specimens mailed to Tripler Drug Testing Laboratory
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	

DA FORM 5180-R, AUG 86

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Figure E-2. Sample completed DA Form 5180-R (not prescreened)—Continued



CHAIN OF CUSTODY			
DATE	RELEASED BY	RECEIVED BY	PURPOSE OF CHANGE/REMARKS
30 Dec 84	SIGNATURE <i>I. A. Watcher</i> TYPED NAME I. A. Watcher	SIGNATURE <i>Susan S. Public(ADC)</i> TYPED NAME Susan S. Public	ADC received URINE SPECIMEN from observer
30 Dec 84	SIGNATURE <i>Susan S. Public</i> TYPED NAME SUSAN S. Public	SIGNATURE <i>Joe C. Officer(187C)</i> TYPED NAME Joe C. OFFICER	Received specimens from ADC
30 Dec 84	SIGNATURE <i>Joe C. Officer</i> TYPED NAME Joe C. OFFICER	SIGNATURE <i>P. I. Operaton</i> TYPED NAME P. I. Operaton	Aliquots of specimens 034-036 removed for Prescreening
30 Dec 84	SIGNATURE <i>Joe C. Officer</i> TYPED NAME Joe C. OFFICER	SIGNATURE <i>Postal Service</i> TYPED NAME Postal Service	Positive prescreened specimens shipped to Triplex Drug Testing Lab.
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	
	SIGNATURE	SIGNATURE	
	TYPED NAME	TYPED NAME	

Figure E-3. Sample completed DA Form 5180-R (prescreened)—Continued

## Appendix F Standard Operating Procedures for Installation Urine Drug Prescreening

### F-1. General

MACOMs and installations have the authority to purchase HQDA-approved equipment and reagents to establish urine prescreening programs at the installation level. Changes in approved equipment, reagents, and training will be announced periodically by letter and/or message by the U.S. Army Drug and Technical Activity. Prescreening may be conducted only for drugs that can be identified by the drug testing laboratory to which the installation is authorized to send the urine specimens.

### F-2. Equipment operation

a. Urine prescreening equipment will be operated only by properly trained and certified operators. Operators should be selected on the basis of maturity and integrity. It is recommended that operators be in the grade of E-5 or above or equivalent civilian grades.

b. All equipment operators must undergo approved advanced training and certification.

c. Newly assigned operators who have not received advanced training may operate the equipment after receiving a minimum of 2 hours of hands-on instruction from a certified and approved operator. New operators must be closely supervised and physically observed by a trained and certified operator at all times while conducting urine prescreening pending completion of advanced training.

d. The installation ADCO or his or her designated representative will certify in writing (DF or memorandum) the level of training of each equipment operator and maintain training and certification documentation for each operator under their supervision.

e. All equipment operators must undergo annual refresher training. This training may be conducted by a certified equipment operator or a manufacturer's field representative. At a minimum, the training will consist of completing the manufacturer's programmed training course for the type of equipment being operated and conducting urine prescreening under the supervision of a currently certified operator or the manufacturer's field representative. All such training must be documented for each equipment operator and authenticated by the ADCO or his or her designated representative.

f. Each operator will maintain copies of training and certification documents in the prescreening work area.

### F-3. Quality assurance

Quality assurance will consist of both internal and external procedures to assure that urine prescreening is properly conducted.

#### a. Internal.

(1) Each time the equipment is used, the operator will comply with the manufacturer's operating procedures concerning the use of both the instrument and test reagents including—

(a) Ensuring that the daily work sheet is properly filled out and signed upon completion of testing.

(b) Checking all reagents for expiration date and assuring all reagents and specimens are allowed to warm/cool to room temperature before prescreening begins.

(c) Ensuring that all control tests are completed and as prescreening progresses, checking to ensure that readings for the calibrator remain consistent (within approximately 20 units of each other)

(d) Ensuring that proper chain of custody procedures are followed during all specimen handling and testing.

(e) Maintaining a copy of all daily work sheet and result cards for a minimum of 5 years after completion of test.

(2) The ADCO or IBTC will establish procedures and controls to ensure that the prescreening area, to include instrument and reagent storage, is a limited access area. The physical security requirements for evidence storage outlined in AR 195-5 should be followed to the extent possible. This will include, at a minimum, an annual physical security evaluation by qualified personnel.

(3) The ADCO and IBTC will closely monitor confirmation results on prescreened positive specimens. As a minimum, 80 percent of positive prescreened specimens should be confirmed when laboratory confirmation is accomplished by Gas Chromatography/Mass Spectrometry. Upon failure to meet the 80 percent minimum, the ADCO will immediately notify USADAOA through the MACOM. Prescreening will be suspended until the problem is identified and corrected.

(4) The IBTC will submit a minimum of 2 percent of prescreened negative specimens (not to exceed 10 percent) to an FTDTL or contract laboratory as an additional internal quality control check. These specimens must be selected by the IBTC and not the equipment operator.

(5) A supervisory review by the ADCO or his or her designated representatives will be conducted at least quarterly on all equipment operators under their supervision. The quarterly review will include a review of daily worksheets to ensure that the operator has analyzed a minimum of 20 specimens during the past 3 months. The quarterly review will be documented. This review may be conducted with the quarterly testing of the external proficiency specimens.

#### b. External.

(1) All internal quality assurance procedures and results will be reviewed during assistance visits conducted by the appropriate MACOM/major subordinate command or USADAOA.

(2) USADAOA will contract annually with a commercial proficiency testing service. The testing service will provide all prescreening sites with a minimum of two unknown quality control urine specimens for each drug prescreened quarterly. This will provide a sufficient quantity of unknown specimens to permit all equipment operators to test each unknown specimen for proficiency purposes.

(3) Proficiency testing results will be provided to both the installation ADCO and USADAOA.

(4) Operators incorrectly identifying the proficiency specimen must undergo refresher training as outlined in paragraph F-2e.

