

Army Regulation 600–85

Personnel—General

The Army Substance Abuse Program

**Headquarters
Department of the Army
Washington, DC
23 July 2020**

UNCLASSIFIED

SUMMARY of CHANGE

AR 600–85

The Army Substance Abuse Program

This major revision, dated 23 July 2020—

- o Incorporates Army Directive 2016–04, Realignment of the Army Substance Abuse Program’s Clinical Care (paras 1–1, 2–5, 2–10*a*, 2–14*a*, 2–15*a-b*, 2–18*a*, 2–18*l*, 2–18*t*, 2–19*a*, 2–20*g*, 2–24, chap 7, 8, 13, and 14).
- o Requires clinical realignment policy updates with primary responsibility for The Surgeon General (paras 1–7, 2–1, 2–2, 2–5, 2–18, 2–21(*o*), 2–24, 2–24*h*, 2–33, 4–2, 4–9, 4–14, 5–8, 7–1, 7–3, 8–1, 8–3, 8–5, 8–6, 8–7, 8–9, 9–4, 9–6, 9–8, 10–12, 10–26, 13–4, B–8, and D–1).
- o Changes the definition of the acronym for Criminal Investigation Command to Criminal Investigation Division and updates the title for special agents (paras 1–7, 2–11, 2–17*h*, app A, and glossary).
- o Requires functional realignment policy updates with responsibility for Installation Management Command (paras 2–18, 2–20, 2–21, 2–31, 4–2, 4–2*d*, 4–2*k*, 4–11*c*, 4–13*a*, 4–13(5), 4–13(6), 4–15, 5–5*h*, 5–12, 5–15, 5–16*b*, 5–17*d*, 6, 6–2*f*, 6–2*j*, 6–5, 6–6, 6–8, 7–3*d*, 7–5*d*, 9–5(6), 9–5(9), 9–12*c*, 9–14, 9–16, 9–17, 12–3*a*, 12–3*b*, 12–5*a*, 12–5*d*, 13–3*e*(1), 15–8*c*, B–3, D–2, D–3*h*, D–3*i*, D–3*n*, E–5*e*, E–5*t*, E–6*f*, E–7*b*, E–10*d*(2), and table 12–1).
- o Updates unit risk inventory administration timing (paras 2–16*f* and 2–28*i*).
- o Incorporates guidance from Army Directive 2012–07, Administrative Processing for Separation of Soldiers for Alcohol or Other Drug Abuse (paras 2–16*j*, 2–21*k*, 3–3*a*, 4–15*f*, 10–6 and 16–6*g*).
- o Replaces DA Form 3997 with Army Law Enforcement Reporting and Tracking System (paras 2–25 and app A).
- o Updates roles and responsibilities for Family Advocacy Program activities (paras 2–32*k*, 12–4, and table 12–1).
- o Incorporates Army Directive 2016–15, Change in the Army Random Deterrence Drug Testing Program (paras 4–2*c* and 4–8*a*(5)).
- o Incorporates Army Directive 2013–10, Synthetic Cannabinoids (“Spice”) and “Bath Salts” Probable Cause and Competence for Duty Testing (paras 4–2*m*).
- o Changes Army Central Clearance Facility to Department of Defense Consolidated Adjudications Facility (paras 4–8*a*(4), 4–8*b*, 5–11*a*, 10–5*a*, 16–8, and 16–8*a*).
- o Implements Army Directive 2015–14, Use of the Electronic Data Interchange Person Identifier for Identification in the Military Personnel Drug Testing Program (paras 4–13*e*(1), 4–15*g*, 5–10*e*(2), 10–10*c*, and D–3).
- o Implements Army Directive 2015–06, Designation of Certain Positions as Testing Designation Positions Under the Army Drug-Free Federal Workplace Program (paras 5–8*b*(13)(*c*)14, 5–8*b*(13)(*c*)17, and .)
- o Updates Soldier substance abuse awareness training requirement (para 9–9*c*).
- o Implements Army Directive 2015–21, Update to the Army Risk Reduction Program (table 12–1).
- o Implements Army Directive 2013–11, Change to the Army Risk Reduction Program (paras 12–5*b* and 12–5*c*).

- o Adds administrative updates and clarification for Army National Guard functions (paras 15–2, 15–5, 15–6, 15–7, 15–8, and 15–9).
- o Adds administrative updates and clarification for Army Reserve functions (para 16–6).
- o Incorporates Army Directive 2016–35, Army Policy on Military Service of Transgender Soldiers (para E–1).
- o Incorporates Army Directive 2018–07–7, Prioritizing Efforts-Readiness and Lethality (Update 7), (para 16–10f).
- o Incorporates Army Directive 2018–07–8, Prioritizing Efforts-Readiness and Lethality (Update 8), (paras 2–19g, 9–11c, 9–12b, and 16–10f).
- o Incorporates Army Directive 2019–12, Policy for Voluntary Alcohol-Related Behavioral Healthcare (paras 8–1).
- o Implements Memorandum, Office of the Assistant Secretary of Defense, December 10, 2016, Subject: Department of Defense (DOD) Response to Draft Report GAO–17–114, “MILITARY PERSONNEL: DOD and Coast Guard Need to Screen for Gambling Disorder Addiction and Update Guidance” with DOD directing Department of the Army to update AR 600–85 to explicitly include gambling disorder (paras 9–1, 9–2, 9–3, 9–8, 9–9, and 9–10).
- o Incorporates Army Directive 2011–09, Use of the Electronic of Licensed Professional Counselors as Fully Functioning Army Substance Abuse Program Practitioners manpower staffing-treatment resources section (para 18–4b).

Personnel—General

The Army Substance Abuse Program

By Order of the Secretary of the Army:

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General, United States Army
Chief of Staff

Official:


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Administrative Assistant
to the Secretary of the Army

History. This publication is a major revision.

Summary. This regulation governs the Army Substance Abuse Program. It identifies Army policy on alcohol and other drug abuse, and it identifies assigned responsibilities for implementing the program.

Applicability. This regulation applies to the Regular Army, the Army National Guard/Army National Guard of the United States when in Title 10 status (National Guard in Title 32 status should refer to chapter 15), U.S. Army Reserve, and Department of the Army civilian employees. Chapter 15 applies specifically to the Army National Guard of the United States, while chapter 16 applies to the U.S. Army Reserve. However, other chapters of the regulation apply to Soldiers of the U.S. Army Reserve and the Army National Guard, when indicated. Chapter 5 applies to Department of the

Army civilian employees. Chapter 6 applies to Department of the Army civilian employees, Family members, and military retirees.

Proponent and exception authority. The proponent of the deterrence, drug testing, prevention, and training provisions of this regulation is the Deputy Chief of Staff, G–1. The proponent of the clinical and rehabilitation provisions of this regulation is The Surgeon General. The proponent of the respective provisions has the authority to approve exceptions or waivers to those provisions that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity’s senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army internal control process. This regulation contains internal control provisions in accordance with AR 11–2 and identifies key internal controls that must be evaluated (see appendix G).

Supplementation. Supplementation of this regulation and establishment of

command and local forms are prohibited without prior approval of the Deputy Chief of Staff, G–1 (DAPE–AR), 300 Army Pentagon, Washington, DC 20310–0300.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Deputy Chief of Staff, G–1 (DAPE–AR), 300 Army Pentagon, Washington, DC 20310–0300.

Committee management. AR 15–1 requires the proponent to justify establishing/continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the U.S. Army Resources and Programs Agency, Department of the Army Committee Management Office (AARP–ZA), 9301 Chapel Road, Building 1458, Fort Belvoir, VA 22060–5527. Further, if it is determined that an established “group” identified within this regulation, later takes on the characteristics of a committee, as found in the AR 15–1, then the proponent will follow all AR 15–1 requirements for establishing and continuing the group as a committee.

Distribution. This regulation is available in electronic media only and is intended for the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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*This regulation supersedes AR 600–85, dated 28 November 2016. The following Army directives are now rescinded: Army Directive 2013-11, dated 2 May 2013, Army Directive 2015-06, dated 27 January 2015, Army Directive 2015-14, 31 March 2015, Army Directive 2015-21, dated 8 April 2015, Army Directive 2016-04, dated 1 March 2016; Army Directive 2016-15, dated 22 April 2016; and Army Directive 2016-35, dated 7 October 2016.

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Glossary

Chapter 1 General

1–1. Purpose

This regulation provides comprehensive alcohol- and drug-abuse prevention and control policies, procedures, and responsibilities for Soldiers of all components, DA Civilians, and other personnel eligible for Army Substance Abuse Program (ASAP) services. The comprehensive program is composed of integrated functions that include deterrence, drug testing, prevention and training, and substance use disorder (SUD) treatment. The Deputy Chief of Staff (DCS), G–1, Army Resilience Directorate (ARD) develops ASAP goals and policies, and directs ASAP operations. The ASAP's, deterrence, drug testing, and prevention and training are part of Installation Management Command (IMCOM), Army Material Command (AMC), Army National Guard (ARNG), and the U.S. Army Reserve (USAR) functional missions. The clinical care functional responsibility is referred to as Substance Use Disorder Clinical Care (SUDCC) and is integrated within the Behavioral Health System of Care (BHSOC).

1–2. References and forms

See appendix A.

1–3. Explanation of abbreviations and terms

See the glossary.

1–4. Responsibilities

Responsibilities are listed in chapter 2.

1–5. Records management (recordkeeping) requirements

The records management requirement for all record numbers, associated forms, and reports required by this regulation are addressed in the Records Retention Schedule-Army (RRS–A). Detailed information for all related record numbers, forms, and reports are located in Army Records Information Management System (ARIMS)/RRS–A at <https://www.arims.army.mil>. If any record numbers, forms, and reports are not current, addressed, and/or published correctly in ARIMS/RRS - A, see DA Pam 25–403 for guidance.

1–6. Program authority

On 28 September 1971, Public Law (PL) 92–129, mandated that the Secretary of Defense develop programs for the identification (ID), treatment, and rehabilitation of alcohol- or other drug-dependent persons in the Armed Forces. Similarly, PL 91–616 and PL 92–255 authorized the Secretary of Defense to develop programs for Department of Defense (DoD) Civilians. In turn, the Secretary of Defense requires each of the Services to develop alcohol- and other drug-abuse prevention and control programs in accordance with Department of Defense instruction (DoDI) 1010.04, DoDI 1010.01, and DoDI 1010.09. In response to these directives, the Army conducts a comprehensive program to prevent and control the abuse of alcohol and other drugs.

1–7. Army Substance Abuse Program concept and principles

a. Substance abuse contributes to high-risk behaviors, runs counter to Army Values and erodes personal readiness. ASAP is a mechanism within the ARD system of support that, when administered appropriately, through engaged and empowered leadership, supports building personal readiness and resilience, and optimizes performance.

b. The command role in substance abuse prevention, drug and alcohol testing, early ID of problems, and administrative or judicial actions is essential. Commanders will ensure that all officials and supervisors support the ASAP. Proposals to provide ASAP services that deviate from procedures prescribed by this regulation must be approved by the Director, ARD, DCS, G–1.

c. The overarching tenets of the ASAP are deterrence, prevention and treatment.

(1) The capabilities supporting deterrence are drug testing, identification/detection, and referral.

(2) The capabilities supporting prevention are awareness, education, risk reduction, interventions, and employee assistance.

(3) While not a part of ASAP, Substance Use Disorder Clinical Care (SUDCC) supports the Army's strategy to prevent substance abuse within the Army and provide treatment services when clinically indicated.

(4) Table 1–1 depicts this alignment and provides definitions for each capability.

**Table 1–1
Overarching tenets and supporting capabilities of Army Substance Abuse Program**

Tenets	Capability	Definition
Deterrence	Drug testing	Action or threat of action to be taken in order to dissuade Soldiers or government employees from abusing or misusing substances. The Army's primary mechanism of deterrence is random drug testing.
Prevention	Identification (ID) or detection	The process of identifying Soldiers and other beneficiaries as potential or actual substance abusers. This ID can be via self-ID, command ID, drug testing ID, medical ID, investigation or apprehension ID.
Prevention	Referral	Modes by which Soldiers and other beneficiaries can access garrison ASAP referral for prevention. Modes are self-referral and command referral.
Treatment	Referral	An in-depth individual biopsychosocial evaluation interview to determine if Soldiers and other beneficiaries need to be referred for treatment. This capability is a Defense Health Agency (DHA) responsibility. Modes are self-referral and command referral.
Prevention	Targeted education	An educational/motivational program that focuses on the adverse effects and consequences of alcohol and other drug abuse.
Treatment	Counseling Services	Clinical intervention with the goal of returning Soldiers and other beneficiaries to full duty or identify Soldiers who are not able to successfully rehabilitated. This capability is a DHA responsibility.
Prevention	Risk reduction	Compile, analyze, and assess behavioral risk and other data to identify trends and units with high-risk profiles. Provide systematic prevention and intervention methods and materials to commanders to eliminate or mitigate individual high-risk behaviors.

d. The Army maintains the following principles:

(1) Abuse of alcohol, use of illegal drugs and misuse of prescription drugs are inconsistent with Army values, and the standards of performance, discipline, and readiness necessary to accomplish the Army's mission.

(2) Unit commanders must intervene early and refer all Soldiers suspected of alcohol- or other drug-use problems to BH for a SUD evaluation. The unit commander will support treatment plans for all Soldiers.

(3) Participation is mandatory for all Soldiers who are command referred and/or subsequently enrolled in mandatory treatment. Failure to attend mandatory counseling sessions may constitute a violation of Article 86 of the Uniform Code of Military Justice (UCMJ, Art. 86).

(4) Soldiers who fail to participate adequately in or to respond successfully to treatment will be processed for administrative separation. In addition to existing separation policies for alcohol- or other drug-abuse treatment failures, Soldiers with a subsequent alcohol- or drug-related incident of misconduct at any time during the 12-month period following treatment or during the 12-month period following removal from the treatment program, for any reason, will be processed for separation as an alcohol- or drug-abuse rehabilitation failure. This expanded period does not prevent separation for other reasons authorized by existing administrative separation regulations or other authorities. The term "process for separation" means that the separation action will be initiated and processed through the chain of command to the separation authority for appropriate action.

(5) Substance use disorder treatment will be addressed in a single program that is integrated with the behavioral health system of care to ensure holistic care. Treatment will generally be short term and conducted in a manner that supports the military environment and the readiness of the force.

(6) An active and aggressive drug- and alcohol-testing program serves as an effective deterrent against alcohol and drug abuse.

(7) The military police (MP), U.S. Army Criminal Investigation Command (USACIDC), and other investigative personnel will not enroll in or otherwise infiltrate substance use disorder treatment for the purpose of law enforcement activities or to solicit information from Soldiers enrolled in mandatory treatment.

1–8. Army Substance Abuse Program eligibility criteria

a. Services are authorized for personnel who are statutorily eligible to receive ASAP services and/or who are eligible to receive medical care for substance use disorder treatment.

b. When Soldiers are under the administrative jurisdiction of another Service, they will comply with the alcohol and drug programs of that Service. All drug test results and records of referrals for counseling and rehabilitation/treatment will be reported through Army alcohol- and drug-abuse treatment channels to the ARD.

c. When elements of the Army and another Service are so located that cost effectiveness, efficiency, and combat readiness can be achieved by combining facilities, the Service to receive the support will be responsible for initiating a local Memorandum of Understanding and/or Inter-Service Support Agreement (refer to DoDI 4000.19).

d. Members of the Army National Guard (ARNG) and U.S. Army Reserve (USAR) who are on active duty (AD) orders for more than 30 consecutive days, or those on AD orders with an approved Line of Duty (LOD), are covered for any injury, illness, or disease incurred or aggravated in the line of duty, are eligible for substance use disorder treatment and required to follow clinical care policies throughout this regulation.

1–9. Labor relations

Activities must meet the applicable labor relations obligations prior to implementing the terms of this regulation as they relate to the conditions of employment of bargaining unit members. Questions regarding labor relations implications and responsibilities concerning civilian drug testing should be addressed through the civilian personnel chain of command to the Deputy Chief of Staff, G–1 (DAPE–AR), 300 Army Pentagon, Washington, DC 20310–0300.

Chapter 2 Responsibilities

2–1. Chief, National Guard Bureau

The CNGB will—

- a.* Develop and execute plans, policies, and procedures of the State ARNG ASAPs.
- b.* Ensure that ARNG units comply with this regulation.
- c.* Advise the DCS, G–1 regarding the impact of alcohol, drug abuse and gambling disorder in the ARNG.

2–2. Deputy Chief of Staff, G–1

The DCS, G–1 will—

- a.* Integrate, coordinate, and approve all nonclinical policies pertaining to the ASAP.
- b.* Exercise general staff responsibility for plans, policies, programs, budget formulation, and related research and program evaluation pertaining to alcohol and drug abuse in the Army.
- c.* Direct the Director, ARD to—
 - (1) Provide guidance and leadership on all nonclinical alcohol and drug policy issues.
 - (2) Exercise staff leadership and supervision over the ASAP.
 - (3) Ensure the Risk Reduction Program (RRP) interfaces with related functional areas within the Director of Human Resources Policy’s responsibilities and coordinates RRP activities with other related DoD, DA, and civilian agencies.
 - (4) Oversee the Army’s Drug- and Alcohol-Testing Program.
 - (5) Direct ASAP operations.
 - (6) Develop ASAP goals and policies.
 - (7) Review, assess, and recommend policy changes, as appropriate.

(8) Interpret ASAP policy in response to inquiries from all internal and external government agencies (including Army commands (ACOMs), Army service component commands (ASCCs), direct reporting units (DRUs) and their subordinate commands, other uniformed Services, DoD, and other Federal agencies).

(9) Prepare budget submissions, direct allocation of funds, monitor execution of resources, and serve as the functional budget program manager for the ASAP.