## Appendix G Clinical Standards for ADAPCP Community Counseling Centers

### Section I

#### Quality Assurance—General Policies and Procedures

##### G-1. Professional staff organization and responsibilities

a. *Overview.* This appendix is medical/clinical in nature, and sets forth the clinical standards, procedures and quality assurance requirements for Tracks II and III of the ADAPCP. Technical (clinical) terminology is used throughout. Appendix G does not apply to Track I of the ADAPCP, nor is the AMEDD responsible for Track I. The term Army Medical Department, includes personnel from Office of the Surgeon General, Health Services Command, and the other medical commands, as opposed to the line chain of command; such as, garrison personnel, and so forth. Alcohol and drug abuse prevention and education are command functions.

b. *Organization and functions.* The installation commander is responsible for, and the ADCO has operational control for local ADAPCP and CCC management. The local MTF commander is responsible for the clinical aspects of the ADAPCP and for the quality of professional/paraprofessional service provided. These responsibilities do not include the prevention/education Track I. The MTF commander will appoint a physician on orders, as clinical consultant. The clinical consultant will provide technical supervision for all clinical aspects of the ADAPCP. A physician will be appointed (may be clinical consultant) to be responsible for evaluation and diagnosis of patients. The MTF commander will ensure that the CCC has sufficient qualified clinical personnel available to assess and address the identified clinical needs of clients. The installation commander will provide sufficient administrative (ADCO, CPC, EDCO, and so forth) and support staff to effectively operate the local CCC and provide comprehensive ADAPCP services. The AMEDD is responsible for quality assurance in all aspects of treatment and rehabilitation services provided by the ADAPCP. In accordance with DOD Instruction 1010.6, ADAPCP clinical personnel, in coordination with the ADCO, will develop a standardized quality assurance plan for each CCC and ensure that it is coordinated with the local MTF plan.

c. *Qualifications.* The clinical professional staff will be selected and reviewed based on well-defined, written criteria that are related to the goals and objectives of the CCC.

(1) Initial appointment and continued professional staff membership depends on professional competence, ethical practice, and compliance with the qualifications,

standards, and requirements set forth by the AMEDD professional staff regulations.

(2) Only those practitioners who are credentialed or certified, and who have demonstrated competence and experience, will be eligible for CCC professional (clinical) staff membership.

(3) The clinical staff will participate in determining what qualifications (training, experience, and documented competence) are required for assuming specific clinical responsibilities.

(4) All members of the clinical staff who have been assigned specific treatment/rehabilitation responsibilities will be qualified by training or experience and demonstrated competence and shall have appropriate clinical privileges; or they will be supervised by professional staff members who are qualified by experience to supervise such treatment.

d. *Method of selection.* Each CCC will develop a process of selection for the professional staff which will ensure that the individual is appropriately credentialed, certified, or experienced and is qualified for the privileges and responsibilities of professional staff membership. These provisions must be coordinated with the local CPO technical services manager who screens applicants for CCC positions. The ADCO will ensure that the local CPO has a thorough understanding of the legal, ethical, and agency requirements for proper selection of ADAPCP personnel and the conditions under which they must be relieved of further duty in the ADAPCP, should they arise.

e. *Privilege delineation.* Regardless of the type and size of the CCC facility, clinical privileges will be established for each member of the professional staff. The clinical director must have clinical privileges and must be credentialed. Counselors must participate in the internship program and must be certified by the Army.

(1) Privileges will be established based on all verified information available in the applicant's or staff member's credentials file as verified by the MTF Credentialing Committee and the Certification Review Board.

(2) The method used to establish clinical privileges for each professional staff applicant must show evidence that the granting of such privileges is based on the member's demonstrated current competence, and in accordance with this regulation, AR 40-66, and DOD Instruction 1010.6.

(3) The clinical consultant, in coordination with the clinical director, will provide a written standard operating procedures manual for the CCC, which will include the qualifications, status, clinical duties, and responsibilities of all ADAPCP clinical personnel.

(a) The training, experience, and demonstrated competence of clinical personnel in such categories will be sufficient to permit them to perform their assigned duties.

(b) The CCC SOP will include provisions for clinical personnel to receive appropriate technical supervision from their designated

professional supervisors. The local MTF commander will ensure that this technical supervision takes place on a regular basis.

b. *Review.* The CCC SOP will provide for review of the privileges and professional staff membership of each professional staff member at least once every 2 years.

(1) The review will be conducted by a designated professional staff committee, such as the credentials committee of the local MTF.

(2) During the review, the committee may require the clinical staff member to submit evidence on current health status, or to submit to an unannounced urinalysis to verify the staff member's ability to discharge his or her responsibilities in a drug free environment.

(3) The committee's review of the clinical privileges of a staff member will include as a minimum, the staff member's past and current professional performance as well as his or her compliance with the CCC SOP.

g. *Rating chain.* For the purposes of meeting clinical standards prescribed in DOD Instruction 1010.6 and ensuring quality assurance for all aspects of the ADAPCP, the clinical director will be rated by the ADCO, the Deputy Commander for Clinical Services (DCCS) will be the clinical director's reviewer and the individual who rates the ADCO will be the approving authority. The clinical director will continue to rate the counselors.

##### G-2. Written plan for professional services and staff composition

a. The ADCO, in coordination with the clinical consultant and clinical director, will formulate and specify CCC goals and objectives and describe CCC programs in a written plan for professional services.

b. The plan will describe the services offered by the CCC so that performance of those services may be objectively evaluated.

c. The written plan for professional services will include the following:

(1) The client population, including age groups and other relevant characteristics.

(2) The hours and days the CCC operates.

(3) The procedures used to carry out initial screening and/or triage.

(4) The intake or admission process, including how the initial contact is made with the client and the family.

(5) CCC assessment and evaluation procedures.

(6) Treatment methodologies.

(7) Therapeutic programs offered by the MTF (or RTF) such as inpatient, partial-day, and outpatient programs.

(8) The treatment planning process and the periodic review of therapy.

(9) The discharge and postdischarge planning processes.

(10) The relationship between therapeutic programs, including channel of staff communications, responsibility, and authority, as well as supervisory relationships.

(11) The means by which the CCC provides the following:

(a) Other medical, special assessment, and therapeutic services;

(b) Patient education services, whether provided by the facility or by agreement;

(c) Emergency services and crisis intervention.

(d) Discharge and aftercare, including postdischarge planning and followup evaluation.

(12) Procedure for the supervision of all clinical activities by qualified, experienced personnel.

d. The written plan for clinical services will be made known and will be made available to all professional personnel, to the DCCS, and to the DPCA.

e. The plan will be reviewed at least annually and be revised as necessary, to meet the changing needs of the patients and the community, and to meet the overall objectives and goals of the CCC. The ADCO and clinical director will sign and date the plan when reviewed or revised.

f. The CCC will maintain records to verify that the clinical staff satisfies all Federal, State, and local requirements for credentialing or certification.

### G-3. Facility and program evaluation

a. The ADCO, in coordination with the clinical director, and clinical consultant, will ensure that the CCC has a written statement of goals and objectives. The goals and objectives will be related to the needs of the population served. The CCC written statement of the goals and objectives will be provided to the DCCS and ADAPCP administration and shall be made available to CCC staff.

b. The CCC will have a written plan to evaluate its accomplishment of goals and objectives.