(10) Oversee programs, develop plans, formulate budgets, and provide technical assistance and training for ASAP civilian services.

(11) Maintain liaison between the Army and the other uniformed Services, other Federal agencies, and the private sector.

(12) Provide operational guidance, monitoring, and oversight of the worldwide ASAP. Coordinate management, funding, and execution of the ASAP with IMCOM, NGB, USAR, and Army Material Command (AMC).

(13) Consolidate all alcohol and drug statistics and provide periodic reports to the Director, ARD, the Army staff, ACOMs, ASCCs, DRUs, DoD, the Department of Health and Human Services (DHHS), and ASAP managers.

(14) Establish and maintain program-level evaluation plans, measures, data collections, analyses, and reporting procedures for implementation at Army, IMCOM, ACOM, ASCC, DRU, and installation levels.

(15) Publish an ASAP Evaluation Plan, which will be updated annually, or as ASAP policy changes.

(16) Provide technical assistance in the use of automation and other emerging technologies in substance abuse programs.

(17) Develop, establish, administer, and evaluate alcohol, drug-abuse and gambling disorder prevention, education, and training programs.

(18) ARD Director will review and approve all ASAP curriculum developed for U. S. Army Training and Doctrine Command (TRADOC) schools/courses.

(19) Provide training at senior leadership training courses upon request.

(20) Develop, establish, administer, and evaluate alcohol, drug abuse, and gambling disorder training and educational programs for installation ASAP professional staff. Establish selection criteria and provide allocations for nominees to attend training sponsored by DA.

(21) Maintain staffing inventory data for the ASAP worldwide.

(22) Serve as DA's lead on all issues related to Drug Demand Reduction (DDR) Programs and alcohol abuse prevention.

(23) Serve as DA's proponent for the RRP, which complements the Army Combat Readiness Center Risk Management process. Direct the operations of the RRP and coordinate RRP policy with appropriate DoD, DA, and civilian agencies.

(24) Serve as the subject matter expert supporting the Army Civilian Education System with training development and analysis for all ASAP positions.

(25) Ensure DA programs comply with the policies of the Office of National Drug Control Policy and the National Drug Control Strategy.

(26) Oversee the duties of the contract officer representative (COR).

(27) Provide guidance regarding alcohol testing, urine collection, chain of custody, handling and shipping, and training of Unit Prevention Leaders (UPLs) and Drug testing Coordinators (DTCs).

(28) Manage and distribute drug testing quota allocations, as required.

(29) Approve proposals through the ARD to provide ASAP nonclinical services that deviate from procedures prescribed by this regulation.

2-3. Deputy Chief of Staff, G-3/5/7

The DCS, G-3/5/7 will appoint a representative to coordinate RRP policy and statistics with the ASAP and serve on a Headquarters, Department of the Army (HQDA) risk reduction working group.

2-4. The Surgeon General

TSG has mission command of ASAP clinical functions and will—

a. Function as the Chief Medical Advisor on matters pertaining to military health readiness requirements and safety of Soldiers.

b. Provide direction and guidance to the Army to recruit, organize, train, and equip military medical personnel to treat addictive behaviors to include substance use disorders (SUD) and gambling disorders.

c. Develop direction and guidance for military medical personnel for substance use disorder treatment.

d. Provide operational guidance, funding, and management to the Forensic Toxicology Drug Testing Laboratory (FTDTL) that supports the Army's Drug- and Alcohol-Testing Program.

- e.* Develop drug and alcohol SUDCC statistical data; evaluate SUDCC; and coordinate with the Director, ARD in total program assessments.
- f.* Provide medical review officer (MRO) services for military and civilian personnel drug testing.
- g.* Provide Substance Abuse Professional (SAP) services for civilian Department of Transportation (DOT) alcohol and drug testing (see DOT guidance at <https://www.transportation.gov/odapc/substance-abuse-professional-guidelines>).
- h.* Design and furnish deployment-specific training packages for behavioral health and combat stress control medical units.

2–5. The Judge Advocate General

TJAG will—

- a.* Evaluate the legal aspects of the ASAP.
- b.* Review laboratory forensic specimen handling procedures (chain of custody) and other drug- and alcohol-testing program elements for legal sufficiency when requested.
- c.* Appoint a liaison to the ARD.

2–6. Commanders of Army commands, Army service component commands, and direct reporting units

The Commanders of ACOMs, ASCCs, and DRUs will—

- a.* Appoint a staff officer to serve as liaison with ARD on substance abuse issues and may request access to substance abuse compliance metric databases that support report reviews.
- b.* Appoint a representative to coordinate the RRP, its policies and statistics with the ARD and serve on a HQDA risk reduction working group.
- c.* During prolonged deployments—
 - (1) Determine optimal number of base area codes (BAC) and their alignment.
 - (2) Provide detailed policy concerning random testing expectations and limitations.
 - (3) Ensure ASAP capabilities are addressed in the personnel and/or medical operations plan or annex for deployments. Minimum services would include drug testing and clinical assessment; however, based on mission, enemy, terrain, troops, time, civil considerations (METT–TC) and security, additional services may need to be provided.

2–7. Commanding General, U. S. Army Training and Doctrine Command

The Commanding General, TRADOC will ensure that current and appropriate training on abuse of substances (illegal drug, controlled drug, alcohol or other), gambling disorder awareness, and information on the ASAP occurs at initial entry, pre-commissioning and is integrated into all other Army professional development courses.

2–8. Commanding General, U.S. Army Installation Management Command

The Commanding General, IMCOM will—

- a.* Provide guidance and leadership on the execution of the deterrence and prevention functions which includes substance abuse prevention and suicide prevention.
- b.* Resource and staff the installation ASAP and support installation programs to achieve program objectives and to respond to the needs of commanders and supervisors.
- c.* Coordinate and monitor the implementation of installation drug- and alcohol-testing programs.
- d.* Appoint a staff officer to serve as a liaison with the ARD on substance abuse issues.
- e.* Establish and implement supporting and supplemental plans consistent with the objectives and procedures established by the ASAP evaluation plan.
- f.* Prepare IMCOM ASAP program objective memorandum and budget submissions, monitor execution of management decision evaluation packages (MDEPs), MDEP code for the ASAP funds and the Quality Assurance Assessment Program (QAAP) and MDEP code for DoD Counternarcotic funds (VCND) allocated to IMCOM, and coordinate ASAP resource management with the IMCOM Chief, ASAP/R2.
- g.* Monitor the installation EAP and keep the Director, ARD updated regarding all ASAP civilian services and related statistical data.
- h.* Collect and maintain necessary management information to assess program effectiveness.
- i.* Appoint a representative who will serve on the HQDA risk reduction working group.
- j.* Ensure all installations with over 500 Regular Army Soldiers appoint a representative to coordinate the RRP policies and statistics with the ARD.
- k.* Serve as an information resource to ACOMs, ASCCs, and DRUs on substance abuse issues for their units.

l. Serve as liaison between ASAP managers and the Director, ARD on matters pertaining to ASAP manpower, budget, and administration.

m. Ensure that installation programs are executing their responsibilities to provide substance abuse and gambling disorder prevention, education, and training to sustain and improve the skills and abilities of the ASAP installation staff in accordance with chapter 9.

n. Allocate and monitor utilization of all available urinalysis (UA) quotas within the IMCOM, as required.

2–9. Commander, U.S. Army Reserve

The Commander, USAR will—

a. Develop and execute plans, policies, and procedures of the USAR ASAP in coordination with the Director, ARD.

b. Recommend policies and operational tasks to the DCS, G–1 regarding the participation of USAR Soldiers and their Families’ in the ASAP. (See chap 16 for specific USAR guidance.)

c. Ensure USAR units comply with this regulation.

d. Advise the DCS, G–1 regarding the impact of alcohol, drug abuse and gambling disorder in the USAR.

2–10. Commanding General, U.S. Army Criminal Investigation Command

The Commanding General, USACIDC will—

a. Conduct and support operations, programs, and activities designed to deter, prevent, and suppress traffic in controlled substances in accordance with AR 190–30.

b. Provide periodic drug assessment reports to the Director, ARD (who has responsibilities for ASAP program management) in accordance with AR 190–45.

2–11. Commander, U.S. Army Corps of Engineers

The Commander, USACE is delegated the authority to promulgate a regulation to address Corps-specific policies, responsibilities, and procedures related to the ASAP. The USACE regulation will comply with the policies and programs contained in this regulation. The Commander, USACE may delegate the responsibilities for implementing this publication to fit the unique organizational structure of the Corps. Prior to publication, the USACE regulation will be submitted to the Director, ARD for review and approval.

2–12. Director of Army Safety

The DASAF will appoint a representative to coordinate RRP policy and statistics with the ARD and serve on a HQDA risk reduction working group.

2–13. Commanders of Regional Health Commands

Commanders, RHC will—

a. Provide oversight for the SUDCC activities staffed by Medical Treatment Facilities within the RHC’s area of responsibility.

b. Ensure medical resources are available to conduct the required medical review of military and civilian drug test results to include deployed areas.

c. Ensure there’s a sufficient number of Professional Officer Filler System providers eligible to serve as MROs who are both trained and certified prior to deployment.

2–14. Commanders of military treatment facilities

Commanders, MTF will—

a. Provide adequate and appropriate administrative support, necessary to ensure high-quality behavior healthcare including treatment for SUD for all healthcare beneficiaries (Soldiers, DA Civilians, and Family members eligible to receive care) within MTF behavior health clinics.

b. Ensure that SUDCC comply with guidance and requirements for Joint Commission accreditation.

c. Ensure there is a sufficient number of Professional Other Filler System providers eligible to serve as MROs who are trained and certified prior to deployment.

d. Establish and maintain relationships with installation HQs leaders, SUDCC, prevention, education, and drug testing personnel.

e. Appoint on orders sufficient MROs to ensure completion of medical reviews within 15 working days in accordance with paragraph 4–14. Ensure that appointed MROs have completed MEDCOM-sponsored MRO training.

f. Provide regular feedback on the major SUDCC related trends and/or metrics to the installation HQs and unit commanders and key staff.

2–15. Commanders of corps, divisions, and brigades

The commanders of corps, divisions, and brigades will—

a. Ensure subordinate commanders execute the military Drug testing Program (DTP), in accordance with chapter 4, during the course of their command or Organizational Inspection Programs.

b. Ensure battalion commanders appoint officers or noncommissioned officers (NCOs) (E–5 promotable or above) on orders as battalion prevention leaders (BPL) and alternate UPLs to perform the duties listed in paragraph 2–32.

c. Ensure units are prepared to conduct drug testing while on temporary duty (TDY), deployed, or areas of operation as required in paragraph 4–7.

d. Ensure participation in and directing subordinate commanders to participate in RRP command consultations provided by the installation RRPC or Installation Prevention Plan (IPP) members.

e. Designate a representative to present RRP-related issues or requests to the installation or installation commander.

f. Ensure the unit risk inventory (URI) is administered to all Soldiers at least 120 days before an operational deployment and the re-integration unit risk inventory (R–URI) is administered to all Soldiers between 30 and 90 days after returning from an operational deployment (see para 12–6).

g. Recommend subordinate commanders use the URI during changes of command to identify high risk behaviors within their units.

h. Ensure subordinate commanders fulfill the unit prevention and education requirements required in paragraph 2–29.

i. Ensure subordinate commanders refer Soldiers to BH for a SUD evaluation within 5 days of notification that the Soldiers received positive UA results for illicit drug use or were involved in alcohol-related misconduct. Ensure unit commanders support Soldier’s treatment plan including level of care needed to return Soldier to full duty status.

j. During extended deployments and areas of operations—

(1) Assign and certify personnel to serve as primary and alternate Base Area Code Managers (BACMs).

(2) Provide guidance to subordinate commanders concerning random drug testing expectations and temporary modifications to testing rates, as applicable.

k. Ensure the first general officer (GO) in the chain of command with a judge advocate or legal advisor receives the appropriate information on drug positive Soldiers from the ASAP and makes the retention decision when required in accordance with paragraph 10–6 before it goes to the General Court-Martial Convening Authority.

2–16. Installation or garrison commanders

The installation or garrison commanders will—

a. Establish a local command ASAP and ensure the full range of ASAP services are available to all eligible personnel. The installation elements of the ASAP should be operationally integrated to achieve maximum command/Soldier readiness.

b. Designate each of the following positions:

(1) An ASAP manager to function as the installation ASAP single point of contact (POC) for administrative functions of the installation ASAP. The ASAP manager will also work with the Installation Director of Psychological Health and/or designed SUD staff to provide effective and efficient integration of the installation ASAP tenets and clinical care.

(2) A PC to administer the prevention and education functions.

(3) An EAP coordinator to administer the ASAP civilian assistance services.

(4) A DTC to administer the drug and alcohol testing program.

(5) An installation breath alcohol technician (IBAT) (in the continental United States, Hawaii, Alaska, and Puerto Rico) to instruct and assist individuals in the alcohol testing process and to operate a breath testing device in accordance with DOT guidelines.

(6) A RRPC, when required by paragraph 12–3*a*, to facilitate risk reduction activities.

c. Establish an installation prevention team (IPT), human resources council, or a similar appropriate forum to focus on installation substance abuse and risk reduction issues. Use this forum to develop and implement an approved IPP to address the issues identified. Serve as chairperson of the IPT or human resources council and ensure the following are represented: chaplain, preventive medicine, medical department activity (MEDDAC), behavioral health (which may include SUDCC staff), installation safety office, RRPC, provost marshal (PM), ASAP manager, PC, USACIDC, legal, and suicide prevention. The installation commander has the authority to adjust the membership, as required.

Any council, team, or committee established will develop and implement a formal charter in accordance with AR 15-1.

- d.* Exercise direct supervision of the installation ASAP manager through the Director, Human Resources.
- e.* Appoint an installation designated management official (DMO) on orders to manage the civilian DTP.
- f.* Notify the Installation Director of Psychological Health (IDPH) of any indications that treatment functions are not being provided in accordance with Army Regulations.
- g.* Develop a mutual support plan among the installation ASAP, PM, and Criminal Investigation Division (CID) to include—
 - (1) Immediately report all offenses involving illegal possession, use, sale, or trafficking in drugs or drug paraphernalia to the Criminal Investigation Division (CID) for investigation.
 - (2) The PM provides the ASAP manager with extracts from Army Law Enforcement Reporting and Tracking System (ALERTS) on all incidents involving abuse of alcohol, drugs, or other substance on a daily basis.
- h.* Support positive and non-attributional approaches to risk reduction.
- i.* Facilitate business processes and structures to support the RRP, as required.
- j.* Evaluate IPPs annually.
- k.* Maintain the means to perform alcohol breath tests on Soldiers and DA Civilians.
- l.* Publish a command policy memorandum that addresses alcohol and drug abuse.
- m.* Complete a memorandum of agreement with their counterpart from another military Service's installation when the Army and the other Service enter a joint basing situation where common services are provided by one Service for both bases. The memorandum of agreement will specify which Service will provide each of the necessary ASAP services.
- n.* Continuous command presence in installation living, working, and recreational areas to reduce alcohol and drug abuse.

2-17. Installation alcohol and drug control officers-Army Substance Abuse Program managers

The installation ASAP managers will—

- a.* Provide direct supervision and management over all installation drug testing and prevention/education components of ASAP staff and programs.
- b.* Prepare installation ASAP budget submissions and monitor execution of the funding.
- c.* Develop, coordinate, and recommend local installation ASAP policies and procedures for implementation.
- d.* Manage and monitor the drug and alcohol testing program (see chaps 3, 4, and 5 of this regulation for information on specific requirements related to the military and civilian alcohol and drug testing). Ensure the drug testing collection point (DTCP) standing operating procedures (SOPs) are reviewed annually.
- e.* Serve as the coordinator of all substance abuse and risk reduction issues for the IPT, human resources council, or other similar appropriate forums.
- f.* Monitor and report as recorded in Drug and Alcohol Management Information System (DAMIS) the commander referral rate, the screening rate, and provide quarterly reports to the installation, battalion commanders and the IMCOM Chief, ASAP/R2.
- g.* Ensure there is a continuous and comprehensive ASAP staff training plan for all installation staff to enhance professional skills.
- h.* Establish communications, a referral network, and administrative coordination between military units and civilian activities and the MTF BH department to facilitate the effectiveness of SUDs treatment.
- i.* Assist commanders and supervisors in the ID and referral of individuals suspected of problematic substance use to include tracking alcohol and drug abuse prevention training (ADAPT) attendance.
- j.* Maintain installation ASAP and EAP records and authenticate all installation ASAP reports furnished to higher headquarters (HQ).
- k.* Institute procedures and strategies designed to enhance the deterrent effect of drug and alcohol testing.
- l.* Consult with the IDPH, local law enforcement personnel, and other installation personnel in designing and implementing the IPP.
- m.* Using input from the PCs, evaluate all prevention education and training aspects of the local ASAP at the end of the fiscal year, and forward through the Commander, IMCOM to the Director, ARD, a written report of the installation prevention program activities and accomplishments.
- n.* For military personnel only, restrict notification of positive drug test results with the ability to transition from using a Soldier's social security number (SSN) to DoD electronic data interchange person identifier (EDI-PI), located on the Soldier's common access card. The EDI-PI will serve as the primary means for Soldiers and sample ID for military drug testing collection procedures. Drug testing laboratories will continue to accept both SSN and EDI-PI

during the transition. The DoD will announce when SSN will no longer be accepted in future correspondence. The notifications will be—

- (1) The commander who ordered the test.
- (2) The chain of command over the commander who ordered the test.
- (3) The supporting legal office when they are acting on behalf of the commander who ordered the test.
- (4) The IDPH and/or clinical director (CD) on all positive drug testing; for rehabilitation tests results, the CD or assigned SUD provider will report results.
- (5) The law enforcement for all illicit drug results, except pre-MRO and rehabilitation tests. ASAP offices will provide a list of positive results for illegal substances to their supporting CID office on a weekly basis.
 - o.* Provide policy guidance and assistance to the servicing Civilian Personnel Advisory Center (CPAC) to identify all Drug-Free Federal Workplace (DFW) testing designated positions (TDP) s and those positions subject to DOT drug and alcohol testing rules at least quarterly and with all supervisors at least annually.
 - p.* Serve as the primary DMO for verified positive drug test results for DA civilian employees in accordance with 49 CFR.
 - q.* Adhere to guidance for the TDPs as provided in chapter 5. Refer to DA Pamphlet (Pam) 600–85 for additional instructions.
 - r.* Maintain ASAP statistics as directed by Director, ARD (see chaps 4, 5, 6 and chap 14).
 - s.* Collect and maintain data on the status of civilian employees' and Family members' participation in the garrison or non-clinical ASAP and provide reports, as required.
 - t.* Promptly furnish extracts from the daily MP desk blotter to the IDPH on all incidents involving alcohol, drugs, and other substance abuse.
 - u.* Appoint a primary and alternate DTC on orders and ensure they are trained and certified through the DA DTC certification course.
 - v.* Assess the installation ASAP on an annual basis using the guide at appendix D. Inspect at least one of the four DTC functional areas on a quarterly basis. Record all assessments and inspection findings on a memorandum for record (MFR) and maintain in accordance with AR 25–400–2. Assess the installation ASAP in accordance with AR 11–2 every 5 years using the guide at appendix G.
 - w.* Supervise the MRO review process and ensure the review timelines in chapter 4 are met.
 - x.* Prepare and submit all required reports in DAMIS or other electronic form as specified in chapter 14.
 - y.* Ensure that DA Form 3711 (Army Substance Abuse Program (ASAP) Resource and Performance Report (RAPR)) is entered into DAMIS by the last working day of the month following the period the report covers.
 - z.* If the installation has personnel who require drug testing under DOT rules, ensure the ASAP has the capability to perform these UA collections in accordance with DOT guidelines.
 - aa.* Provide reports derived from the DAMIS concerning drug positive data by unit identification code (UIC) and drug type to CID on a recurring basis.
 - bb.* Ensure that a Soldier's DAMIS record is reviewed after receiving a positive result for illegal substances and that the Soldier's company commander, as well as the first GO in the chain of command, is notified of all positive UA results in the Soldier's record.
 - cc.* Report all drug positives within 5 working days to the Soldier's Commander.