(1) The written plan will specify when evaluations shall be conducted.

(2) The written plan will specify the information to be collected and the procedures for retrieving and analyzing this information.

(3) The written plan will specify procedures for assessing the utilization of resources to meet the goals and objectives of the CCC.

c. The written plan will require a documented annual review, and appropriate revision, if required, of CCC goals and objectives.

(1) The documentation will contain an explanation of any failure to achieve goals and objectives.

(2) The documentation also will establish that the results of the evaluation were provided to DCCS and ADAPCP administration and were made available to the CCC staff.

(3) Documentation will establish that the findings of the evaluation have influenced CCC planning.

### G-4. Quality assurance

a. The clinical director in coordination with the clinical consultant will ensure that the CCC has an ongoing quality assurance plan designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.

b. Professional and administrative staffs will monitor and evaluate the quality and appropriateness of patient care and clinical performance, resolve identified problems, and report information to the DCCS, as needed, to ensure the quality of patient care.

c. The clinical director in coordination with the clinical consultant will establish a written plan for the quality assurance which describes the CCC's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities.

d. The quality assurance plan will include, at a minimum, the following activities:

(1) Review patient care services, including—

(a) Individual patient care monitoring.

(b) Evaluation of treatment plans and goal achievement.

(c) Review of patient care incidents.

(2) Monitoring and evaluating the quality and appropriateness of patient care and the clinical performance of all clinical staff members through—

(a) Meetings of all CCC clinical staff members to consider findings from ongoing review activities of the professional staff.

(b) Clinical supervision aspects of patient care monitoring.

(c) Patient care evaluation.

(3) Ensuring that the following CCC functions are reviewed:

(a) Utilization.

(b) Maintenance of the quality and content of medical records.

(4) Monitoring and evaluating the quality of patient care and clinical performance of those individuals who do not have clinical privileges.

(5) Considering relevant findings from the quality assurance activities described in this paragraph as part of—

(a) The reappraisal of professional staff members.

(b) The renewal or revision of individual clinical privileges.

(c) The appraisal of the competence of all those clinical personnel who do not have clinical privileges.

e. The Quality Assurance Program will use objective criteria which reflect current knowledge and clinical experience to improve the quality of patient care.

(1) Each CCC participates in the development and/or application of criteria relating to the care or service it provides.

(2) Each CCC participates in the evaluation of the information collected in order to identify important problems or opportunities to improve patient care and clinical performance.

f. The Quality Assurance Program will ensure that—

(1) The findings, conclusions, recommendations, actions taken, and results of actions taken are documented and reported through channels established by the CCC.

(2) The status of identified problems is tracked to assure improvement or resolution.

(3) Information (from departments) and the findings of discrete quality assurance activities are used to detect trends, patterns of performance, or potential problems.

(4) The objectives, scope, organization, and effectiveness of the Quality Assurance Program will be evaluated at least annually by the local MTF and Quality Assurance Committee and revised as necessary.

### G-5. Patient care monitoring

a. Each CCC SOP will include a written plan designed to ensure that individual treatment plans are evaluated and updated.

b. Patient care monitoring meetings will be held and documented.

(1) Patient care monitoring reviews will be conducted periodically and will include review of the following:

(a) Problems in unresolved diagnosis.

(b) Unimproved patients.

(c) Diagnostic errors.

(d) Treatment failures.

(e) Complications in treatment.

(f) Other treatment issues.

(2) An essential feature of the patient care review is the supervision and consultation that the professional staff gives to the providers of services. This supervision and consultation will be documented in one or more of the following places:

(a) Patient records.

(b) Minutes of staff meetings and conferences.

(c) Schedules maintained for individual and group supervision of all clinicians.

(d) Minutes of patient care review meetings.

(e) Notes of supervisory sessions or clinical consultations. All technical consultation, visits, and so forth, provided by the clinical consultant will be documented in the ADAPCP log book.

### G-6. Staff growth and development

a. Appropriate staff development programs will be provided for administrative, professional, and support personnel.

b. The clinical director, in coordination with the clinical consultant, will supervise and direct staff development. The clinical director may delegate responsibility for staff development to appropriately qualified individuals.

c. The participation of administrative, professional, and support personnel in staff development programs will be documented.

d. Appropriate orientation and a training program will be provided for all CCC personnel.

(1) Orientation programs will be held either before or on the first day of duty.

(2) Orientation programs for new CCC personnel may include event training or incident training and will familiarize CCC personnel with existing staff backup and support systems.

e. Staff development programs will reflect all administrative and service changes in the CCC, and will prepare personnel for promotions and greater responsibilities.

f. A continuous professional education program will be provided to keep the professional staff informed of significant clinical and administrative developments and skills.

(1) The professional staff development program will include inservice activities.

(2) Inservice activities will be planned and scheduled in advance and will be conducted on a continuing basis.

g. The CCC's staff development programs will include opportunities to participate in education programs outside the installation, such as workshops, institutes, seminars, and formal continuing education courses. The ADCO will include funding (TDY and tuition) for staff development in all budget requests.

h. The CCC will communicate and coordinate with appropriate national and local mental health professional organizations in planning and providing continuing education programs.

i. The result of patient care evaluations or quality assurance activities will be an important part of staff development programs.

(1) Staff development activities will be designed to meet needs identified in the quality assurance program, as well as individual needs.

(2) Written documentation will demonstrate that staff development activities are influenced by the findings of the quality assurance program.

j. The clinical director will evaluate staff education and inservice training programs annually. Evaluations will be signed and dated by the clinical director.

### G-7. Patient rights

The ADCO will ensure that the CCC will have a written plan which describes the rights of patients and the means by which these rights may be exercised. These rights will include the following:

a. Each patient will have impartial access to treatment, regardless of rank, race, religion, sex, ethnicity, age, or handicap. Each patient's personal dignity will be recognized and respected, to the greatest extent possible, in the provision of all care and treatment.

b. Each patient will receive individualized as well as group therapy, which will include the following at a minimum:

(1) The provision of adequate and humane services.

(2) The provision of services within the least restrictive environment possible.

(3) The provision of an individual treatment plan.

(4) The periodic review of the patient's treatment plan.

(5) The active participation of patients over 12 years of age and when permitted by their responsible parents, relatives, or guardians in planning for treatment.

(6) The provision of an adequate number of competent, qualified, and experienced professional clinical staff to supervise and implement the treatment plan.