2–18. Installation prevention coordinators

The installation PCs will—

- a.* Promote ASAP and SUDCC services using marketing, networking, and consulting strategies.
- b.* Provide training and any other services to assist organizations in ensuring all military and civilian personnel are provided prevention education training. The DOT-designated positions and other high risk civilian positions should receive targeted training pertaining to their jobs. The PCs will track all training conducted by unit or directorate, as appropriate.
- c.* Coordinate with the installation training officer to assist in integrating the preventive education and training efforts into the overall installation training program.
- d.* Design, develop, and administer target group-oriented alcohol and other drug abuse prevention education and training programs in coordination with the ASAP staff and other installation prevention professionals.
- e.* Maintain liaison with schools serving military Family members, civic organizations, civilian agencies, and military organizations to integrate the efforts of all community preventive education resources.
- f.* Oversee the UPL training program. Provide UPLs with education and training materials.

g. Maintain lists of available continuing education and training courses and workshops provided by ASAP, IMCOM, and appropriate civilian agencies for ASAP installation staff and coordinate allocations for military and civilian training courses through the IMCOM.

h. Address military community risk levels and work toward reducing the risk factors.

i. Maintain class rosters for all training annotated on DA Form 3711 and track all substance abuse training on the installation by unit.

j. Conduct pre- and post-deployment, TDY, and area of operation substance abuse training.

k. Teach the ADAPT course to all individuals with a positive UA and indicated prevention requirement (see chap 9 for specific requirements).

l. To the extent possible, teach at least one class to each unit per year.

m. Develop, in consultation with ASAP staff members, a substance abuse prevention plan annually.

2–19. Installation Employee Assistance Program coordinators

The installation EAP coordinators will—

a. Assess, plan, and establish local procedures for providing comprehensive EAP services for eligible DA civilian employees and military and civilian Family members within the military community (refer to DA Pam 600–85 for a discussion of comprehensive EAP services).

b. Provide screening, assessment, short-term counseling, and referral services for employees who self-refer or whom management refers. Providing short-term guidance, education, and mediation to civilian employees for resolution of work-related and non-work-related productivity problems associated with employees impaired by personal concerns including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, and other personal concerns which may adversely affect employee job performance. If clinical counseling is indicated, the EAP coordinators will make a referral to a BH clinic or to a referral source in the local civilian community, depending on where the employee is eligible to receive care and desires to use the services.

c. Conduct evaluation of EAP services to ensure effectiveness of referrals and resolution of personal concerns, as needed.

d. Advise and update supervisors concerning their employees' progress to the extent permitted by paragraph 6–8 and any applicable law.

e. Consult with the installation CPAC, SAP, and supervisors of DA Civilian employees throughout the installation within the limits required by Title 42 United States Code (USC) 290dd-2 and 42 CFR Part 2.

f. Maintain an updated list of available community counseling and rehabilitation/treatment resources that address the full spectrum of work-related and non-work-related productivity problems associated with employees impaired by personal concerns.

g. Coordinate with the PC on prevention education and training for supervisors and DA Civilian employees on abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder awareness and appropriate information on work-related and non-work-related productivity problems associated with employees impaired by personal concerns that are specific to the needs of the population serviced (refer to DA Pam 600–85 for employee education and supervisory training prerequisites). Civilian personnel may receive prevention education as mission needs dictate.

h. Publicize and market ASAP services available for civilian employees.

i. Assist the PC in developing and executing prevention campaigns and conducting education and prevention programs.

j. Collect information required for reports.

k. Maintain EAP files in accordance with the EAP Guidebook and all Federal laws governing the confidentiality of records.

2–20. Drug testing coordinator

The DTCs will—

a. Operate an installation drug and alcohol testing program control point.

b. Serve as the installation subject matter expert on UA collection and testing.

c. Augment the installation Inspector General (IG) inspection teams.

d. Ensure that urine collections from Soldiers are performed, as required, in accordance with chapter 4 and appendix D.

e. Teach the drug testing procedures portion of the UPL certification course and, in coordination with the PC, provide pre- and post-deployment training to UPLs.

f. Advise unit commanders and the ASAP managers on test procedures and results.

- g.* Manage drug testing supplies and expenditures.
- h.* Ensure the substance abuse programs and UA collection procedures of all units are inspected in accordance with chapter 4.
- i.* Be prepared to testify as an expert witness about the UA collection process during courts-martial.
- j.* Maintain drug testing records in accordance with AR 25–400–2 while keeping military and civilian documentation in separate filing cabinets.
- k.* Retrieve Soldiers’ drug test results from the FTDTL Web portal, and notify the commanders who ordered the tests. For any positive results, review the Soldiers’ past UA records in DAMIS to determine if they have previous positive UA results.
 - (1) Notify the Soldiers’ company commanders of all positive UA results in the Soldier's DAMIS record. In addition, the DTC will provide the commander a list of the required actions to take on the Soldier (referral to BH, suspension of favorable actions (Flag), process for separation, and so forth).
 - (2) Ensure law enforcement only receives the BAC, UIC, laboratory accession number, specimen collection date, specimen laboratory report date, test basis, and the illicitly used drug(s). For military personnel only, restrict notification of positive drug test results with the ability to transition from using a Soldier’s SSN to DoD EDI–PI, located on the Soldier’s common access card. The EDI–PI will serve as the primary means for Soldiers and sample ID for military drug testing collection procedures. Drug testing laboratories will continue to accept both SSN and EDI–PI during the transition. The DoD will announce when the SSN will no longer be accepted in future correspondence. Individual Soldier drug testing and treatment histories will not be provided.
 - l.* Initiate medical review process for drug positive results requiring such in accordance with chapter 4.
 - m.* Maintain the installation/command drug testing SOP and ensure that the ASAP manager reviews it annually and the legal office supporting installation reviews it when changes are made to the SOP document
 - n.* Conduct drug testing background check on UPL candidates.
 - o.* The IDPH and/or CD on all positive drug testing; for rehabilitation tests results, the CD or assigned SUD provider will report results.
 - p.* Manage installation quotas, if required.
 - q.* Manage UPL inquiries to DA and DoD.
 - r.* Ensure a 3% or less discrepancy rate (including laboratory fatal and non-fatal, and installation specimen rejections) is maintained.
 - s.* Utilize Drug Testing Technician-assists with drug testing duties.

2–21. Installation Risk Reduction Program coordinators

The installation RRPCs will—

- a.* Coordinate and facilitate RRP data collection and analysis and Web-based applications, as needed.
- b.* Review RRP data and analysis with commanders and coordinate appropriate prevention/intervention services.
- c.* Develop, coordinate, and recommend local RRP policies.
- d.* Serve as the coordinator of all RRP issues for the IPT, human resources council, or similar forum.
- e.* Ensure RRP data is collected from the data providers monthly and input the data into the ASAP Web-based system by the 10th of the month following the previous month. The RRPC has the overall responsibility in terms of ensuring the data's accuracy.
- f.* Assist commanders with identifying high-risk units, conducting URI and R–URI surveys, and identifying appropriate intervention service. Ensure that the URI is administered to all Soldiers at least 120 days before an operational deployment, and the R–URI is administered to all Soldiers between 30 and 90 days after returning from an operational deployment.
- g.* Institute procedures and strategies designed to enhance RRP visibility on the installation.
- h.* Ensure that RRP responsibilities are being met in support of unit deployment cycles.
- i.* Control access to the RRP Web portal by installation personnel, and keep all installation-level point of contact information on the Web portal updated.
- j.* Coordinate and ensure the IPT meets at least quarterly to discuss prevention issues affecting the entire installation community.
- k.* Assist the PC in the development and implementation of an IPP, in collaboration with the IPT. The IPT may be combined with other installation councils or prevention teams as directed by the installation commander as long as risk reduction is incorporated and issues are discussed.
- l.* Actively participate in the development of prevention programs, supporting other agencies when called upon.

2–22. Installation Director of Psychological Health

The IDPH will—

- a.* Monitor SUD related trends within the installation, such as acute psychiatric admissions, serious incident reports (SIRs), or utilization of SUD services. Common techniques used to monitor SUD related trends include frequent discussion with installation HQs and unit leaders, garrison councils (such as the Commander's Ready and Resilient Council (CR2C) and the Risk Reduction Committee).
- b.* Provide peer review for SUD providers to ensure adherence to clinical substance abuse documentation standards and report findings to SUD counselors and/or supervisor, as needed.
- c.* Provide regular feedback on the major SUD related trends to the installation HQs and unit commanders and key staff.
- d.* Maintain visibility on the medical readiness of installation Service members with SUD diagnoses.
- e.* Ensure data elements are entered in DAMIS in a timely manner.
- f.* Establish and maintain rapport with installation HQs leaders, ASAP prevention, education, and drug testing personnel.
- g.* Appoint a SUD provider to serve as a member of the Family Advocacy Case Review Committee and the installation Fatality Review Board to serve as liaison and provide information as appropriate.
- h.* Assess the MTF SUD execution on an annual basis using the guide at appendix E. Record all assessments and inspection findings on a MFR and maintain in accordance with AR 25–400–2.
- i.* In accordance with local MTF and BH department policy, participate in at-risk/high interest collaborative care meetings to review individual safety, unit trends, and impacts on mission readiness.
- j.* Ensure SUD providers attend all required team meetings, including the daily morning meeting and the weekly Multidisciplinary Psychological Health (MDTP) meetings.
- k.* Medical supervisors will ensure that MTF privileging committees are notified for determination of appropriate actions to take to maintain medical standards of practice in SUD care.
- l.* Monitor MEDCOM SUD metrics and report any issues and concerns to MTF Commander for action. Submit reports through the MTF Commander to the Region and/or OTSG/MEDCOM.

2–23. Installation provost marshals

The installation PMs will—

- a.* Screen all incident reports for all incidents involving alcohol, drug, or other substance abuse and provide the ASAP manager with extracts from ALERTS in accordance with AR 190–45 on a daily basis.
- b.* Support the ASAP manager on matters pertaining to the alcohol testing of DOT designated positions.
- c.* Provide quarterly RRP data to the installation ASAP manager or RRPC.

2–24. Installation safety officers

The installation safety officers will—

- a.* Coordinate with the ASAP manager and provide data on the incidence of alcohol and/or drug involvement in accidents or other safety mishaps.
- b.* Inspect installation DTCPs annually for the presence of necessary safety equipment and compliance with applicable safety regulations and local requirements.
- c.* Provide quarterly RRP data to the installation ASAP manager or RRPC.

2–25. Installation physical security officers

The installation physical security officers will inspect installation drug and alcohol test collection points biennially to ensure they meet the requirements for storing UA specimens and records in accordance with this regulation (see ASAP website).

2–26. Installation prevention team members

The IPT members will—

- a.* Support the data collection and analysis efforts of the RRP.
- b.* Review prevention/intervention methods and materials in their areas of expertise with commanders to prevent and resolve Soldiers' high-risk behaviors.
- c.* Meet quarterly to discuss the RRP and address prevention issues that affect the installation.

2–27. Civilian Personnel Advisory Center

The servicing CPAC will—

- a. Code management-identified Drug Free Workplace (DFW) testing designated positions (TDPs), and those positions subject to Department of Transportation (DOT) drug and alcohol testing rules, in the Defense Civilian Personnel Data System (DCPDS) or other successor data system. The position is coded in DCPDS.
- b. Once concurrence has been obtained from the serviced organization, ensure position descriptions and vacancy announcements contain appropriate language about random alcohol (for DOT covered positions) and drug testing conditions of employment for Drug-Free Workplace testing designated positions identified by the appropriate command or management officials.
- c. Ensure that the completed DA Form 5019 (Condition of Employment for Certain Civilian Positions Identified Critical under the Department of the Army Drug-Free Federal Workplace Program) and DA Form 7412 (Condition of Employment for Certain Civilian Positions Identified Safety-Sensitive Under the Department of Transportation, Federal Highway Administration Rules on Drug and Alcohol Testing) are filed in the employee's electronic Official Personnel Folder.
- d. Provide assistance to management when an employee has a confirmed positive drug test under the DFW testing program and/or has engaged in DOT-prohibited conduct described in 49 CFR Part 382.
- e. Ensure that employees assigned to TDPs complete the following as required:
 - (1) DA Form 5019.
 - (2) DA Form 7412.
- f. Ensure the employee, supervisor, and ASAP manager receive copies of the completed forms.
- g. Provide a roster, which identifies all personnel who occupy DFW TDPs and personnel who are subject to DOT-regulated drug and alcohol testing, to the installation ASAP manager and U.S. Army Reserve Command (USARC) DCS, G-1, if applicable, at least once each quarter with any updates. The roster will contain at a minimum, the employee's name, position, title, department/directorate assigned, and supervisor or point of contact for testing notification purposes.
- h. Refer to DA Pam 600-85 for additional instructions for the CPAC.

2-28. Battalion and/or squadron commanders

The battalion and/or squadron commanders will—

- a. Implement a battalion/squadron drug and alcohol testing program (see chap 4 for guidance).
- b. Implement ASAP prevention and education initiatives (see chap 9 of this publication for guidance).
- c. Appoint an officer or NCO (E-5 promotable or above) on orders as the BPL and alternate BPL, who must be certified through the UPL training (see para 9-5).
- d. Ensure all newly assigned Soldiers are briefed on ASAP policies and services within 30 days of arrival.
- e. Maintain liaison with installation ASAP and BH including SUD staffs.
- f. Maintain ASAP elements while TDY, deployed, and area of operation to the maximum extent possible. (See para 4-7 of this publication for details.) Ensure subordinate units are prepared to conduct drug testing while TDY, deployed, and area of operation in accordance with paragraph 4-7.
- g. Foster a positive command climate that discourages abuse of substances (illegal drug, controlled drug, alcohol or other) and problematic gambling and is supportive of those who need assistance from behavioral health (BH/SUDCC). Support substance abuse prevention campaigns and alcohol-free activities in the unit and on the installation.
- h. Initiate administrative separation in accordance with AR 635-200, AR 600-8-24, and paragraph 10-6.
- i. Ensure that the URI is administered to all Soldiers at least 120 days before an operational deployment and the R-URI is administered to all Soldiers between 30 and 90 days after returning from an operational deployment (see para 12-6 of this publication).
- j. Immediately report all offenses involving illegal possession, sale, or trafficking in drugs or drug paraphernalia to the CID. Commanders are no longer required to report positive UA results to local law enforcement. This does not alleviate them of the requirement to: initiate administrative separation, or refer the Soldier to BH for a SUD evaluation by completing DA Form 8003 (Army Substance Abuse Program (ASAP) Enrollment).
- k. Ensure company commanders refer any Soldier to BH for a SUD evaluation within 5 duty days of notification that the Soldier received a positive UA for illicit drug use. Commanders of geographically-remote units should contact the IDPH of the nearest installation for guidance. Ensure company commanders refer any Soldier to BH-Family Advocacy Program (FAP) immediately when drug abuse is related to a child abuse or domestic abuse altercation.
- l. Ensure company commanders refer any Soldier to BH for a SUD evaluation within 5 duty days of notification that the Soldier was involved in a problematic alcohol incident. Commanders of geographically-remote units should contact the IDPH of the nearest installation for guidance. Ensure company commanders refer any Soldier to BH-

Family Advocacy Program (FAP) immediately when alcohol abuse is related to a child abuse or domestic abuse altercation.

m. Assist the BPL in the development of a battalion/squadron substance abuse program SOP and review and sign it annually. Direct BPL to conduct inspection of subordinate units annually and provide results to the DTC.

n. Consider participating in RRP command consultations provided by the installation RRPC or IPT members.

o. Bring or designate a representative to bring RRP-related issues or requests to the attention of the installation or installation commander and RRPC.

p. Ensure that the URI is administered to all Soldiers at least 120 days before an operational deployment and the R-URI is administered to all Soldiers between 30 and 90 days after returning from an operational deployment (see para 12-6 of this publication).

q. Recommend subordinate commanders use the URI during changes of command to identify high risk behaviors within their units.

r. Battalion commanders will ensure that the initiation and final disposition for all Soldiers with an illicit positive drug test and Soldiers involved in two serious incidents of alcohol-related misconduct within 12 months is reported to the ASAP manager. In addition, battalion commanders will ensure that a DA Form 4833 (Commander's Report of Disciplinary or Administrative Action) is completed and submitted in accordance with AR 190-45.

s. Consult with the servicing legal office for all drug and alcohol related offenses.