### G-8. Patient records

a. The CCC will maintain a written patient record on each client.

(1) The patient record will describe the patient's health status at the time of admission, the service provided and the patient's progress in the facility, and the patient's health status at the time of discharge.

(2) The patient record will provide information for the review and evaluation of the treatment provided to the patient.

(3) When appropriate, data in the client record will be used in training, research, evaluation, and quality assurance programs, in accord with 600-85, paragraph 6-10f.

(4) When indicated, the client record will contain documentation that the rights of the client and the client's family are protected.

(5) The patient record will contain documentation of the client's and, as appropriate, family members' involvement in the client's treatment program.

(6) When appropriate, a separate record may need to be maintained on each family member involved in the client's treatment program.

(7) The patient record will contain identifying data recorded on standardized forms. This identifying data shall include the following:

(a) Name.

(b) Home address.

(c) Home telephone number.

(d) Date of birth.

(e) Sex.

(f) Race or ethnic origin.

(g) Next of kin.

(h) Education.

(i) Marital status.

(j) Type and place of employment.

(k) Date of initial contact of admission to the facility.

(l) Other identifying data as indicated.

(m) Date the information was gathered.

(n) Signature of the staff member gathering the information.

(8) The patient record will contain information on any unusual occurrences, such as the following:

(a) Treatment complications.

(b) Accidents or injuries to the patient.

(c) Morbidity.

(d) Death of a patient.

(e) Procedures that place the patient at risk or cause unusual pain.

(9) As necessary, the patient record will contain documentation of the consent of the client, appropriate family member, or

guardians for admission, treatment, evaluation, aftercare, or research.

(10) The patient record will contain both physical and emotional diagnosis that have been made using a recognized diagnostic system.

(11) The patient record will contain correspondence concerning the client's treatment, and signed and dated notations of telephone calls concerning the client's treatment.

(12) A discharge summary, DA Form 4466, will be entered in the patient's record following release, as determined by the professional staff bylaws, rules, and regulations.

(13) The patient record will contain a plan for aftercare.

(14) All entries in the patient record will be signed and dated.

(a) Symbols and abbreviations will be used only if they have been approved by the regulation and only when there is an explanatory legend.

(b) Approved symbols and abbreviations will be used in the recording of diagnoses on the DA forms 4465 and 4466.

b. The patient administration department will control and supervise patient records. The clinical director will be responsible for maintaining their quality and attests to this by signing the forms. The records will be kept in the Community Counseling Center in accordance with AR 600-85 and applicable medical regulations.

(1) A written SOP will govern the compilation, storage, dissemination, and accessibility of patient records.

(a) The SOP will be designed to ensure that the facility fulfills its responsibility to safeguard and protect patient records against loss, unauthorized alteration, or disclosure of information.

(b) The SOP will be designed to ensure that each patient record contains all required information.

(c) The SOP will be designed to ensure uniformity in the format and forms in use in patient records.

(d) The SOP will require entries in patient records to be dated and signed.

(2) The CCC will provide adequate facilities for the storage, processing, and handling of patient records, including suitably locked and secured rooms and files.

(3) The disposal of patient records will be documented and in accordance with AR 600-85 and AR 40-66.

(4) Methods of disposal will be designed to ensure the confidentiality of patient information.

(5) The CCC will have a written SOP that protects the confidentiality of patient records and governs the disclosure of information in the records.

(6) The SOP will specify the conditions under which information on applicants or patients may be disclosed, and the procedures for releasing such information. (See para 6-7.)

## Section II Patient Management

### G-9. Intake

a. The CCC will have the written SOP governing the intake process which will specify the following:

- (1) The information to be obtained on all applicants or referrals for admission.
- (2) The procedures for accepting referrals from outside agencies and organizations.
- (3) The records to be kept on all applicants.
- (4) The statistical data to be kept on the intake process.
- (5) The procedures to be followed when an applicant or a referral is found ineligible for admission.

b. Methods of intake will be based on the services provided by the CCC and the needs of clients.

c. Criteria for determining the eligibility of individuals for admission will be clearly stated in writing and be discussed with the rehabilitation team.

d. The intake procedure shall include an initial assessment of the client, as indicated on DA Form 4465.

(1) The intake assessment will be done by the clinical staff.

(2) The results of the intake assessment will be clearly explained to the client, the commander and any other member of the rehabilitation team.

(3) The results of the intake assessment will be clearly explained to the client's family when appropriate and permitted.

e. Acceptance of a client for treatment will be based on the commander's decision and an intake procedure that results in the following conclusions:

(1) The treatment required by the client is appropriate to the intensity and restrictions of care provided by the CCC.

(2) The treatment required can be appropriately provided by the CCC.

(3) The patient record contains the source of any referral.

(4) During the intake process, every effort is made to assure that applicants understand the following:

(a) The nature and goals of the treatment programs.

(b) The hours during which services are available.

(5) Sufficient information will be collected during the intake process to develop a preliminary treatment plan.

(6) Staff members who will be working with the patient but who did not participate in the initial assessment will be informed about the patient prior to meeting him or her.

### G-10. Assessment

a. The intake counselor will recommend to the clinical director, the type and extent of special clinical examinations, tests, and evaluations necessary for a complete assessment. The clinical consultant will determine

which, if any, routine laboratory and special clinical examinations are required upon enrolling the client in the ADAPCP. Additionally, the commander or his designated representative, will serve on the rehabilitation team which participates in the assessment.

b. The CCC will have an assessment procedure for the early detection of mental problems that are life-threatening, are indicative of severe personality disorganization or deterioration, or may seriously affect the treatment or rehabilitation process.

c. An emotional and behavioral assessment of each client will be completed and entered in the client's record. The assessment will include, but not necessarily be limited to, the following:

(1) A history of previous emotional, behavioral, and substance abuse problems and treatment.

(2) The client's current emotional and behavioral functioning.

(3) When indicated, a direct psychiatric evaluation.

(4) When indicated, a mental status examination appropriate to the age of the client.

(5) When indicated, psychological assessments, including intellectual, projective, and personality testing.

(6) When indicated, other functional evaluations of language, self-care, and social-affective and visual motor functioning.

(7) In programs serving children and adolescents, the assessment shall include evaluation of the developmental age factors of the client.

d. A social assessment of each client will be undertaken and shall include information relating to the following, as necessary:

(1) Environment and home.

(2) Childhood history.

(3) Military service history.

(4) Financial status.

(5) The social, peer-group, and environmental setting of the client.

(6) The client's family circumstances, including the constellation of the family group; the current living situation; and social, ethnic, cultural, emotional, and health factors, including drug and alcohol use.

### G-11. Treatment plan

a. Each client will have a written, individualized treatment plan that is based on assessments of his or her clinical needs.

(1) Overall development and implementation of the treatment plan will be assigned to an appropriate member of the professional staff.

(2) The treatment plan will be developed as soon as possible after the client's enrollment.

b. The treatment plan will reflect the CCC's philosophy of treatment and the participation of staff from appropriate disciplines.

c. The treatment plan will reflect consideration of the client's clinical needs.

d. The treatment plan will specify the services necessary to meet the client's needs.

e. The treatment plan will include referrals for needed services that are not provided directly by the CCC.

f. The treatment plan will contain specific goals that the client must achieve to attain, maintain, and/or reestablish emotional and/or physical health as well as maximum growth and adaptive capabilities. These goals will be based on assessments of the client and, as appropriate, the client's family.

g. The treatment plan will contain specific objectives that relate to the goals, are written in measurable terms, and include expected achievement dates.

### G-12. Progress notes

a. Progress notes will be entered in the patient's record and will include the following:

(1) Documentation of implementation of the treatment plan.

(2) Documentation of all treatment rendered to the client.

(3) Chronological documentation of the client's clinical course.

(4) Descriptions of each change in each of the client's conditions.

(5) Descriptions of the response of the client to treatment, the outcome of treatment.

b. Progress notes will be dated and signed by the individual making the entry.

c. All entries involving subjective interpretation of the client's progress will be supplemented with a description of the actual behavior observed.

d. Efforts will be made to secure written progress reports for clients receiving services from outside sources.

e. When available, patient records from outside sources will be included in the client's record.

f. The client's progress and current status in meeting the goals and objectives of his or her treatment plan will be regularly recorded in the client's record.

g. The efforts of staff members to help the client achieve stated goals and objectives will be regularly recorded.

h. Progress notes will be used as the basis for reviewing treatment plans.

i. The treatment plan will describe the services planned for the client and will specify the staff members assigned to work with the client.

j. The treatment plan will specify the frequency of treatment procedures.

k. The treatment plan will delineate the specific criteria to be met for termination of treatment. Such criteria shall be part of the initial treatment plan.

l. When appropriate, the client will participate in the development of his or her treatment plan, and such participation shall be documented in the client's record.

m. A specific plan for involving the family, when possible, will be included in the treatment plan.

### **G-13. Treatment plan review**

a. The CCC will conduct multidisciplinary case conferences to review and evaluate each client's treatment plan and progress.

b. Multidisciplinary case conferences will be documented and the results of the review and evaluation will be recorded in the client's record.

c. The treatment plan will be reviewed and updated and discussed with the clinical director every 20 visits or every 6 months, whichever comes first.

### **G-14. Release from program and aftercare**

a. *Program release.* A DA Form 4466, for release from the program will be entered in the client's record following release from outpatient programs. The release summary will include—

(1) Significant findings.

(2) The course and progress of the client.

(3) The final assessment, including general observation and understanding of the clients condition initially, during treatment, and at release.

(4) The recommendations and arrangements for further treatment or the commander's decision for subsequent discharge/separation from the Service.

b. *Aftercare or followup.* The aftercare program will assist the individual in developing an individualized continuing support plan, and when appropriate will involve the client's commander or supervisor. This summary will be documented in the remarks section of DA Form 4466.

(1) *Following inpatient care.* An individualized aftercare plan designed to identify the continued support of the patient, to include at least monthly monitoring for 1 year, will be developed and submitted to the patient's commander and the local servicing CCC.

(a) During the patient's first year of recovery, a quarterly evaluation of the patient's progress will be conducted by a committee comprised of the patient's commander or supervisor, when appropriate, the patient, an aftercare coordinator, and the patient's counselor.

(b) Every effort will be made to involve the patient's commander and supervisor when appropriate in the implementation of the aftercare plan. Commanders and supervisors will be informed in writing that residential or inpatient admission is only the initial stage of treatment, to be followed by an intensive aftercare rehabilitation program for a total of 360 days.

(2) *Following outpatient care.* A written plan describing the soldier's further rehabilitative responsibilities will be developed and submitted to the patient's commander. The patient's progress will be evaluated on a quarterly basis during the first year of recovery with reports from the patient, an alcohol counselor or aftercare coordinator and the patient's commander.