2-29. Commanders of companies, detachments, and equivalent units

The commanders of companies, detachments, and equivalent units will—

a. Assist the battalion commander in implementing the battalion drug and alcohol testing program (see chap 4 for guidance).

b. Implement ASAP prevention and education initiatives addressed in chapter 9.

c. Appoint an officer or NCO (E-5 or above) on orders as UPL and alternate UPL, who must be certified through the UPL training addressed in chapter 9 of this publication.

d. Maintain documentation indicating all newly assigned Soldiers have been briefed on ASAP policies and services within 30 days of arrival.

e. Maintain liaison with ASAP and SUD staffs.

f. Maintain ASAP elements while deployed, to the maximum extent possible (see para 4-7 of this publication for details).

g. Foster a positive command climate that discourages abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder and is supportive of those who need assistance for problems. Support substance abuse prevention campaigns and alcohol-free activities in the unit and on the installation.

h. Consult with the servicing legal office for all drug and alcohol related offenses.

i. Immediately report all offenses involving illegal possession, sale, or trafficking in drugs or drug paraphernalia to CID. Commanders are no longer required to report positive UA results to local law enforcement; however, this does not alleviate commanders of the requirement to: Flag the Soldier in accordance with paragraph 10-6 and refer the Soldier to BH for a SUD evaluation and possible treatment by completing DA Form 8003.

j. Commanders will report the initiation and final disposition for all Soldiers with an illicit positive drug test and Soldiers involved in two serious incidents of alcohol-related misconduct within 12 months to the ASAP manager. In addition, commanders must complete and submit DA Form 4833 in accordance with AR 190-45.

k. Ensure that Soldiers promptly provide medical evidence for legitimate use of a prescribed drug to the MRO when requested.

l. Refer any Soldier to BH for SUD evaluation within 5 duty days of notification that the Soldier received a positive UA for illicit drug use or was involved in alcohol-related misconduct. Commanders of geographically-remote units should contact IDPH of the nearest installation for guidance.

m. Assist the UPL in the development of a unit problematic substance use program SOP and sign it at least annually.

n. Initiate separation for all alcohol and drug rehabilitation failures in accordance with paragraph 1-7d(4).

o. The commander or designee will attend all Battalion At-Risk meetings with Behavioral Health and SUD providers in order to maintain visibility of at-risk Soldiers.

p. Ensure the URI is administered to all Soldiers at least 30 days before an operational deployment and the R-URI is administered to all Soldiers between 30 and 180 days after returning from an operational deployment (see para 12-6 of this publication).

2–30. Supervisors of Department of the Army Civilian employees

The supervisors will—

- a.* Consult with the CPAC employee relations specialist—
 - (1) Before initiating any formal disciplinary or adverse action.
 - (2) When an employee appears to be under the influence of alcohol or other drugs while on duty.
 - (3) When an employee has been reported as an illegal drug user (verified positive drug test).
- b.* Consult with an appropriate legal advisor when there is a reasonable suspicion that an employee is engaged in criminal conduct involving alcohol or drugs (for example, trafficking, theft, or illegal possession).
- c.* Privately inform their employees in TDPs when they are to report for random drug testing no earlier than 2 hours before they must report to the test site. If an employee is unavailable for testing for legitimate reasons, the supervisor will coordinate with the ASAP manager or designee for a new testing time. At no time will the supervisor inform deferred employees that they have been selected for random drug testing outside of the new two-hour drug testing window. Supervisors will verbally notify employees to be tested; use of any other means of notification is unauthorized.
- d.* Ensure all employees receive integrated resilience training. Ensure employees in TDPs and those who are subject to drug and alcohol testing under DOT regulations receive any additional required substance abuse training.
- e.* Attend substance abuse training for supervisors.
- f.* Be familiar with the EAP and how to refer employees.
- g.* Refer to DA Pam 600–85 for additional instructions and procedures for supervisors of DA Civilian employees.

2–31. Battalion prevention leaders

The BPL and/or squadron prevention leaders will—

- a.* Meet the criteria in paragraph 9–5 to be a UPL.
- b.* Be appointed on orders by their battalion commander.
- c.* Be trained and certified using the ARD UPL Certification Training Program (CTP).
- d.* Supervise and provide technical guidance to UPLs.
- e.* Inspect and document subordinate company on an annual basis and assist UPLs in the performance of their duties in coordination with the installation DTC.
- f.* Be the battalion commander’s subject matter expert on the ASAP.
- g.* Coordinate with other UPLs within the battalion to support the battalion DTP as necessary to accomplish the specimen collection mission.
- h.* Use the DoD DTP software as the primary method of randomly selecting Soldiers for drug testing and for preparing the drug testing forms and bottle labels, and ensure that the commander approves all lists of randomly selected Soldiers before notifying them to report for testing.
- i.* In coordination with the battalion commander, design and implement the battalion Substance Abuse Program SOP and prevention plan. Provide a copy, signed by the battalion commander, to the local ASAP.
- j.* In coordination with the PC, ensure company UPLs deliver informed prevention education and training to all Soldiers assigned to the battalion.
- k.* Inform the commander of the status of the ASAP and of trends in alcohol and other drug abuse in the battalion.
- l.* Develop command support for prevention activities by establishing an open, honest, and trusting relationship with the unit commander and subordinate leaders.
- m.* Advise and assist unit leaders on all matters pertaining to ASAP.

2–32. Company, detachment, and equivalent unit prevention leaders

The UPLs will—

- a.* Meet the criteria in paragraph 9–5 to be a UPL.
- b.* Be appointed on orders by their company or equivalent commander.
- c.* Be trained and certified using the ARD UPL CTP.
- d.* In coordination with the company commander, design and implement the Company Substance Abuse Program SOP and prevention plan.
- e.* In coordination with the PC, deliver informed prevention education and training to all Soldiers assigned to the unit.
- f.* Assist in briefing of all new unit personnel regarding ASAP policies and services.
- g.* Assist the BPL in administering the battalion Drug and Alcohol Testing Program.
- h.* Inform the commander of the status of the ASAP and of trends in alcohol and other drug abuse in the company.

- i.* Maintain liaison with the servicing BH clinic offering SUDCC when in installation and with the servicing behavioral health unit when deployed.
- j.* Develop command support for prevention activities by establishing an open, honest, and trusting relationship with the unit commander and subordinate leaders.
- k.* Advise and assist unit leaders on all matters pertaining to ASAP.

2–33. Officers and noncommissioned officers in leadership positions

Officers and NCOs in leadership positions will—

- a.* Use the Army values to set the example for their Soldiers in terms of not abusing drugs and alcohol and supporting the Army's DTP.
- b.* Educate, train, and motivate subordinates to create a climate that rejects substance abuse and reinforces positive individual and social activity on and off duty.
- c.* Observe individuals under their supervision and fully document evidence of substandard performance or misconduct which may indicate substance abuse problems. When appropriate, refer subordinates to the commander or the ASAP.

Chapter 3 Alcohol

Section I

General

3–1. General

- a.* Individuals who choose to consume alcoholic beverages must do so lawfully and responsibly. Responsible use includes the application of self-imposed limitations of time, place, and quantity when consuming alcoholic beverages.
- b.* Responsible drinking is defined as drinking in a way that does not adversely affect an individual's ability to fulfill their obligations and does not negatively impact the individual's job performance, health, well-being, or the good order and discipline in a unit or organization.

3–2. Policy

- a.* Alcohol abuse and resulting misconduct will not be condoned. On-duty impairment due to alcohol consumption is not acceptable. Impairment of Soldiers is defined as having a blood alcohol concentration based on a blood alcohol breathalyzer test that is equal to or greater than .04 grams of alcohol per 100 milliliters of blood. For provisions regarding DA Civilian employees, see paragraphs 3–10 and 3–11 of this publication.
- b.* Alcohol consumption is prohibited during duty hours, unless specifically authorized by the first GO or civilian equivalent Senior Executive Service (SES) in the supervisory chain or, if not available, the installation commander.
- c.* Underage drinking is prohibited. Army policy governing the minimum age for dispensing, purchasing consuming, and possessing alcoholic beverages is found in AR 215–1. Any underage Soldier using alcoholic beverages will be referred to the SUDCC for screening within 5 working days, except when such use is permitted by AR 215–1.
- d.* Soldiers should never permit alcohol to—
 - (1) Impair rational and full exercise of their behavioral and physical faculties while on duty.
 - (2) Reduce their personal readiness and/or reliability.
 - (3) Bring discredit upon themselves, another Soldier, or the Army as a whole.
 - (4) Result in behavior that is in violation of this regulation and/or the UCMJ.
- e.* Commanders and leaders will—
 - (1) Promote personal responsibility and informed decision making.
 - (2) Ensure subordinates are educated about alcohol abuse, signs and symptoms, intervention techniques, and effects on the individual, Family members, and the Army's readiness.
 - (3) Integrate installation, unit and/or individual alcohol abuse prevention strategies.
 - (4) Publicize the fact that problematic alcohol abuse will not be tolerated.
 - (5) Identify Soldiers with possible problematic alcohol abuse and refer them within 5 working days to BH for a SUD evaluation.
- f.* Commanders may use unannounced unit inspections and fitness for duty testing for alcohol with evidentiary DOT-approved alcohol testing breathalyzers in coordination with Provost Marshal support to—
 - (1) Promote military fitness, good order, and discipline.

- (2) Promote safety.
- (3) Deter problematic alcohol abuse.
- (4) Assist in the early ID and referral to BH for a SUD evaluation of Soldiers at risk.
- g. Commanders/supervisors will confront suspected problematic alcohol abusers, regardless of rank or grade, with the specifics of their behavior, inadequate performance, or unacceptable conduct.
- h. Self-referral does not absolve an individual from accountability for alcohol-related misconduct.

3–3. Alcohol sanctions

a. Commanders will process all Soldiers for separation, in accordance with paragraph 10–6, who are involved in two serious incidents of alcohol-related misconduct in a 12-month period; any Soldier who is convicted of driving while intoxicated (DWI) or driving under the influence (DUI) two times during his or her career will be processed for separation.

b. Military personnel will not be impaired on duty; any violation of this provision provides a basis for disciplinary action under the UCMJ and a basis for administrative action, to include characterization of service at separation. Only results from evidentiary tests may be used in support of disciplinary or administrative actions. (Refer to AR 190–5 for guidance related to alcohol testing). Actions must be consistent with the Limited Use Policy addressed in chapter 10.

Section II

Military Alcohol Testing

3–4. Authorized purposes for military alcohol testing

The decision to test and how to organize the testing event is made by the commander. Unpredictable testing patterns will produce an accurate indicator of alcohol impairment. To realize the objectives of the Army's Alcohol Testing Program, there are eight circumstances for alcohol testing of Soldiers.

a. *Inspection.* An inspection is an examination of a unit, or part thereof, conducted as a function of command, the primary purpose of which is to ensure the security, military fitness, or good order and discipline of the unit, and is conducted pursuant to Military Rules of Evidence (MRE) 313, alcohol breath testing.

b. *Search or seizure/probable cause.* This may include searches based on probable cause (in accordance with MRE 315 alcohol breath testing) or those conducted pursuant to a recognized exception to the probable cause requirement.

c. *Competence for duty.* During evaluation of a Soldier, the commander may direct alcohol testing to determine the Soldier's competence for duty (CO) or need for counseling, rehabilitation, or medical treatment when the commander has reason to question the Soldier's competency for duty based on aberrant, bizarre, or uncharacteristic behavior, breaches of discipline, or other similar behavior. This test may be based on less than probable cause, but may not be used for disciplinary action under the UCMJ.

d. *Treatment.* Soldiers enrolled in SUD treatment will submit to alcohol testing through blood or breath tests on a monthly basis as a part of the alcohol or other drug treatment program. The treatment team will determine if an increased frequency is required and will communicate this to commanders.

e. *Mishap or safety inspection.* A specimen may be collected for alcohol testing from personnel contributing to any Class A, B, or C aviation accident or when deemed appropriate by a commander or physician after an accident which will require an investigation. Specimens which are collected in compliance with MRE (for example, inspection by command policy, search, seizure, or consent) may be used for any lawful purpose. However, specimens may also be collected for mishap investigatory purposes only and may not satisfy the requirements of the MRE for admissibility in a court-martial. If specimens do not satisfy the standards of admissibility, these tests will be protected by the Limited Use Policy.

f. *Consent.* A specimen for alcohol testing may be provided voluntarily by a Soldier as part of a consent search conducted in accordance with MRE 314(e).

g. *New entrant.* Alcohol testing may be required during the pre-accession physical, initial period of military service, or for physicals in connection with the selection/attendance of specific military schools.

h. *Medical.* A specimen for alcohol testing may be required during any examination for a valid medical purpose (for example, emergency treatment, periodic physical examinations, and such other medical examination (MOs) as are necessary for diagnostic or treatment purposes in accordance with MRE 312).

3–5. Screening Alcohol testing (not for evidence use)—military

a. Commanders may use alcohol screening devices that are listed on the DOT Conforming Products List of Alcohol Screening Devices.

b. Commanders should request devices for testing through the ASAP office.

c. Alcohol results received with these devices cannot be used in any administrative action until the Soldier's test is confirmed with an evidentiary alcohol breath measuring device or through a legal blood sample alcohol test under chain of custody.

d. Soldiers who screen positive using the alcohol breath measuring device will be referred to the commander for a determination as to whether probable cause exists and further search is warranted. Under no circumstance will the Soldier who screened positive drive any privately owned vehicle (POV) or military vehicle until identified as not impaired by a Substance Abuse Professional (SAP).

3–6. Confirmation Alcohol testing (for evidence use)—military

a. Commanders will request evidentiary testing through the MP or their MTF based on established policies on the installation. Contact the ASAP manager for installation specific information.

b. In order for an alcohol test to meet the evidentiary requirements for use by trial by court-martial, the following standards must usually be met. However, these are provided as a guideline only. Nothing in this paragraph confers more rights on the accused or respondent and failure to meet the guidance may make the test inadmissible in a court of law or other adverse proceeding.

(1) Chain of custody documents must be correctly completed and maintained.

(2) The instrument used must be calibrated in accordance with established procedures and the manufacturer's recommendations.

(3) The instrument operator must be certified on the instrument's use, usually by the manufacturer, on an annual basis.

(4) The instrument must be properly maintained in accordance with standard operating procedures and the manufacturer's recommendations.

(5) The operator will print and maintain a copy of test data. This will include calibration, quality control, and the Soldier's specimen data.

3–7. Alcohol testing rate—military

Although no testing rate is currently mandated, commanders may conduct alcohol screening tests, and confirmation tests as required, on the whole or a part of their units for the primary purpose of ensuring the security, military fitness, and good order and discipline of their units. This inspection is to determine if Soldiers are maintaining proper standards of readiness, and are fit and ready for duty. Alcohol screening and confirmation tests should only be performed during duty hours when the Soldiers selected for testing have prior knowledge that they should be on duty. For example, if a commander calls an unannounced alert and Soldiers report for duty at 0430 when they were originally scheduled to report at 0630, then the alcohol test cannot be administered until at least 0630. However, if the Soldiers were previously told that they had to report at 0430, then they may be tested for alcohol at 0430. Commanders must avoid the appearance of selective testing or using screening tests to target individuals.

3–8. Alcohol incident referral—military

The commander will refer all Soldiers identified by alcohol testing, DUI/DWI, investigation, apprehension, underage drinking or reportable incident involving the use of alcohol to the BH clinic for a SUD evaluation within 5 days of the incident or investigation using DA Form 8003 for evaluation and potential enrollment.

Section III

Civilian Alcohol Testing

3–9. Civilian employees not subject to Department of Transportation regulations on alcohol testing

a. A civilian employee's decision to consume alcohol is normally a personal matter. However, when alcohol abuse interferes with the employee's ability to perform their official duties, the Army as an employer does have legitimate concerns regarding the proper performance of duties, health and safety issues, and employee conduct at the work place.

b. Supervisors have an important role in dealing with alcohol problems in the workplace, along with other agency officials. Supervisors have the day-to-day responsibility to monitor work and on-the-job problems, holding employees accountable. There are many signs that may indicate a problem with alcohol. When performance or conduct problems are coupled with the smell of alcohol; staggering or unsteady gait; bloodshot eyes; mood and behavior changes such as excessive laughter and inappropriately loud talk; avoidance of supervisory contact, especially after lunch; sleeping on duty.

c. The supervisor should immediately contact medical personnel and/or law enforcement, as appropriate and necessary, when dealing with an employee who appears to be under the influence or intoxicated at work and is a safety risk to themselves or others. Once the safety of the employee and the workplace has been addressed, the supervisor should then contact an employee relations specialist in the servicing CPAC and the servicing legal office for advice and assistance on next steps.

3–10. Civilian employees subject to Department of Transportation rules--prohibitions and consequences

a. The DOT rules at 49 CFR Part 382 apply to DA Civilian employees who operate a commercial motor vehicle in commerce in any State and who are subject to the commercial driver's license requirements of 49 CFR Part 383.

b. Performance of DOT-defined safety-sensitive functions is prohibited when the driver:

- (1) Has used alcohol while on duty.
- (2) Has an alcohol concentration of 0.04 percent or greater as indicated by an alcohol breath test.

(a) Additionally, drivers who have an alcohol concentration of 0.02 percent or greater but less than 0.04 percent on a confirmation test may not perform or continue to perform safety-sensitive functions until the start of the driver's next regularly scheduled duty period, but not less than 24 hours after administration of the test. (A return-to-duty test is not required.)

(b) If a driver's behavior or appearance indicates a violation of a DOT prohibition, and notwithstanding the absence of a reasonable suspicion alcohol test, the driver must be removed immediately from performing safety-sensitive duties until at least 24 hours has elapsed following the reasonable suspicion determination. (A return-to-duty test is not required.)

- (3) Used alcohol within 4 hours of otherwise having to perform safety-sensitive duties.
- (4) Refuses to submit to an alcohol or drug test as defined in the DOT regulations.

3–11. Categories of alcohol testing and required procedures for employees who are subject to Department of Transportation regulations (49 Code of Federal Regulation Part 382, Subpart C)

a. The DOT regulations require employers to implement five categories of alcohol testing. (DA Civilian employees subject to testing under DOT rules are not required to take a pre-employment alcohol test but are required to take a pre-employment drug test.)

b. At the workplace/installation, effective implementation of DOT alcohol testing requires the involvement of the supervisor, the ASAP manager, the EAP coordinator, the DTC, the DOT qualified collector, the DOT qualified screening test technician (STT), the DOT qualified breath alcohol technician (BAT), the installation SAP and the servicing CPAC. Installation commanders must maintain the means to perform an evidentiary alcohol breath test.

c. The DOT categories of alcohol testing are as follows:

(1) Reasonable suspicion alcohol testing. The supervisor will initiate testing when there is reasonable suspicion that a driver has violated a DOT prohibition; mere hunches or rumors are not sufficient to initiate testing. Reasonable suspicion must be based on specific, contemporaneous, articulable observations concerning the appearance, behavior, speech, or body odors of the driver. A properly trained supervisor must determine that there is reasonable suspicion before testing. The individual who made the reasonable suspicion determination will not conduct the testing. A trained supervisor is one who has received at least 60 minutes of training on alcohol misuse and at least an additional 60 minutes of training on controlled substance use, including the physical, behavioral, speech, and performance indicators of probable alcohol misuse and use of controlled substances. An alcohol test is authorized only if the observations required above are made during, just preceding, or just after the period of the work day that the driver is required to perform safety sensitive functions. The supervisors will document the reasonable suspicion determination. The supervisor will consult with a higher level supervisor and the servicing CPAC before directing the test. The supervisor will notify the ASAP manager immediately and arrange for the test, which will be conducted promptly. If a test is not administered within 2 hours of the time the determination is made, the supervisor will document the reasons for the delay. If the test is not administered within 8 hours following the determination, the supervisor will cease all attempts to test and will state the reasons for not administering the test. Notwithstanding the absence of a reasonable suspicion alcohol test under this section, no driver will report for duty or remain on duty requiring the performance of safety-

sensitive functions while the driver is under the influence of or impaired by alcohol, as shown by the behavioral, speech, and performance indicators of alcohol misuse, nor will a supervisor permit the driver to perform safety-sensitive functions, until:

(a) An alcohol test is administered and the employee's alcohol concentration measures less than 0.02 percent; or greater but less than 0.04 percent on a confirmation test.

(b) Twenty-four hours have elapsed following the determination that there is reasonable suspicion to believe that the driver has violated the DOT prohibitions concerning the use of alcohol. Except as provided above, no supervisor may take any action under the DOT regulations against a driver based solely on the driver's behavior and appearance, with respect to alcohol abuse, in the absence of an alcohol test.

(2) Post-accident testing. Post-accident tests must be conducted as soon as practicable following an occurrence involving a commercial motor vehicle operating on a public road in commerce that is covered by the DOT regulations. Post-accident testing is required for each surviving driver who was performing safety-sensitive functions with respect to the vehicle, if the accident involved the loss of human life; or who receives a citation within 8 hours of the occurrence under State or local law for a moving traffic violation arising from the accident, if the accident involved either bodily injury to any person who, as result of the injury, immediately received medical treatment away from the scene of the accident, or if one or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle.

(a) If the alcohol test is not administered within 2 hours following the accident, the supervisor will record the reasons the test was not administered promptly. If the test is not administered within 8 hours following the accident, the supervisor will cease attempts to administer an alcohol test and will document why the test was not promptly administered. The employee is prohibited from using alcohol for 8 hours after the accident, or until he/she undergoes a post-accident alcohol test, whichever occurs first.

(b) A driver who is subject to post-accident testing should remain readily available for such testing, or the driver may be deemed to have refused to submit to testing.

(c) Nothing in this section should be construed to require the delay of necessary medical attention for injured people, or to prevent the driver from leaving the scene of the accident for the period necessary to obtain assistance in responding to the accident or to obtain necessary emergency medical care.

(d) The supervisor should provide drivers with necessary "post-accident" information, procedures, and instructions, prior to a driver operating a commercial motor vehicle.

(e) The results of a breath or blood test conducted by Federal, State, or local officials having independent authority for the test shall be considered to meet the requirements of this section, provided such test conforms to the applicable Federal, State or local requirements and that the results are obtained by the employer.

(3) Return-to-duty alcohol testing. Before a driver may resume performing safety-sensitive duties after having engaged in conduct prohibited by the applicable regulations, the driver must take a return to duty test under the procedures of 49 CFR Part 40, Subpart O. The employee must have an alcohol test with an alcohol concentration of less than 0.02. This test cannot occur until after the SAP has determined that the employee has successfully complied with prescribed education and/or treatment.

(4) Follow-up testing. An employee is subject to unannounced follow-up testing for at least the first 12 months of safety-sensitive duty following the employee's return to safety-sensitive functions. The SAP determines the number and frequency of the follow-up tests. The employee must pass at least 6 unannounced follow-up tests in the first 12 months. The SAP may also require follow-up tests during the 48-months of safety-sensitive duty following this first 12-month period. The supervisor selects the specific dates for the follow-up tests prescribed by the SAP.

(a) Follow-up testing is separate from and in addition to the random testing program. Drivers subject to follow-up testing will remain in the random testing pool and will be tested whenever selected for random testing.

(b) The supervisor will meet with the driver and obtain written acknowledgment that the driver is aware of the requirement for follow-up testing.

(5) Random testing. Random testing will use a scientifically valid system for randomly selecting employees to be tested. Random testing will be imposed without an individualized suspicion that a particular individual is using illegal drugs or misusing alcohol. Each driver will have an equal chance of being tested each time selections are made. Each driver selected shall be tested during the selection period.

(a) Frequency of random testing. DOT regulated personnel will be randomly tested for alcohol at a minimum rate established by the DOT. Each calendar year, the Federal Motor Carrier Safety Administration will publish in the Federal Register the minimum annual percentage rate for alcohol and other drug testing of drivers. The testing will be conducted monthly and be distributed evenly throughout the year. Although subject to both random alcohol and drug testing under the DOT regulations, a driver shall only be tested for alcohol while the driver is performing safety-sensitive functions, just before the driver is to perform safety-sensitive functions, or just after the driver has ceased

performing such functions. Employees will proceed to the testing facility within 2 hours of having been notified except that if the driver is performing a safety-sensitive function other than driving a commercial motor vehicle at the time of notification, the driver must cease performing the safety-sensitive function and proceed to the site as soon as possible.

(b) Identification.

1. The DMO will prepare a memo for the installation commander's signature tasking all directorates to identify all installation civilian driver positions which meet the applicability criteria provided in paragraph 5–24. Management will ensure that the position descriptions for the identified DOT safety-sensitive positions clearly document their safety-sensitive functions.

2. The DMO, with the assistance of management, will establish and maintain an updated DOT driver roster, which identifies the incumbents in those positions and will provide a copy to the DTC or designee. The DOT driver rosters may be in any format, but will contain at a minimum the position title and number; the name, and work telephone of incumbent; the name and work telephone of the first line supervisor, and date supervisor was trained regarding the DOT Testing Program.

3. Management will inform employees of conditions of employment by the issuance of the 30-day individual notices to incumbents of DOT safety-sensitive positions and the requirement for employee acknowledgement and signature on DA Form 7412.

(c) Notification.

1. The DMO (or other individuals designated by the DMO) will randomly select the drivers to be alcohol tested. The DMO, or designee, will then notify the first level supervisors of those selected drivers. The DMO's notification will include the instructions that the supervisor will tell the selected drivers they must report to the testing site immediately, but no later than 2 hours after notification. If the first level supervisor is unavailable, the next higher level supervisor will be contacted. The DMO or designee should record the names of drivers selected, name of supervisor(s) and times notified, and time scheduled for specimen collection in an MFR.

2. The supervisor will privately explain to the driver that they are under no suspicion of consuming alcohol, that the employee's name was selected randomly, and that the employee is to report promptly to the testing facility with photo ID. Supervisors should record the names of individuals advised to report for alcohol testing, time notified, and time when employees were advised to report for random testing in an MFR.

3. Supervisors of drivers who work shift duty or are assigned special duty hours (for example, not a typical day shift like 0800–1700 hours) will advise the DMO, who will develop a plan for testing these employees.

(d) Not available to test. Supervisors will notify the DMO or designee promptly when the drivers selected for random testing are not available due to leave or travel status. The supervisor will record why the driver was not available. Supervisors should not approve leave once a driver has been selected for a random test. The DMO or designee will reschedule the employee for an unannounced test within the next 60 days.

(e) Failure to appear or provide an alcohol specimen.

1. The DMO or designee will notify the supervisor when a driver refuses to provide a specimen or fails to report to the designated collection site within the designated time. The DMO or designee will document the failure to appear for testing, or refusal to provide a specimen, and provide a copy to the employee's first line supervisor.

2. The supervisor will notify the higher level supervisor and the servicing CPAC.

(f) Evenly distributed. The DMO or designee will ensure that random testing is evenly distributed throughout the year (approximately 8–10 percent of the testing pool per month).

d. Effective deterrence requires a random selection process which ensures all employees subject to random testing believe they may be required to provide a breath specimen any day they report to work.

3–12. Alcohol tests for civilian employees under Department of Transportation rules

a. The installation/commander will designate an IBAT to conduct all DOT-regulated alcohol tests. If the installation does not have the personnel or equipment to conduct DOT-regulated alcohol tests, the installation/commander will coordinate or contract with an agency in the local area to conduct the tests.

b. The designated BAT/STT or contractor at each installation that employs personnel tested under DOT alcohol testing rules will be trained to proficiency in the operation of the breathalyzer testing, and will be able to provide documentation indicating they have met all the collection requirements prescribed by DOT alcohol and other testing rules and procedures identified in 49 CFR Part 40, Subpart J.

c. The BAT/STT will follow all alcohol testing procedures provided in 49 CFR, Part 40 and use the Form DOT F 1380 (U.S. Department of Transportation (DOT) Alcohol Testing Form). The Form DOT F 1380 must be three-part carbonless manifold form and may be viewed at <http://www.dot.gov>. The Form DOT F 1380 may not be modified or revised, except as permitted in 49 CFR 40.225.

d. The BAT/STT will notify the employee's supervisor immediately of all breathalyzer test results, of any refusal by drivers to participate in testing or to sign necessary forms, or in the event of a subject's inability to provide an adequate amount of breath. Notifications will be fully documented and maintained by the BAT/STT.

e. When the results require the driver to be removed from performing safety-sensitive functions, the BAT/STT will contact the individual's supervisor immediately to confirm the test results, to advise about the requirement to remove an employee from performing safety-sensitive functions, and request that the supervisor arrange for transportation of the driver back to the work site, as the driver will not be allowed to operate a vehicle. Additionally, the BAT/STT will advise the supervisor to notify the CPAC and to obtain additional guidance concerning the employee's removal from safety-sensitive functions. The BAT/STT will document the discussion and provide a copy of the record along with employer's copy of the Form DOT F 1380 to the driver's supervisor and the ASAP manager.

f. Records will be disclosed and maintained in accordance with 49 CFR 40.321 through 40.333.

3–13. Installation substance abuse professional evaluation of employees tested under Department of Transportation rules

a. The Substance Abuse Professional (SAP) evaluation provides a comprehensive face-to-face assessment and evaluation to determine if the employee/driver needs assistance resolving problems associated with alcohol abuse or prohibited drug abuse. If the employee is determined to need assistance as a result of this evaluation, the SAP will recommend a course of treatment with which the employee must demonstrate successful compliance prior to returning to DOT safety-sensitive functions.

b. The SAP must be licensed or certified per CFR 49 Part 40 (physician, social worker, psychologist, employee assistance professional, marriage and family therapist, or a drug and alcohol counselor certified by an organization listed at transportation government sap website (<https://www.transportation.gov/odapc/sap>)).

(1) Evaluation, referral, and follow-up evaluation and testing are the basic SAP responsibilities. The specific duties and responsibilities of the SAP are described in The Substance Abuse Professional Guidelines published by DOT.

(2) Commanders of MEDDAC/medical centers will designate a qualified SAP to conduct required counseling and evaluations at the installation.

(3) When a SAP evaluation is required, the installation EAP coordinator will manage the evaluation with the driver, the supervisor, and the SAP. Additionally, the EAP coordinator may function as the supervisor's primary point of contact. In consultation with the SAP (provided the employee has signed the civilian employee consent statement), the EAP coordinator may inform the supervisors of the ongoing status of the driver's rehabilitation or treatment.

Chapter 4 Military Personnel Deterrence Drug testing Program

4–1. General

a. Drug abuse is inconsistent with Army values and readiness. The Army's drug testing policy is dependent on an aggressive and thorough UA program requiring the participation of all Soldiers selected for testing, observers, and UPLs. It is imperative that those selected for testing provide a specimen in a controlled and secure environment. Therefore, Soldiers will not avoid providing a urine specimen when ordered; dilute a urine specimen to reduce quantitative value of possible drug metabolites of the urine specimen; substitute any substance for their own urine, including the urine of others; chemically alter, adulterate, or modify their own urine; or assist another Soldier in doing any of these actions.

b. The objectives of the Army's DTP are to—

(1) Deter Soldiers from abusing drugs (including illegal drugs, other illicit substances, and prescription medication).

(2) Facilitate early detection of drug abuse.

(3) Enable commanders the opportunity to assess the security, readiness, good order and discipline of their units, and to use information obtained to take appropriate disciplinary or administrative actions, including referral to BH clinic for a SUD evaluation and possible treatment.

(4) Drug test those enrolled in alcohol and/or other drug abuse treatment, as indicated.

(5) Collect data on the prevalence of problematic substance use within the Army.

4–2. Policy

a. Unpredictability of testing is a determining factor deterring Soldiers from using drugs. High frequencies of unpredictable random testing events contribute to deterring Soldiers from using drugs because they know that they have

the possibility of being selected at any time. "Smart testing" is random testing conducted in such a manner that it is unpredictable by the testing population. This randomness must extend beyond random selection of Soldiers; it must include randomness of frequency (how often the commander tests) and periodicity (when during the month/week/day the commander tests).

b. The Army DTP is a commander's program and is executed by commanders at every level. Commanders will develop a completely random DTP as described in this chapter.

c. Commanders at every level will ensure random UA testing at the rate of 10 percent assigned end strength each month. Commanders may conduct several collections of smaller percentage within a month to meet the 10 percent monthly requirement. The primary method for selection should be the inspection random drug testing code. In addition to the monthly random testing, Soldiers not selected for random UA during the first three quarters of each fiscal year will be selected for testing during the fourth quarter using the inspection other test basis code. Unit sweep testing should not be used to meet this random testing requirement.

d. In addition to random testing, commanders should conduct periodic unit sweeps. The most effective testing programs use inspection unit testing in addition to and supplementary to a good random DTP. Inspection unit testing will not be used as a mean of testing a Soldier the commander suspects of abusing drugs, but does not have sufficient probable cause to conduct a collection code PO.

e. In areas where Soldiers receive hostile fire pay, local brigade or higher commanders will determine the required periodic testing rate (see para 4–7 for details of testing while deployed).

f. The most important elements of the Army's DTP are that it is conducted randomly and is executed with consistency. The test basis available for commanders to conduct drug testing is identified in paragraph 4–5. Drug testing must be executed in a fair and equitable manner, meaning that in spite of a Soldier's previous drug testing or SUDCC history, the program must be applied to all Soldiers consistently.

g. A Soldier testing positive on previous drug tests or pending separation for drug test failure is not valid reason to exempt such Soldier from continued testing regardless of test basis.

h. Commanders must not stop random testing or probable cause testing on any Soldier. Soldiers must only be exempted from drug testing when they are truly not available to provide a specimen (leave, temporary duty, and so forth); the procedures to test non available Soldiers are found in paragraph 4–5a (2) and must be implemented in these cases. All military urine specimen collections will be conducted in accordance with procedures set forth in appendix E of this regulation. (See ASAP website at: <https://asap.army.mil/>).

i. Field testing of urine specimens is unauthorized; all urine specimens will be forwarded to the supporting FTDTL for testing.

j. Soldiers who test positive for illicit drugs will be evaluated for a substance use disorder, disciplined as appropriate, and considered for separation within 30 calendar days of the company commander receiving notification of the positive result from the ASAP in accordance with paragraph 10–6. If the positive drug report is for a MRO-reviewable drug, no adverse administrative and legal actions will be initiated pending MRO determination whether the use was for legitimate medical purposes. Soldiers diagnosed with a drug related SUD will be offered SUDCC services prior to separation. Participation in SUD treatment need not interfere with normal command administrative actions.

k. Article 112a, UCMJ specifically prohibits the unlawful use of the following substances: amphetamines, barbiturates, cocaine, ecstasy, opiate, heroin, phencyclidine, tetrahydrocannabinol (THC), oxycodone/oxymorphone, benzodiazepines, lysergic acid diethylamide (LSD), steroids, and synthetic cannabis (Spice) and any compound or derivative of any such substance. It also prohibits the unlawful use of any other substance prescribed by the president or listed in Schedules I through V of Section 202 of the Controlled Substances Act (21 USC 812).

l. Soldiers are prohibited from using the following substances for the purpose of inducing excitement, intoxication, or stupefaction of the central nervous system:

- (1) Chemicals, propellants, or inhalants (huffing).
- (2) Dietary Supplements. The DoD does not maintain a list of dietary supplements or supplement ingredients that are either "allowed" or "banned." If the Drug Enforcement Administration (DEA) declared an ingredient or dietary supplement illegal, then DoD considers it banned or illegal as well. Substances "banned" for use by Soldiers include:
 - (3) Any substance FDA has declared "illegal" or "not allowed" for use in dietary supplements (such as "ephedra"/ephedrine alkaloids, dimethylamylamine (DMAA), dimethoxybenzaldehyde (DMBA), beta-methylphenethylamine (BMPEA)).
 - (4) Anything on DEA's controlled substance list (spice, marijuana, and synthetic cannabinoids).
 - (5) *Salvia divinorum* (diviner's sage).
 - (6) Naturally occurring substances (to include but not limited to *Salvia divinorum*, Jimson Weed) which are on the DEA's list of illegal substances.
 - (7) Any prescription drug without a current prescription written specifically for the Soldier.