## Glossary

### Section I Abbreviations

**AA**  
Alcoholics Anonymous

**ABMD**  
Alcohol Breath Measuring Device

**ACOFs**  
Assistant Chief of Staff

**ADAPCP**  
Army Drug and Alcohol Prevention and Control Program

**ADCO**  
alcohol and drug control officer

**ADIC**  
alcohol and drug intervention council

**ADT**  
active duty for training

**AF**  
Air Force

**AFB**  
Air Force Base

**AFCENT**  
Allied Forces, Central Europe

**AG**  
adjutant general

**AIT**  
Advanced Individual Training

**AMC**  
U.S. Army Materiel Command

**AMEDD**  
Army Medical Department

**APO**  
Army Post Office

**ARNG**  
Army National Guard

**ASD (HA)**  
Assistant Secretary of Defense (Health Affairs)

**AV**  
AUTOVON

**AWOL**  
Absent without leave

**BCT**  
basic combat training

**bde**  
brigade

104

**bn**  
battalion

**CCC**  
Community Counseling Center

**CECOM**  
Army Communications Electronics Command

**CIR**  
Client Intake Report

**CIVPERCEN**  
Civilian Personnel Center

**CMF**  
Career Management Field

**CODARS**  
Client Oriented Drug and Alcohol Reporting System

**CONUS**  
continental United States

**CPC**  
civilian program coordinator

**CPO**  
civilian personnel office

**CPR**  
Client Progress Report

**CQ**  
charge of quarters

**CSA**  
Chief of Staff, U.S. Army

**CTA**  
common table of allowances

**DAMIS**  
Drug and Alcohol Management Information System

**DCCS**  
deputy commander for clinical services

**DCSPER**  
Deputy Chief of Staff for Personnel

**DLA**  
Defense Logistics Agency

**DMA**  
Defense Mapping Agency

**DOD**  
Department of Defense

**DODDS**  
Department of Defense Dependent Schools

**DPCA**  
Director of Personnel and Community Activities

**DTL**  
drug testing laboratory

**DUI**  
driving under the influence

**DWI**  
driving while intoxicated

**Ed**  
Education

**EDCO**  
educational coordinator

**EER**  
enlisted evaluation report

**EUSA**  
Eighth US Army

**FOA**  
field operating agency

**FORSCOM**  
U.S. Army Forces Command

**FRG**  
Federal Republic of Germany

**FTDTL**  
Forensic Toxicology Drug Testing Laboratory

**FY**  
fiscal year

**HHC**  
Headquarters and Headquarters Company

**HQDA**  
Headquarters, Department of the Army

**HQUSASCH**  
Headquarters, US Army Support Command, Hawaii

**HSC**  
U.S. Army Health Services Command

**IADT**  
inactive duty training

**IBCP**  
installation biochemical collection point

**IBTC**  
Installation Biochemical Test Coordinator

**INSCOM**  
Intelligence and Security Command

**JCAH**  
Joint Commission on Accreditation of Hospitals

**MACOM**  
major Army command

**MDW**  
Military District of Washington

**MEDCEN**  
U.S. Army Medical Center

**MEDCOM**  
medical command

**MEDDAC**  
medical department activity

**MILPO**  
military personnel office

**MOS**  
military occupational specialty

**MOU**  
Memorandum of Understanding

**MSC**  
major subordinate command

**MTF**  
medical treatment facility

**MTMC**  
Military Traffic Management Command

**NAF**  
nonappropriated fund

**NCO**  
noncommissioned officer

**NGR**  
National Guard Regulation

**NHTSA**  
National Highway Traffic Safety Administration

**NLT**  
not later than

**NSN**  
national stock number

**ODCSPER**  
Office of the Deputy Chief of Staff for Personnel

**OER**  
officer evaluation report

**OPM**  
Office of Personnel Management

**OSD**  
Office of the Secretary of Defense

**OTSG**  
Office of The Surgeon General

**PCP**  
phencyclidine

**PCS**  
permanent change of station

**PMOS**  
primary military occupational specialty

**POS**  
Positive

**PRP**  
personnel reliability program

**QA**  
quality assurance

**QC**  
quality control

**RDD**  
required delivery date

**Rehab**  
rehabilitation

**RTF**  
residential treatment facility

**SDO**  
staff duty officer

**SJA**  
staff judge advocate

**SQT**  
skill qualification test

**SSN**  
social security number

**TACOM**  
Tank Automotive Command

**TAG**  
The Adjutant General

**TASO**  
Training Aids Service Office

**TDA**  
table of distribution of allowances

**TDY**  
temporary duty

**TECOM**  
U.S. Army Test and Evaluation Command

**THC**  
tetrahydrocannabinol

**TJAG**  
The Judge Advocate General

**TRADOC**  
U.S. Army Training and Doctrine Command

**TSG**  
The Surgeon General

**UADC**  
Unit Alcohol and Drug Coordinator

**UCMJ**  
Uniform Code of Military Justice

**USADART**  
U.S. Army Drug and Alcohol Rehabilitation Training

**USADAOA**  
U.S. Army Drug and Alcohol Technical Activity

**USAG**  
U.S. Army Garrison

**USAISC**  
U.S. Army Information Systems Command

**USAR**  
U.S. Army Reserve

**USAREUR**  
U.S. Army, Europe

**USARJ**  
U.S. Army, Japan

**USMA**  
United States Military Academy

**WESTCOM**  
U.S. Army Western Command

## **Section II** **Terms**

### **Alcohol and Drug Abuse Prevention and Control Program**

A manpower conservation program that includes prevention, identification, education, and rehabilitation services. The program includes nonresidential and residential treatment. The ADAPCP is responsive to the chain of command and supports the morale, safety, and combat readiness of the Army.

### **Alcohol abuse**

Any irresponsible use of an alcoholic beverage which leads to misconduct, unacceptable social behavior, or impairment of an individual's performance of duty, physical or mental health, financial responsibility, or personal relationships.

### **Alcoholism**

A treatable, progressive condition or illness, characterized by excessive consumption of alcohol to the extent that the individual's physical and mental health, personal relationships, social conduct, or job performance are impaired.

### **Alcohol and Drug Abuse Residential Treatment Facility**

A facility which provides intensive full-time residential care and treatment for eligible personnel.

### **Alcohol and drug control officer**

The person having staff responsibility for implementing, operating, and monitoring the ADAPCP at MACOM installation or major tenant unit level.

### **Armed Forces**

As used in the status upon which this regulation is based, refers to active members of the Army, Navy, Air Force, Marines, and Coast Guard. This includes former members of these components for any period in which they were on active duty. It does not include their dependents or civilian employees of the Armed Forces.

### **Awareness education**

Education which aims at increasing knowledge of the effects and consequences of alcohol or other drugs on both an organizational and personal level.

### **Civilian client**

Any U.S. citizen DA employee, including NAF employees, enrolled in an ADAPCP or referred by the ADAPCP to an approved civilian rehabilitation program.

### **Civilian program coordinator**

The individual who is responsible to the ADCO for the civilian aspects of the ADAPCP. (At MACOM, designated as civilian program administrator.)

### **Clinical consultant**

The military physician who is responsible for providing, coordinating, and supervising consultative and medical support to the ADAPCP for the MEDCEN/MEDDAC commander.

### **Clinical director**

The behavioral science professional who is responsible to the ADCO for implementing and monitoring the medical rehabilitation aspects of the ADAPCP. This includes supervision and training of the counselors.

### **Command consultation**

The coordination process through which members of the ADAPCP staff and/or the MEDCEN/MEDDAC staff meet with an immediate commander to discuss or recommend a course of action concerning a service member. (See rehabilitation team.)

### **Community Counseling Center**

The facility where local ADAPCP counseling services are provided. The Alcohol and Drug Control Office may or may not be colocated with the CCC.

### **Confidential information**

Personal information revealed by a client to a counselor which will be used only for counseling or official ADAPCP purposes in accordance with Federal regulations.

### **Drug abuse**

The illegal, wrongful, or improper use of any narcotic substance or its derivative, cannabis or its derivative, other controlled substances or dangerous drugs. This includes the improper use of drugs prescribed by a physician.

### **Education Coordinator**

The individual who is responsible to the ADCO for administering an alcohol and other drug abuse prevention education and training program.

### **Enrollment**

The formal action taken by a commander to enter a service member into the ADAPCP. Or the formal admission or direction to the ADAPCP of all other categories of clients by the CCC staff, physicians, or appropriate law enforcement personnel.

### **Family member**

Spouse and minor children of a service member or a DA civilian. Use of the term in this regulation is intended to include only those persons eligible for ADAPCP services by law or regulation.