(8) Prescription or over-the-counter drugs and medications when used in a manner contrary to their intended medical purpose, in excess of the prescribed dosage, or in a manner other than what is specifically prescribed.

(9) A controlled substance analogue is a substance that is intended for human consumption and is structurally or pharmacologically substantially similar to, or is represented as being similar to, a Schedule I or Schedule V substance and is not an approved medication in the United States.

(a) The use of products made or derived from hemp (as defined in 7 USC. 1639o), including cannabidiol CBD, regardless of the product's THC concentration, claimed or actual, and regardless of whether such product may lawfully be bought, sold, and used under the law applicable to civilians, is prohibited, regardless of the route of administration or use, subject to the exceptions below. Examples of products that are prohibited include, but are not limited to, the following: products that are injected, inhaled, or otherwise introduced into the human body; food products; transdermal patches, topical lotions and oils; soaps and shampoos; and, other cosmetic products that are applied directly to the skin. This provision is punitive, and violations may be subject to punishment under Art. 92(1), UCMJ. Violations of this prohibition constitute a general intent offense. This prohibition will not apply to use: (1) pursuant to legitimate law enforcement activities; (2) by authorized personnel in performance of medical duties; or (3) without knowledge that the product was made or derived from hemp, including CBD, where that lack of knowledge is honest and reasonable. The use of durable goods containing hemp, such as rope or clothing, is not prohibited. The ingestion, consumption, or use of cannabinoid formulations approved as drugs by the FDA for which the Soldier has a valid prescription, such as dronabinol (Marinol, Syndros) and cannabidiol (Epidiolex®) is excepted from this prohibition.

(b) One example of a controlled substance analogue is derivatives of 2-aminopropanal, such as mephedrone and methylenedioxypyrovalerone (MDPV) that are listed as "drugs of concern" by the U.S. Drug Enforcement Agency. Derivatives of 2-aminopropanal are the active ingredients in the class of drugs commonly called "bath salts," which are designed solely to be used as a means to produce excitement, intoxication and/or stupefaction of the central nervous system.

(c) Another example of a controlled substance analogue is synthetic cannabis and other tetrahydrocannabinol (THC) substitutes that have no known application other than mimicking the effects of THC in the human body. Numerous synthetic THC substitutes are now available on the open market in many States. Synthetic cannabis and THC substitutes are used in drugs such as "spice," which are so closely related in action to THC as to make it obvious that synthetic cannabis and THC substitutes will have the same potential for abuse as THC.

(d) Army personnel are prohibited from using, possessing, manufacturing, selling, distributing, importing into or exporting from the United States any controlled substance analogue. This includes, but is not limited to, synthetic cannabis (also known as "spice"), substances containing derivatives of 2-aminopropanal (also known as "bath salts"), cathinone substitutes or the cocaine analogue RTI 126. Army personnel may not introduce these substances into any installation, vessel, vehicle or aircraft used by or under the control of the Army. This policy does not apply to alcohol, caffeine, tobacco, or lawfully used prescription or over-the-counter medications, nor does it prohibit the lawful use of traditional "bath salt" or "Epsom salt" products.

(e) This prohibition is punitive, and violations of its provisions may result in punitive actions against Soldiers.

(f) Army testing of synthetic cannabinoids ("spice") will be conducted during inspection random (collection code IR) testing, probable cause (collection code PO) or competence for duty (collection code CO) testing exist. Commanders can request a special test for Synthetic cathinones (bath salts).

m. Violations of paragraph 4-2l may subject offenders to punishment under the UCMJ and/or administrative action. This is applicable to the Regular Army, the Army Reserve and the Army National Guard of the United States when in Title 10 status. This is punitive and violations of the provisions may result in adverse action against Service members. This does not apply to alcohol, caffeine, tobacco, or lawfully used prescription or over-the-counter medications, nor does it prohibit the lawful use of traditional "bath salt" or "Epsom salt" products. If a commander has any question regarding whether a substance or its use is prohibited by this provision, they should contact the servicing legal office before initiating any adverse action. All military personnel are subject to probable cause, competency for duty, and limited inspection testing when a commander, in consultation with their supporting legal office, determines a violation of this policy has occurred or probable cause exists to warrant a test.

n. All Soldiers assigned to a Joint Service command will participate in the Joint Service command's UA program unless specific authorization is granted by the Director, ARD to establish and maintain a separate UA program.

o. Neither a UPL nor an observer should be involved with processing their own UA specimen.

p. Commanders must employ direct observation of urine collection to maintain the integrity and effectiveness of their UA programs. In all cases, observers will be briefed on and provided a demonstration of their duties before they perform them. Observers will also sign a UA Observation Briefing Memorandum that outlines those duties and the

failing to perform their duties as an observer could subject them to prosecution under the UCMJ and/or adverse administrative action. Commanders should use senior NCOs or officers in the chain of command as observers whenever possible to reinforce command support for the program

q. The Director, ARD may institute, at any time, an allocation system to control the amount and frequency of urinalyses conducted.

r. When a Soldier is selected for a random UA, but is not present for duty, their commander will collect a UA specimen from the Soldier upon their return or during the next random UA test after the Soldier's return. If a Soldier's UA specimen is not tested and is destroyed because the specimen or DD Form 2624 (Specimen Custody Document-Drug Testing) were not forensically correct or the FTDTL determined it to be untestable due to adulteration, the commander will retest the Soldier as soon as practical.

4-3. Hallmarks of a good unit Drug testing Program

A good unit DTP will—

a. Employ a truly random DTP, varying frequency (how many times per month/week) and periodicity (day(s) of the week, time of day, and week of the month) of random testing.

b. Submit UA specimens to the FTDTL using the DoD DTP to prepare all required documents (DD Forms 2624, bottle labels, and UA unit ledgers).

c. Apply smart testing techniques (see chap 4-10).

d. Have at least two UPLs on appointment orders signed by the commander and certified in accordance with the ARD UPL CTP.

e. Have passed a unit-level inspection, by a higher unit or the ASAP staff.

f. Have a unit-level substance abuse program SOP signed by the commander.

g. Collect random UA specimens in one or more events monthly to total 10 percent of the unit.

h. Have command team presence during all UA collections.

i. Use officers and senior NCOs as observers during UA collections when possible to reinforce command support for the program.

j. Take every step to prevent Soldiers from learning that a UA test will be conducted until the selected Soldiers are notified to report to the testing site.

4-4. Drugs for which testing is conducted

The FTDTLs will test UA specimens for the current drug testing panel listed in DoDI 1010.16 or the most recent DoD Policy Memorandum, whichever is more current. If a commander needs to test for a drug not specified by the DoD policy, they will coordinate with the ASAP staff for guidance on specimen requirements and shipment to the appropriate DoD laboratory/Armed Forces Medical Examiner System (AFMES).

4-5. Purposes for conducting drug testing

In accordance with DoDI 1010.01, there are nine purposes for ordering UA testing of Soldiers. Commanders should consult with their legal advisor, ASAP manager, or DTC when unsure of which test basis code to use for testing. The test basis (with DTP test codes in parentheses) are—

a. *Inspection*. An inspection is an examination of a unit, or part thereof, conducted as a function of command, the primary purpose of which is to ensure the security, readiness, and good order and discipline of the unit, and is conducted pursuant to MRE 313. Inspection testing is imposed without individualized suspicion that a particular individual is using illicit drugs.

(1) *Inspection random (collection code IR)*. Random drug testing is a scientifically valid system of selecting a portion of a command for testing without individualized suspicion that a particular individual is using illicit drugs. Each Soldier will have an equal chance of being selected for drug testing each time inspection random testing is conducted.

(2) *Inspection other (collection code IO)*. This is a valid inspection under circumstances specified by a commander's policy memorandum. Some inspection other examples include testing Soldiers who were selected but unavailable for testing during recent inspection random testing or who are returning from absent without leave (AWOL) or certain leaves, passes, or temporary duty. When a commander tests a Soldier under the mandatory annual requirement specified in paragraph 4-8 because the Soldier has not been previously selected under inspection random testing, the commander will use the inspection other test code.

(3) *Inspection unit (unit sweep) (collection code IU)*. This method is used to test an entire unit or command or readily identifiable sub-unit or segment of a command, such as a platoon or staff section. Unit sweeps are an effective tool for the commander, but should not be conducted routinely. Commanders will not use a unit sweep to target an

individual Soldier or small group of Soldiers they suspect of using drugs; testing under these circumstances should be based on probable cause (collection code PO).

b. Search or seizure/probable cause (collection code PO). This may include searches based on probable cause (in accordance with MRE 312(d) and 315). It is ordered to collect evidence when there is probable cause to believe a Soldier possesses an illicit drug within their body.

c. Competence for duty (collection code CO). During evaluation of a Soldier, the appropriate command authority may direct UA to determine the Soldier's competency for duty or need for counseling, rehabilitation, or medical treatment when there is reason to question the Soldier's competency for duty based on aberrant, bizarre, or uncharacteristic behavior, breaches of discipline, and other similar behavior. This test may be based on less than probable cause.

d. Rehabilitation (collection code RO). Production of a specimen is required as a part of enrollment in an alcohol or other drug rehabilitation program. The rehabilitation team will determine the frequency, which will then be included in the rehabilitation plan and communicated to the commander to execute.

e. Mishap or safety inspection (collection code AO). A specimen may be collected for drug testing from personnel contributing to any Class A, B, or C aviation accident or when deemed appropriate by a commander or physician. Specimens which are collected in compliance with MRE (for example, inspection by command policy, search, seizure, or consent) may be used for any lawful purpose. However, specimens may also be collected for mishap investigatory purposes only and may not satisfy the requirements of the MRE for admissibility in a court-martial. If specimens do not satisfy the standards of admissibility, these tests will be protected by the Limited Use Policy.

f. Voluntary (Member Consent) (collection code VO). A command representative, who suspects a Soldier of having unlawfully used drugs, may request that the Soldier consent to UA after advising the Soldier that they may decline to provide the specimen. Where practical, the command representative should obtain the consent in writing, but this is not required. UCMJ, Art 31(b) warnings are not normally required in such cases provided no other questioning of the Soldier takes place. Further guidance is contained in MRE 314(e).

g. Medical examination (collection code MO). A specimen may be required during any examination for a valid medical purpose (for example, emergency treatment, periodic physical examinations, and other medical examination as are necessary for diagnostic or treatment purposes in accordance with MRE 312).

h. New entrant (collection code NO). Testing of personnel as part of an application for entry to the Army in accordance with DoDI 1010.01.

i. Other (collection code OO). An inspection directed by HQDA or for another authorized purpose.

4–6. Drug testing in the reserve components

a. Army National Guard in Title 10 status and U.S Army Reserve Soldiers on AD for 30 days or longer are subject to every provision of this regulation. Army National Guard and Army Reserve Soldiers on AD for less than 30 days are subject to every provision of this regulation with the modifications specified in chapters 15 and 16, respectively. Nothing in this provision is intended to limit the authority of the command to take punitive or adverse administrative action against a Soldier who tests positive for drugs before serving 30 days on AD.

b. The scheduled date of release from AD should not preclude reservists on extended AD from receiving appropriate treatment while on AD. The date of release from AD may be extended to complete appropriate treatment, if necessary. Any aftercare would then be completed while the Soldier was on inactive duty and would be monitored by the USAR or ARNG chain of command.

c. Army Reserve Soldiers and Army National Guard on initial AD for training (IADT) may be referred for ADAPT. If an Army Reserve Soldier or Army National Guard on IADT is diagnosed with a SUD, that Soldier may be referred for treatment at an MTF if eligible to receive services. When MTF care is not available, the command should counsel the Soldier to seek appropriate rehabilitation through available civilian resources.

d. An Army Reserve Soldier or Army National Guard who is alleged to have committed a drug-related offense while on AD or IADT may be subject to non-judicial punishment or courts-martial jurisdiction following the offense if their duty status changes.

e. An Army Reserve Soldier or Army National Guard in an IADT status involved in a confirmed drug-related incident, including a conviction in civilian court, is subject to administrative action and/or processing for separation, as appropriate, even though disciplinary action may not be possible. Soldiers not on active duty may be processed for an other than honorable discharge for drug abuse established through UA conducted during IADT or at other duty times, for example during battle assembly.

4–7. Deployed drug testing

a. Commanders will maintain their substance abuse programs to the maximum extent practical while deployed or on contingency missions. A leader's responsibility to deter illegal drug use and identify problematic substance users does not stop during deployments. On the contrary, given the nature of operations and the potential presence of live ammunition, explosives, and hostile forces, the impact of ignoring this responsibility is serious and irreversible.

b. In areas where Soldiers receive hostile fire pay, O–6 level or higher commanders can authorize temporary suspension or reduction of random drug testing for specific subordinate elements based on METT–TC and/or safety and security issues.

c. Commanders will not endanger Soldiers' safety and security in hostile fire areas solely to conduct drug testing.

d. All company and larger units, to include mobilized USAR and ARNG units, will mobilize and deploy with at least two trained UPLs and enough drug testing supplies to meet testing requirement throughout the deployment or contingency mission. Units smaller than company strength will receive drug testing support from the next higher unit in the chain of command. As needed, rear detachments will support forward units.

e. The BACs are assigned for selected deployment areas by special instructions. The senior commander for each deployed unit that is assigned a base area code (BAC) will appoint a base area code manager (BACM) to manage the ASAP for the command and maintain liaison with higher commands and the ASAP. A BACM must be in the rank of a senior NCO or officer (E–7 or above); qualifications for BACM are equivalent to that for DTCs (see para 9–5). If a member of another service is appointed to BACM duty, the appointing authority or security manager must provide statements justifying the appointee's qualifications and clearance verification to ARD ASAP for processing of access to sensitive DoD and Army drug testing data.

f. The BACM will—

(1) Retrieve UA test results for the command on a regular basis from the designated FTDTL Web portal, and forward the results via a secure means to unit commanders and MROs, as appropriate.

(2) Coordinate with the command's MRO to obtain their review of those results that could be the result of a legitimate prescription. The BACM will forward the MRO's decision to the unit commander and enter it in DAMIS. The BACMs in deployed areas will provide positive results for illicit substances to their supporting CID office in theater. Positive UA results on rehabilitation tests will not be released to CID/MP. Positive UA results that require a MRO evaluation will only be released to CID/MP if the MRO determines the results to be illegitimate use. Results determined to be legitimate medical use will not be released.

(3) Monitor drug testing rates, trends, specimen discrepancy rates, and MRO delinquency rates.

(4) Provide reports, as requested.

(5) Monitor UPL certification.

(6) Maintain ASAP files in accordance with AR 25–400–2.

g. The MTF commanders in deployed areas who have been assigned a BAC will—

(1) Appoint in writing enough MROs to review presumptive positive drug test results for the drugs determined by MEDCOM as requiring a medical review.

(2) Coordinate with MEDCOM for MRO training and certification for appointed MROs if they are not certified to perform the duties.

(3) Monitor MRO workloads and coordinate MRO-related issues with commanders and the BACMs.

h. Installation ASAPs will provide drug testing supplies as required to deploying units with enough supplies. Deployed units will order supplies through the supply system.

i. The BACMs of deployed units will forward test results for redeployed units to the respective home or mobilization station ASAP managers. Mobilization station ASAP managers will forward the test results for demobilized units to the respective state DTC or MSC ASAP managers.

4–8. Special drug testing programs

a. Alcohol and other drug abuse by Soldiers in critical safety or security positions is of special concern because of the adverse impact on readiness, public health and safety, operations, life and property, and the possible disclosure of national security information. To minimize safety and security risks, special provisions allow—

(1) Release of potentially disqualifying information obtained from the Soldier during the SUD evaluation and treatment.

(2) Suspension and/or revocation of a Soldier's access to classified material, chemical agents, or nuclear agents.

(3) Restriction or suspension of aviation, firefighting, police, corrections, rigging, and certain medical duties.

(4) Notification to the Department of Defense Consolidated Adjudications Facility (DoD CAF).