### **Limited use**

Protection from the use of certain information, determined to be confidential by Federal regulation, to support disciplinary action under the UCMJ or administrative separation with a less than honorable discharge.

### **Medical evaluation**

Examination of an individual by a physician to determine whether there is evidence of alcohol or other drug abuse or dependency.

### **Military client**

Any active duty soldier or active duty for training member (30 days or more) of the Armed Forces who is enrolled in the ADAPCP.

### **Other client**

Any retired member of the Armed Forces who became enrolled in an ADAPCP after retirement from active duty. Any family member (spouses, children) of active and retired military or of US citizen civilian employee (to include, where authorized, certain foreign nationals) who are enrolled in an ADAPCP. ARNG and USAR personnel when on active duty for training for less than 30 days and participating in the ADAPCP.

### **Prevention procedures**

Those actions designed to increase the likelihood that individuals will make responsible decisions regarding the use of alcohol or other drugs. Those actions taken to eliminate to the extent possible, abuse or misuse of alcohol or other drugs.

### **ADAPCP record**

Forms, records, or other documents required by this regulation. This includes any information, whether recorded or not, which relates to a client and which is received or acquired in connection with any function of the ADAPCP, including evaluation for possible enrollment in the ADAPCP. The creation or maintenance of alcohol or other drug abuse records that would identify an individual as a client of

the ADAPCP, other than as required by this regulation, are prohibited.

### **Recovering client**

A person who no longer abuses alcohol or other drugs.

### **Rehabilitation services**

Preventive education, referral and clinical services provided to clients by the ADAPCP. These services are intended to reverse an individual's drug or alcohol related impairment and restore satisfactory job performance.

### **Rehabilitation team**

An informal coordinating group consisting of the client's unit commander or his designee, immediate supervisor, and counselor plus other appropriate personnel as required (that is, clinical director, chaplain, physician). The group reviews all pertinent information about the client and recommends to the commander when rehabilitation is required. It selects the appropriate rehabilitation track and assists the commander in setting standards of behavior and goals for evaluation of the client's progress in rehabilitation.

### **Sensitive position**

Any position within the DA in which the occupant could cause, by virtue of the nature of his or her position, a material adverse effect on the national security. (See AR 690-1, para 6, sec.I.)

# ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM TRANSMITTAL SUMMARY

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

REQUIREMENT CONTROL  
SYMBOL CSGPA-1291(R4)

## SECTION A—INSTALLATION/MACOM IDENTIFYING DATA

1. INSTALLATION AND MAILING ADDRESS OF COMMUNITY COUNSELING CENTER (CCC)	2. REPORT PERIOD ENDING:	3. ADAPCP SERVICE AREA CODE:
4. NAME, TITLE, AUTOVON TELEPHONE NUMBER OF PERSON PREPARING REPORT	5. NAME, GRADE, AND TITLE OF ADCO/ CLINICAL DIRECTOR/CPC	6. SIGNATURE

## SECTION B—ADAPCP REHABILITATION FACILITIES AND STAFF

7. TYPE OF FACILITIES A. <input type="checkbox"/> OUT-PATIENT				B. <input type="checkbox"/> IN-PATIENT				8. TYPE OF TREATMENT PROVIDED A. <input type="checkbox"/> ALCOHOL      B. <input type="checkbox"/> DRUG      C. <input type="checkbox"/> COMBINED			
LINE	STAFF <i>a</i>	OFFICER		ENLISTED				CIVILIAN		SPECIAL DUTY	
		AUTHORIZED <i>b</i>	ASSIGNED <i>c</i>	91G		OTHER		AUTHORIZED <i>h</i>	ASSIGNED <i>i</i>	MILITARY <i>j</i>	CIVILIAN <i>k</i>
				AUTHORIZED <i>d</i>	ASSIGNED <i>e</i>	AUTHORIZED <i>f</i>	ASSIGNED <i>g</i>				
9	Administration										
10	Counseling Services										
11	Clinical Director										
12	ADCO										
13	EDCO										
14	CPC										
15	Prevention Ed/Trng										
16	TOTAL										

## SECTION C—ADAPCP FUNCTIONS, ACTIVITIES, AND SERVICES—MANHOURS AND WORKLOAD

LINE	FUNCTION/ACTIVITY/SERVICE	TIME EXPENDED <i>a</i>	MANHOURS <i>b</i>	NUMBER OF COURSES <i>c</i>	NUMBER OF STUDENTS <i>d</i>	NUMBER OF VISITS <i>e</i>
17	Administrative Support					
18	Clinical Recordkeeping					
19	Planning and Evaluation					
20	Other ADAPCP Related Functions					
<b>PREVENTION EDUCATION AND TRAINING</b>						
21	Commander and Staff Education					
22	Unit Education					
23	Dependent Youth Education					
24	Civilian Employee Supervisor Education					
25	ADAPCP Staff Education Training					
26	Alcohol Drug Awareness Education					
27	Other Education and Training					
<b>SCREENING, REHABILITATION, AND TREATMENT</b>						
28	Screening Interviews					
29	Individual Counseling					
30	Group Counseling					
31	Command Consultation					
32	Other Rehabilitation Services					



# ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM TRANSMITTAL SUMMARY

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REQUIREMENT CONTROL  
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## SECTION D—PENDING CASES BY REFERRAL METHOD

PENDING CASES		PRESCREENED <i>b</i>	CONFIRMED <i>c</i>	SELF-REFERRED <i>d</i>	COMMANDER REFERRED <i>e</i>	INVESTIGATION APPREHENSION <i>f</i>	MEDICALLY REFERRED <i>g</i>
<i>a</i> Number of Persons Requiring Disposition							
33	Total Beginning of This Period						
34	Total Screened/Dispositioned This Period						
35	Total Gained This Period						
36	Total End of This Period						

## SECTION E—BIOCHEMICAL TESTING OF URINE SPECIMENS FOR DRUG ABUSE

ADAPCP SERVICE AREA CODE:

ITEMS <i>a</i>		COMMANDER DIRECTED		PHYSICIAN DIRECTED <i>d</i>	REHAB CLIENTS <i>e</i>	ENTRY ON ACTIVE DUTY <i>f</i>	TREATMENT REHAB STAFF <i>g</i>
		INDIVIDUAL <i>b</i>	UNIT SWEEP <i>c</i>				
<i>Data This Period</i>							
37	Total Specimens Submitted to Lab						
38	Total Persons Tested						
<i>Field Tests This Period</i>							
39	Total Prescreening Specimens Collected						
40	Total Prescreening Specimens Positive						
41	Total Prescreening Persons Positive						
42	Total Prescreening Specimens Submitted to Lab						
<i>Lab Results Received This Period</i>							
43	Total Specimens Returned Negative						
44	Total Persons Negative						
45	Total Specimens Returned Positive						
46	Total Persons Positive						
47	Total Prescreening Specimens Lab Confirmed						