(5) Increased frequency of random testing. See paragraph 4–2*c* for guidance on random UA testing rate.

b. Alcohol and drug abuse by Soldiers with access to top secret or sensitive compartmented information is of particular concern because of the potential adverse impact such abuse may have on national security. Therefore, all Soldiers who maintain a top secret clearance or have sensitive compartmented information access are required to submit a UA specimen a minimum of once in each fiscal year. Participation in the SUD treatment program is not in itself sufficient cause to identify a Soldier as a security risk in accordance with AR 380–67. However, circumstances of a given case may warrant suspension of an individual’s access to classified material. (Refer to AR 380–67 and/or the supporting security office for guidelines on suspending access to classified information and/or reporting information to the DoD CAF.)

c. The Biological, Chemical, and Nuclear Surety Programs are command programs designed to ensure that only those Soldiers who comply with the highest possible standards of reliability are allowed to perform duties associated with biological, chemical, or nuclear agents. Such reliability is maintained through the initial and continual evaluation of Soldiers assigned to Personnel Reliability Program (PRP) duties. No one is assigned to a PRP position until screened and certified by the certifying official. The failure of an individual to be certified for PRP duties does not necessarily reflect unfavorably on the individual’s suitability for assignment to other duties. The decision to remove or disqualify a Soldier enrolled in the PRP is a command decision. ASAP policies are designed to fully support the Biological, Chemical, and Nuclear Surety Programs (refer to AR 50–1, AR 50–5, and AR 50–6 for details).

d. The treating provider must ensure that potentially disqualifying information related to the Soldier’s enrollment into a formal treatment program will be made available promptly to the PRP certifying official for consideration. SUDCC staff should be familiar with their PRP responsibilities identified in AR 50–1, AR 50–5, and AR 50–6.

e. Before PRP certification, all Soldiers must submit to a UA for illicit drug use. Military personnel performing PRP duties will be tested a minimum of once in each fiscal year.

f. Alcohol and other drug abuse by aviation personnel are a special concern because of their impact on aviation safety. Therefore, aviation personnel on flight status are required to submit to UA a minimum of once in each fiscal year. Aviation specialties are:

- (1) Officer personnel in the 15-series military occupational specialty (MOS) and 67J specialty.
- (2) Warrant officer personnel in the 150–155 specialties.
- (3) Enlisted personnel in the 15-series MOS.
- (4) Flight medics, door gunners, or others who are “Special Detailed” into the aviation mission.

g. DA Pam 40–501 provides medical fitness standards. AR 600–105 provides policies and procedures for restricting, suspending, and terminating medically unfit personnel from aviation duties and includes guidance for reinstating rehabilitated abusers determined fit to return to aviation duties.

h. Aviation personnel with a diagnosis of alcohol abuse disorder in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) are “medically disqualified” from aviation duties in accordance with DA Pam 40–501. Further, a medical waiver must be obtained for all Regular Army and USAR aviation personnel (Class 2 standards), with such diagnosis, prior to their returning to aviation duties. The authority for waiver is the Commander, U.S. Army Human Resources Command (AHRC–PLP–A), 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5001, per Secretary of the Army Memorandum dated 28 Apr 2016, subject: Delegation of Authority to Grant Aeromedical Waivers, Exception to Policy and Suspension Authority. The requirements and process to obtain a waiver for a disqualified aviator is as follows:

- (1) Abstinent from any mood altering substances for a minimum of 90 days.
- (2) Successfully progressing in the SUD treatment.
- (3) Written assessment and recommendation from the SUD provider/Joint Service equivalent, commander, and flight surgeon with the endorsement of a GO in the chain of command. This documentation of assessments and recommendations will be submitted to Director, U.S. Army Aeromedical Activity (USAAMA) (MCXY–AER), Fort Rucker, Alabama 36362–5000, for medical review and recommendation.

(4) Recommendation for waiver of disqualification(s) from the Director, U.S. Army Aeromedical Activity accompanied by all relevant documentation to Commander, U.S. Army Human Resources Command (AHRC–PLP–A), 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5001.

(5) Commander, HRC considers the request and recommendations for waiver. If the recommendation is received prior to the normal 12-month period (date of grounding to recommendation for waiver) the recommendation will be considered based on the strength of the assessments and the background of the individual aviation person.

- (6) All waivers must be reviewed for renewal each year.

i. Aviation personnel who are involved in alcohol related incidents or are otherwise identified, and determined by treating provider to not meet the criteria for alcohol use disorder (AUD) as defined by current edition of the DSM, need to be reviewed for continuation of aviation duties. These personnel may be “temporarily suspended from aviation duties” for a period of evaluation and review, ensuring that the aviation personnel poses no unusual threat to aviation

safety. When the treating provider, local commander, and flight surgeon agree that the aviation personnel is ready to return to flying, the temporary suspension may be lifted, and the aviator may return to flying.

j. Aviation personnel who test positive for or use illicit drugs will be disqualified by their commander from flying duties in addition to being subject to appropriate disciplinary and administrative actions.

k. 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.

l. All Soldiers, regardless of MOS or additional duties assigned, are required to be drug tested.

m. To ensure their continuing fitness for the positions they hold and the integrity of the DTP, all UPLs will submit to UA testing a minimum of once in each 12-month period.

4–9. Drug testing coordinator, base area code manager, battalion prevention leader, Unit Prevention Leader, and observer qualifications, training, and certification

a. Since DTCs, BACMs, BPLs, UPLs, and observers perform duties that are crucial to the integrity and success of the ASAP and must be prepared to testify about their actions in court, they must be very carefully selected, trained, and certified to perform their duties. Reserve component DTCs, BACMs, BPLs, UPLs, and observers must meet the same standards as Regular Army personnel.

b. Specific requirements for DTC, BACM and BPL or UPL qualifications, training, and certification are explained in chapter 9.

c. Observers must—

(1) Be an officer, warrant officer, NCO (E–5 or above), DA Civilians (general schedule (GS–5) or pay grade equivalent), or contract employee (or pay grade equivalent).

(2) Be the same gender as the Soldier being observed.

(3) Possess unimpeachable moral character and sufficient maturity to preserve the dignity of the Soldier being tested.

(4) Not have been enrolled in mandatory SUD treatment in the past twelve months.

(5) Not be under investigation for any offenses.

d. Observers must be briefed on and receive a demonstration of their duties by a UPL each time they are selected to perform them. Before performing their duties, observers must sign a UA Observation Briefing Memorandum that outlines their duties and the penalties for not properly performing them. (see fig D–4 for an example memorandum.) The observers' duties are to—

(1) Maintain direct eye contact with the specimen bottle from the time the UPL hands it to the Soldier until the time the UPL places it in the collection box.

(2) Observe urine leaving the Soldier's body and entering the specimen bottle.

(3) Ensure no one tampers with the Soldier's specimen.

(4) Guide the Soldier through the collection process.

(5) Report unusual occurrences and attempts to adulterate the specimen to the UPL.

4–10. Smart testing techniques

a. A Soldier who knows when the UA will be conducted may attempt to substitute another fluid for their specimen or contaminate their specimen so that it is untestable. Any testing technique used must be consistent with the requirements of a valid health and welfare inspection. The keys to obtaining a good UA specimen are to—

(1) Prevent Soldiers from knowing when they will be tested until just before the test.

(2) Maintain control of them until they provide their specimens.

(3) Ensure the observers perform their duties correctly.

b. Soldiers will have 2 hours and no more than 6 hours to report to the testing site from the time they are notified. Once a Soldier is in the testing site holding area, only the commander who ordered the test may authorize Soldiers to leave before providing their specimen. If the commander allows a Soldier to leave the holding area, the commander should provide an NCO or officer escort for the tested Soldier while they are away from the holding area. Some examples of smart testing techniques include:

(1) Back-to-back testing (for example, Friday/Monday).

(2) Weekend/holiday testing.

(3) During field exercises.

(4) At the end of the duty day.

(5) During afternoon physical training.

c. Some examples of poor UA collection techniques include:

(1) Always testing on Mondays.

- (2) Asking for volunteers.
- (3) Listing the test on the training schedule.
- (4) Announcing the next day's test at the end of the duty day or by email.
- (5) Calling Soldiers in for an alert but telling them it's for a UA.
- (6) Calling attention to future drug testing by conspicuously handling UA supplies or preparing required forms.
- (7) Stopping collections before every Soldier selected has provided a specimen.
- (8) Printing out testing documents and labels on shared printers.

4-11. Pre-collection procedures

The following actions will be conducted before a random selection or unit sweep UA:

- a.* The commander orders the test and selects the testing date and time. After the commander has determined the date, time, and unit(s) or subunit(s) to be tested in a unit sweep, commanders should implement positive measures to ensure that the selected Soldiers remain unaware of the UA until no more than 2 hours before Soldiers are to report to the testing site.
- b.* The commander may randomly select the Soldiers to test or may delegate this to the UPL. When conducting a random test, the commander or UPL should use the DoD DTP to randomly select Soldiers to be tested and to print the test materials. Commanders may use alternative selection methods, but whatever method the commander uses must be written in the unit substance abuse program SOP. If a UPL performs the random selection for the commander, the commander must approve the selection before any Soldier provides a UA specimen. Soldiers selected but not available for a random test must be tested upon their return or during the next random UA after the Soldier's return. For unit sweeps, the battalion commander must designate which unit(s) or sub-unit(s) will be tested.
- c.* The commander orders the Soldiers selected for the test to report to the UA collection site within 2 hours of notification, but no more than 6 hours. The commander may use the chain of command to accomplish the notification. Verbal notification is preferred and should be the primary method of notification.
- d.* The UPL sets up the UPL station on a table, preferably in a non-carpeted area with the UPL's back to a wall and as close to the latrines as possible. The testing area should be a controlled area where only testing and command personnel are present. The UPL station may be in the same area as the holding area, though separate areas are preferred to minimize distractions at the UPL station. The UPL inspects the latrine(s) before the collection to remove any possible adulterants, and to ensure Soldiers will have soap and paper towels to wash their hands after providing a specimen. The UPL will place the latrine(s) "OFF LIMITS" to non-testing personnel.
- e.* The UPL sets up the holding area near the UPL station. The commander will select an NCO or officer to maintain control of Soldiers in the holding area, but may delegate this to the UPL. Non-testing personnel are barred from the holding area. The UPL should provide the only water or other fluids in the holding area, and Soldiers, who are unable to provide a specimen, should drink eight ounces of fluids every half hour, not to exceed 40 ounces. Soldiers will remain in the holding area until they are ready to provide a specimen. In exceptional cases, an individual with an NCO/officer escort and the permission of the commander may leave for a brief period.
- f.* The UPL should notify the DTC prior to conducting unit collections in order to coordinate sample turn in and unit inspections by the DTC. This notification is recommended to improve the efficiency of specimen processing when the UPL later arrives at the DTCP. The UPL should be prepared to temporarily store the unit's specimens if the number of specimens being turned in by all units exceeds the DTC's capability to receive and process them the day of the test.
- g.* The commander will brief the Soldiers to be tested, but may delegate this to the UPL. The briefing will include the purpose for conducting the test, and will constitute a legal order for the Soldiers to provide a specimen of their urine. (See fig D-2 for an example briefing.) Intentional failure to provide a specimen absent a verified medical condition is a violation of a lawful order and may subject the Soldier to punishment under the UCMJ or other adverse action.
- h.* The UPL will brief the observer(s) on the collection process and demonstrate how to directly observe both male and female Soldiers properly. The UPL will ensure each observer reads and signs an observer's memorandum that clearly explains the observer's duties and the penalties for not complying completely. (See fig D-4 for an example memorandum.)
- i.* The UPL will brief the Soldiers to be tested on the procedures for the test and who the observers will be. (See fig D-3 for an example briefing.)
- j.* If a Soldier to be tested arrives after the commander's and UPL's briefs have been conducted, the UPL or holding area NCO/officer will brief the Soldier.

4-12. Collection procedures

- a.* The complete list of collection procedures that will be followed by all components is explained in appendix D.

b. If a Soldier does not provide a specimen within a reasonable period of time, but not less than 3 hours, of reporting to the UA collection site, the commander may refer the Soldier for medical evaluation. If this occurs, the commander should ensure the Soldier is escorted to the MTF by a more senior Soldier. If the Soldier is determined to not have a medical condition precluding them from providing a specimen, the commander should consult with the servicing judge advocate for further guidance.

4–13. Post-collection procedures

a. If the UPL or observer suspects the Soldier adulterated the specimen, the UPL will secure the specimen bottle and its contents and complete the collection process, but will not release the Soldier. The UPL will have another observer or NCO notify the commander, and the UPL will explain the circumstances to the commander. The commander may order the tested Soldier to provide a probable cause specimen after consulting with the appropriate legal advisor. The UPL will collect this specimen under a separate chain of custody. The Soldier will remain in the holding area until the specimen is provided. If the UPL, not the observer, discovered the possible adulteration, the commander should replace the observer immediately for not properly observing the specimen collection, and contact the appropriate legal advisor for further guidance. The first specimen should be sent to the FTDTL for testing with a special request memorandum from the commander to test the specimen for validity. The second sample will also be sent to the FTDTL for testing.

b. When the DTC receives UA specimens, they will review the DD Forms 2624, unit ledgers, and specimen bottles for completeness and correctness. The DTC will also examine each specimen to ensure it contains at least 30ml of urine, does not appear to be adulterated, and has an intact tamper evident tape.

c. If the DTC finds a discrepancy, the DTC will correct it by creating a memorandum titled, “Certificate of Correction” (see fig D–1 for an example) that will explain the discrepancy, the circumstances, and the corrective action taken. All personnel involved, including the person(s) who made the error, must sign this certificate.

d. The DTC will, without exception, accept all specimens collected.

e. The DTC is not authorized to dispose of or have the UPL dispose of any specimens except as listed below:

(1) When the specimen cannot be identified as a unique specimen by the EDI–PI/SSN (for example, EDI–PI/SSN on bottle does not match EDI–PI/SSN on DD Form 2624 and cannot be verified).

(2) When the specimen bottle has two labels on it.

(3) The specimen is from the UPL who is turning in the specimen.

(4) When the unit ledger (testing ledger) is missing the Soldier’s or observer’s signatures.

(5) With approval from the installation SJA.

(6) At the time of collection, specimen was collected by a non-certified UPL.

f. The DTC will create an MFR to record the reason for any authorized disposal and include who authorized it by name and title.

g. All urine specimens will be forwarded to the supporting FTDTL using one of the following methods:

(1) United States Postal Service (USPS) by First Class Mail (official military mail).

(2) Hand-carried by surface transportation.

(3) Military aircraft transportation system.

(4) The U.S. flag commercial airfreight, air express, and airfreight forwarder (for example, Federal Express (FedEx) or United Parcel Service (UPS)).

(5) As a last resort, by foreign flag air carrier.

h. Drug and alcohol testing specimens are defined as “Exempt Human Specimens” by the international and domestic mail regulations and instructions. Package the specimens in accordance with instructions in USPS Publication 52, UN instruction PI650, or the carrier’s instructions meeting the US DOT 49CFR 173.134(B) (11) and International Air Transport Association instruction. Mark the package with hand written word or label stating “Exempt Human Specimen”.

i. If the UPL is deployed or is a reserve component UPL, whose unit does not have a DTC for post-collection quality control and inspection procedures, the UPL will perform the steps above.

4–14. Medical review officers and review of positive urinalysis drug testing results

a. This establishes policy for physicians, toxicologists, nurse practitioners, and physician assistants assigned duties as MROs in determining if a valid medical explanation exists for a positive UA drug test result. The medical review serves as a critical safeguard in the UA program to ensure that positive drug tests resulting from legitimate medications and foods are not misinterpreted as illegal drug use.

b. This applies to all physicians, physician assistants, and nurse practitioners as MROs, as well as to civilian and military forensic toxicologists that support the Army DTP. This applies only to military forensic drug testing.

- (1) The MEDCOM Program Manager for Forensic Toxicology will—
 - (a) Appoint in writing a doctorate level civilian and/or military toxicologist as an MRO consultant and subject matter expert.
 - (b) Appoint in writing a civilian and military forensic toxicologist(s) assigned to MEDCOM to serve as an MRO.
 - (c) Perform quality assurance (QA) reviews of all results reported to the DAMIS Web site.
 - (d) Maintain the master list of certified MROs.
 - (2) The MTF commander, Theater Senior Medical Officer, and MSC Commander will—
 - (a) Appoint on orders a qualified medical clinician meeting the requirements set forth in this regulation to serve as an MRO.
 - (b) Ensure that a sufficient number of MROs are appointed so that reviews are completed within 15 days for AD and 90 days for reserve component of receipt of laboratory result.
 - (c) Ensure that the MRO completes MEDCOM sponsored training and certification described in paragraph b. (3) (a.) and (b.), below, prior to performing any MRO review.
 - (3) The MRO will—
 - (a) Complete MEDCOM sponsored training and certification prior to performing any MRO review. There are two training options, both providing full certification. MROs may complete the web based training at <https://iftdtl.amedd.army.mil> or by attending the training onsite at the Army Medical Department Center and School (AMEDDC&S) held annually.
 - (b) Obtain and maintain MRO certification by completing training and passing the MRO examination. Certification must be renewed every 3 years. Retraining can be obtained by accessing the MRO Web training module and passing the examination.
 - (c) Review positive UA drug test results on Soldiers for the drugs that require an MRO review as required by DoD policy. For questions contact your local ASAP office, or the BAC manager.
 - (d) There is no requirement for the MRO to have a telephonic or in-person interview with the Soldier as long as the review can be resolved by reference to the Soldier's available medical record. Soldiers will be provided the opportunity to present evidence of legitimate prescription use if the electronic or hard-copy medical records show no explanation for the positive result. If an interview does occur with the Soldier, the MRO will advise the Soldier of their rights from DA Form 3881 (Rights Warning Procedure/Waiver Certificate).
 - (e) Findings will be updated in DAMIS for AD within 15 days and 90 days for Reserve Component by the MRO. MRO will obtain access and input results into DAMIS.
- c. Policies.
- (1) Appointed MROs must meet the requirements set forth in this regulation.
 - (2) The MRO will report findings using only the standard reporting language contained in chapter 14. The Web-based MRO reporting system in DAMIS will provide documentation and archival records of each MRO review. A QA review of electronically reported MRO results will be conducted by the MEDCOM Forensic Toxicology Program Office. If an issue is discovered during the QA review of MRO results, the Program Office will return the results with additional comments, and a corrected review may be required.
 - (3) In locations where access to DAMIS is not available, the MRO will maintain all documentation of completed medical reviews until it can be entered into DAMIS.
 - (4) MROs are directed to consider any legal prescription that explains the UA positive result for a controlled substance when evaluating "authorized use."
 - (a) A Soldier's use of their lawfully prescribed and dispensed medication, for medical purposes, after the prescription's expiration date, does not in itself constitute a violation of Art 112a, UCMJ and such use does not require an automatic "illegitimate use" finding under this regulation.
 - (b) An MRO determination of "authorized use" is an administrative action which does not preclude the MRO from communicating concern for controlled medication misuse to other providers or to commanders in accordance with Department of Defense Instruction 6490.08. MROs are also not precluded from communicating concern for harmful weight loss practices to other providers or to commanders in accordance with AR 600-9.
 - (c) Documentation of clinical actions taken should be made in the electronic medical record. Only the minimum necessary clinical information should be entered into DAMIS in order to evaluate the positive result. Excessive clinical documentation in DAMIS should be avoided.
 - (d) Use of cannabis products for medical reasons or by prescription will not constitute an "authorized use" under this regulation because military personnel at all locations are prohibited from using cannabis products regardless of state, district or territorial legislation. However, prescriptions for FDA approved medications that can cause THC positive results will be considered authorized use.