## SECTION F—INSTALLATION DEMOGRAPHIC INFORMATION

POPULATION SERVED	PERMANENT PARTY SOLDIERS	CIVILIAN EMPLOYEES	DEPENDENTS AND RETIREES	TRAINEES	OTHER SERVICES	USAR ADI
48	Assigned/Attached/MOU					

Remarks

COMMAND/INSTALLATION MAILING ADDRESS

DATE (month and year)



**CIVILIAN EMPLOYEE CONSENT STATEMENT**

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

**NOTE:** Prepare this form in the original only and file in the ADAPCP client case file folder. Reproduction and distribution of this form are prohibited.

**JUSTIFICATION**

Purpose of this statement is to request and enlist the cooperation and assistance of your immediate supervisor in your behalf. His/her involvement in your treatment plan will greatly assist us in providing ADAPCP services. For this purpose, however, it is necessary to obtain your consent, pursuant to S 1401.21 of the Public Law cited as follows: Section 408, Public Law 92-255, The Drug Abuse Office and Treatment Act of 1972 (21 USC 1175), as amended in 1974 by Section 303, Public Law 93-282.

**UNDERSTANDING**

I understand that I must give my consent before any involvement or participation by my supervisor can take place concerning my treatment plan. (By "supervisor", it is intended the person who initiates and/or rates all personnel actions concerning myself.) I further understand that my supervisor will only receive information on progress and attendance. No personal information of any kind will be disclosed without my specific consent each time information is either required or given. I also understand that, with or without consent for release of information to my supervisor, ADAPCP services will be equally available to me. I understand that my consent to provide my supervisor with pertinent information is necessary to avert or suspend any adverse personnel action relating to my performance and/or conduct during the period of rehabilitation.

**CONSENT**

Having understood the basis for consent, I \_\_\_\_\_  
(name of client)  
agree/do not agree with the Civilian Program Coordinator on the involvement of my supervisor,  
\_\_\_\_\_ in my treatment plan. I understand that I may with-  
(name of supervisor)  
draw this consent at any time.

**REMARKS**

SIGNATURE OF CLIENT

DATE

NAME AND TITLE OF WITNESS (Type or print)

SIGNATURE

DATE

**WITHDRAWAL OF CONSENT**

(Sign below if and when you decide to withdraw your consent.)

SIGNATURE OF CLIENT

DATE



**ADAPCP CLIENT'S CONSENT STATEMENT FOR RELEASE OF TREATMENT INFORMATION**

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

**SECTION A – CONSENT**

I, \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_,  
(client's full name)

do hereby voluntarily consent to the release of the following information by \_\_\_\_\_  
(name of installation ADAPCP)

\_\_\_\_\_pertaining to my identify, diagnosis, prognosis, or treatment from any  
 Army maintained in connection with alcohol or other drug abuse education, training, treatment,  
 rehabilitation, or research to \_\_\_\_\_ for the purpose of

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_namely,

\_\_\_\_\_  
(extent or nature of information to be disclosed)

**SECTION B – EXPIRATION/REVOCAION**

(Check applicable paragraph)

1. I understand that this consent automatically expires when the above disclosure action has  
 taken in reliance thereon and that, except to the extent that such action has been taken, I can  
 revoke this consent at any time.

– Or –

(For disclosure to civilian criminal justice officials under the provisions of paragraphs 6-9b(4)(b) and 6-10e(3),  
 AR 600-85)

2. I understand that this consent automatically expires 60 days from today's date or when  
 my present criminal justice system status changes to \_\_\_\_\_

Further, I understand that if my release from confinement, probation, or parole is conditioned  
 upon my participation in the ADAPCP, I cannot revoke this consent until there has been a  
 formal and effective termination or revocation of my release from such confinement, pro-  
 bation, or parole.

SIGNATURE OF CLIENT		DATE
NAME OF WITNESS <small>(Type or print)</small>	SIGNATURE	DATE

**SECTION C – APPROVAL AUTHORITY FOR RELEASE OF INFORMATION**

NOTE: Other than the MEDCEN/MEDDAC Commander, approval authority for release of information may be dele-  
 gated to the Program Physician of the Clinical Director.

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

NAME OF MEDCEN/MEDDAC COMMANDER OR DESIGNATED REPRESENTATIVE <small>(Type or print)</small>	DATE
SIGNATURE	



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

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

**SECTION A - REQUIREMENTS**

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

**SECTION B - AGREEMENT**

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

SIGNATURE OF EMPLOYEE/APPLICANT

DATE SIGNED







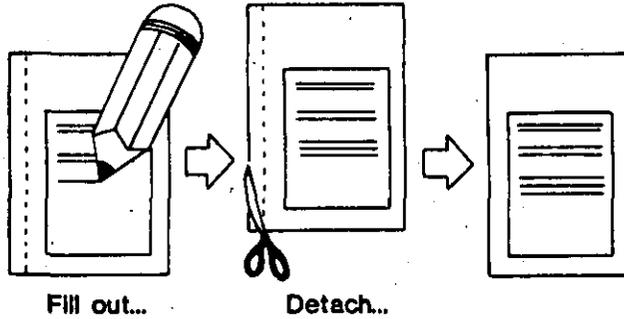
**CHAIN OF CUSTODY**

DATE	RELEASED BY	RECEIVED BY	PURPOSE OF CHANGE/REMARKS
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3 NOVEMBER 1986 UPDATE • R-FORMS

# ARMY UPDATE PUBLICATIONS SUBSCRIPTION FORM



Forward to unit publications officer for consolidation on DA Form 12-9U-R.

This page is for internal use within your unit.

1. To change their initial distribution requirements, individual users or sections of a unit should complete this DA Form 12-13 (UPDATE Subscription Page) and submit it to their unit publications officer.

2. The unit publications officer should consolidate the entire unit's requirements, enter those requirements on DA Form 12-9U-R, and submit the DA 12-9U-R to the address preprinted on the form. Only unit publications officers may submit DA Form 12-9U-R. (DA 12-Series Circular).

(Publication No.) AR 600-85

To: Publications Officer

## FOR COMPLETION BY USER OF PUBLICATION

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