(e) The DOD expanded military drug testing of the more commonly abused prescription (controlled) drugs beginning with hydrocodone and hydromorphone, including oxycodone, oxymorphone, and selected benzodiazepines. While these powerful pain management drugs can alleviate suffering, they are potentially highly addictive and their use outside of medical supervision places the Soldier and those around them at risk. Soldiers who are using prescription (controlled) drugs that have not been prescribed or dispensed by their health care provider are encouraged to voluntarily seek medical treatment and rehabilitation for themselves in a military medical treatment facility on a self-referral basis prior to the initiation of testing for these drugs. Prescription (controlled) drugs are inappropriately used when they are used outside the directions given by the legally prescribing health care provider, or when a Soldier uses another individual's prescribed medications.

(f) Individuals who do not self-refer for treatment and are subsequently identified as positive for controlled substances for which they do not have a valid prescription may be considered in violation of the UCMJ for drug misuse/abuse. Prescription drugs are inappropriately used when they are used outside the directions given by the legally prescribing health care provider, or when a soldier uses another individual's prescribed medications.

d. Procedures.

(1) The MRO will receive a request for review from the ASAP office. At a minimum, the referral information will include the Soldier's DoD employee ID number, and the drug(s) which were identified as exceeding the established DoD cutoffs for the drug(s).

(2) Upon notification the MRO will review any medical evidence in the form of a prescription documented in an electronic health record system, in a hard copy medical record, on a prescription bottle, and/or a statement from the Soldier's physician or dentist documenting the drug prescribed/administered and the date of the medical or dental procedures. MROs in a deployed area may have difficulty obtaining medical documentation. It is acceptable for the MRO to request and obtain assistance from units in the rear to gather the required documentation. It is acceptable for command/medical staff members to gather the documentation needed for the MRO's evaluation in order to expedite the review of positive urine drug test findings.

(3) To expedite the review process, the MRO will attempt to complete the review using the medical information available without having to interview the Soldier. If it is not possible to determine whether or not the positive result is due to an authorized use, the MRO will conduct a telephonic or in-person interview with the Soldier; this interview will be scheduled through the Soldier's unit commander.

(4) When conducting a telephonic or in-person interview, the individual contacting the Soldier will advise the Soldier that the purpose of the interview is to determine if there is a valid medical reason for the positive UA drug test result. The MRO is an investigative officer, and there are no patient-physician privileges concerns in the MRO process. Therefore, the MRO will advise the Soldier of their rights listed on DA Form 3881 and then ask for medical information related to the positive UA drug test result. The MRO should document any comments made by the Soldier relating to the positive UA. Soldier's refusal to speak with the MRO or request for an attorney, information requested to evaluate the positive UA results such as a valid prescription or medical condition must be submitted to MRO within 30 days from date of request. The Soldier or his or her legal representative must provide medical review officer the required documents within 30 days. If no information is provided, the MRO will report use as "illegitimate."

(5) If attempts to contact the Soldier for the interview are not successful, the MRO will contact the Soldier's unit commander, and ASAP office or BAC manager. The MRO must document these attempts, to include the date, time, and method of attempted contact. If after 60 days, the Soldier has not been reached or has been reached but not interviewed due to no fault of the MRO, then the MRO may report the evaluation as "illegitimate use". If the Soldier comes forward at a later date with a valid prescription then the results can be changed to authorized use.

(6) The MRO will make a determination regarding the positive urine drug test result. The standard reporting language is—

(a) "EVALUATION COMPLETE - AUTHORIZED USE." The Soldier has a prescription(s) or valid medical explanation for a drug(s) that caused the positive UA result. Required fields to enter determination in DAMIS include: MRO Evaluation Result, Drug Prescribed, Prescription Date (must be prior to UA collection date), and MRO Evaluation Date.

(b) "EVALUATION COMPLETE - ILLEGITIMATE USE." The MRO did not find a prescription(s) or valid medical explanation for a drug(s) that would account for the positive UA test result. Required fields to enter determination in DAMIS include: MRO Evaluation Result and Comments.

(c) "EVALUATION INCOMPLETE- SOLDIER UNAVAILABLE." The Soldier is unavailable for any of the following reasons: AWOL, death, discharge, dropped from the rolls of the Army, expiration of term of service, incarceration, permanent change of station, deployed, or redeployed. Required fields to enter determination in DAMIS include: MRO Evaluation Result and Reason Soldier is Unavailable.

(7) The MRO will document the results of the review and provide comments in DAMIS.

4–15. Managing drug test results and medical reviews

a. The FTDTLs will post drug test results on the Web portal located at <https://ifdtl.amedd.army.mil>. The ASAP managers, DTCs, and BACMs will register with the Web portal to download the test results for their installation/state/MS/Command, and will then forward the test results to the respective commanders in a secure fashion that complies with the provisions of the Privacy Act and Health Insurance Portability and Accountability Act HIPAA. The commander will receive their unit results but should also designate another responsible individual in writing to receive the results for him or her as an alternate for the command if needed.

b. If there is a flaw in the specimen or the accompanying forms or package, the FTDTL will decide if the discrepancy makes the specimen non-testable. The FTDTL will not test a specimen with a fatal discrepancy because the discrepancy will prevent the specimen from being used as acceptable evidence during administrative or disciplinary proceedings. The FTDTL will test all nonfatal discrepancies. The FTDTL will record and post all discrepancies to its Web portal.

c. Both the ASAP and the FTDTL will maintain negative test results for 1 calendar year after the FTDTL reporting date and positive results for 3 calendar years after the FTDTL reporting date.

d. If the ASAP manager, DTC, or BACM receives a positive drug result that was posted to the FTDTL and requires a medical review, the ASAP staff will forward the result to the commander and the MRO. The MRO will make a determination of Authorized or Illegitimate Use and update DAMIS with their determination. In deployed areas, where the MRO is unable to access DAMIS, then a SF 513 (Medical Record - Consultation Sheet) will be forwarded to the unit servicing ASAP for input into DAMIS. This process should take no longer than 90 days for Reserve Component/deployed areas. The process to conduct MRO reviews is outlined in figure 4–1, below.

e. All Soldiers who test positive for illicit drug use must be evaluated by the BH clinic for a SUD evaluation. Soldiers receiving a positive UA test for an illicit drug that is determined to be authorized use by a MRO review do not require evaluation.

f. Before reporting a Soldier's positive UA results for illicit substances to their commander, the ASAP manager, DTC or BACM will review the Soldier's past UA results in DAMIS to determine if the Soldier has a previous positive UA results for illicit substances. The ASAP manager, DTC or BACM will notify the Soldier's commander of all positive UA results for illicit substance in the Soldier's career and any previous enrollments in the SUDCC for treatment that are in the Soldier's records.

The Medical Review Process

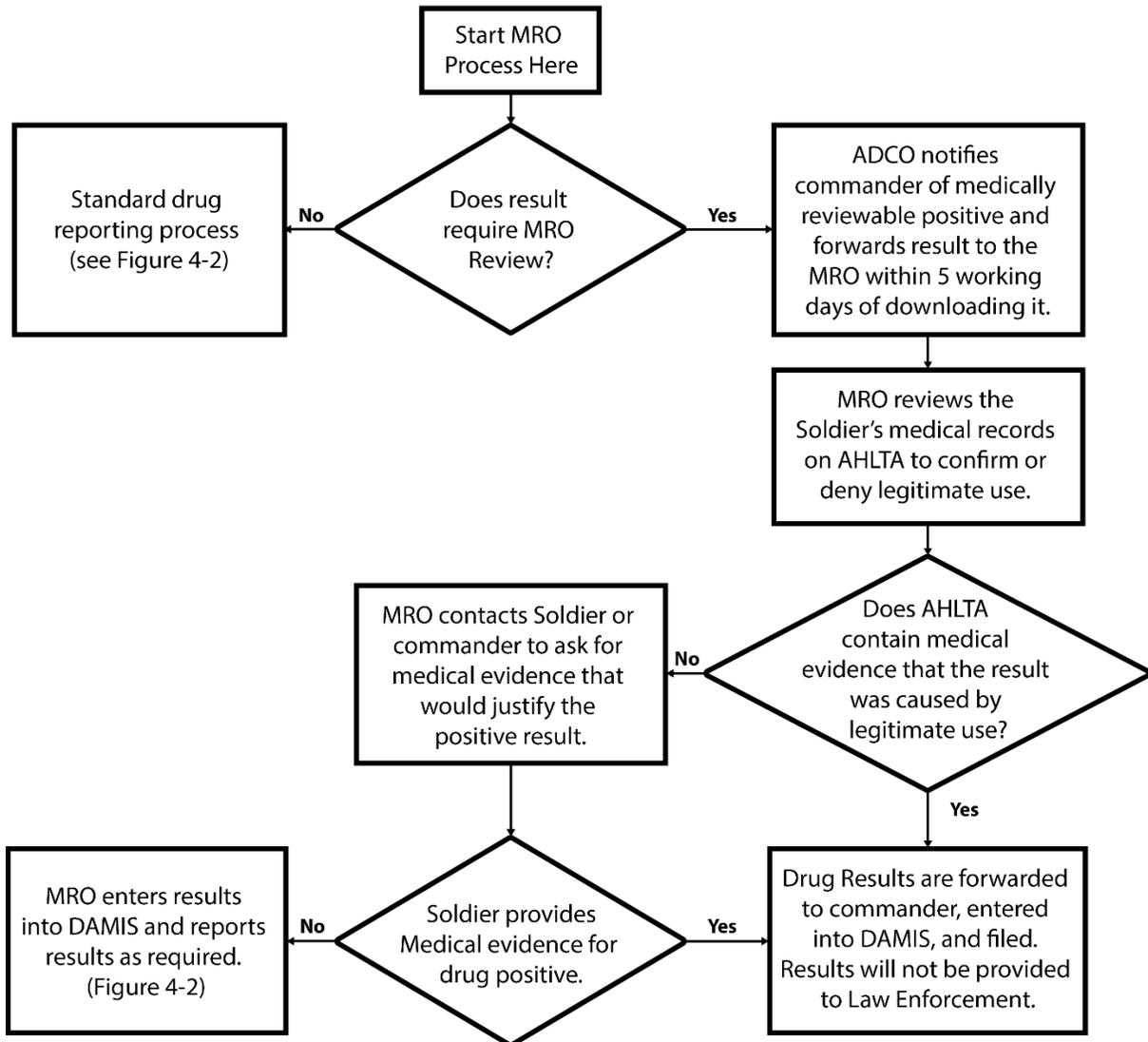


Figure 4-1. The medical review process

g. Each ASAP is also required to report positive UA results for illicit substances (except rehabilitation and competence for duty test basis) directly to their supporting CID office. Data of positive UA results that require a MRO evaluation will only be released to CID if the MRO determines the results to be illegitimate use. Results determined to be legitimate medical use will not be released to CID. The ASAP will only provide CID and/or Office of the Provost Marshal General with the BAC, UIC, EDI-PI, laboratory accession number, specimen collection date, specimen laboratory report date, test basis, and the illicit drug(s) used. Individual Soldier drug testing and treatment histories will not be provided to law enforcement (see fig 4-2). The DD Form 2624, and MRO report from DAMIS or SF 513 will not be released to CID by ASAP staff.

The Drug Result Reporting Process

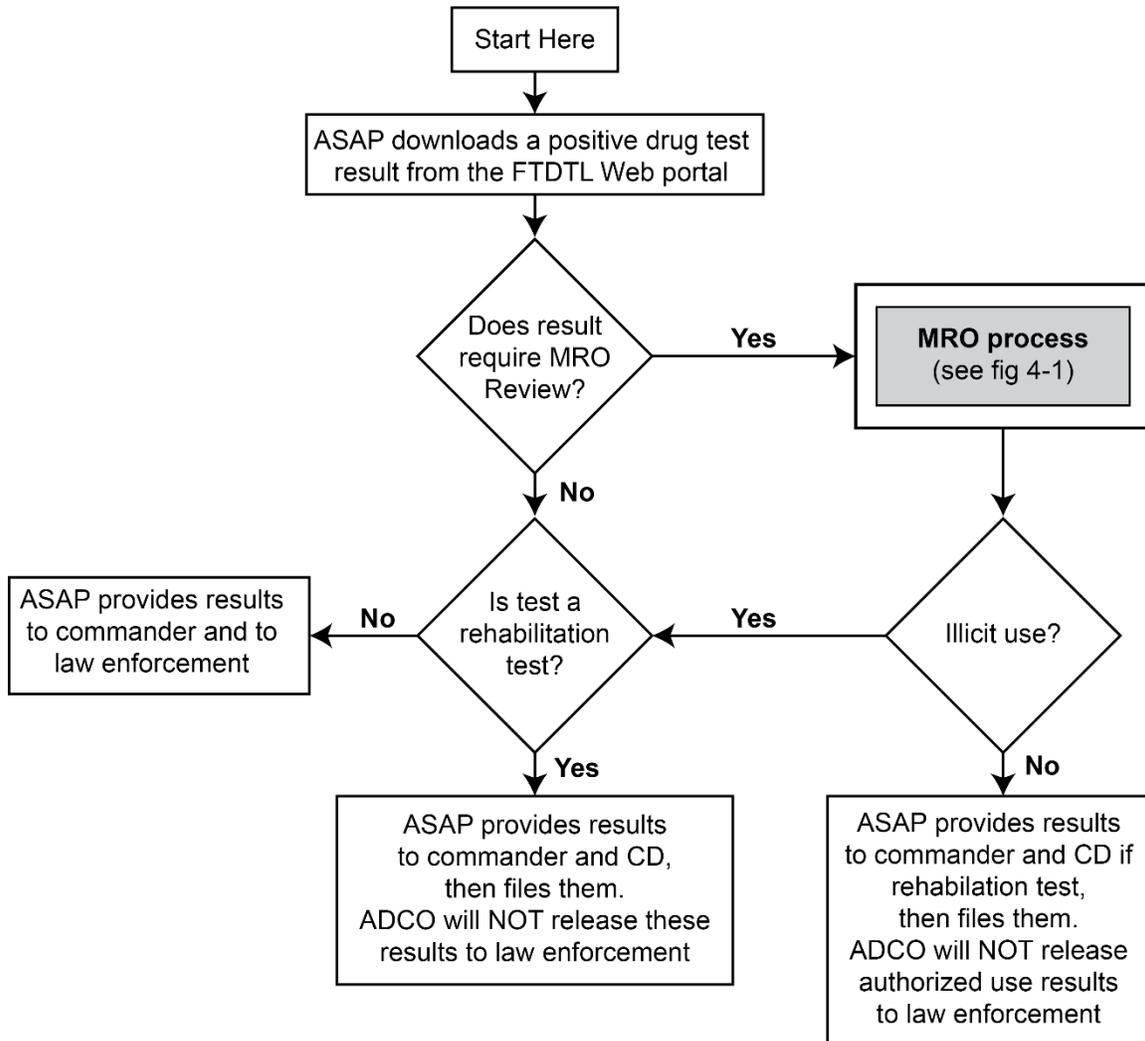


Figure 4–2. The drug result reporting process

4–16. Inspections

a. Internal and external inspections of units and the military DTP will ensure the integrity of the system and increase the program’s deterrent effect.

b. Required inspections of the military DTP:

(1) The ASAP manager will inspect the DTCP operations quarterly using at least 25 percent of the ARD DTC inspection checklist.

(2) The installation or command safety officer will inspect the DTCP and review the DTCP safety SOP annually.

(3) The installation or command physical security officer will inspect the DTCP biennially for compliance (see <https://asap.army.mil>, and appendix E) and any applicable local regulations.

(4) The DTC will inspect and document the inspection of every battalion-level unit biennially.

(5) The BPL or their alternate will inspect and document inspections of company-level programs annually.

(6) The ARD will conduct an evaluation plan of the core functions of drug testing annually.

(7) Army FTDTLs will be inspected three times a year and will be certified annually in accordance with DoDI 1010.01 and DoDI 1010.16. An ARD representative will periodically accompany the inspection team.

4-17. Statistical management

a. To assess and manage the garrison ASAP services, the ASAP manager must collect, maintain, and analyze ASAP statistics, but must also be careful to prevent the disclosure of personal information to unauthorized personnel. The ASAP manager will use ASAP service statistics to—

(1) Brief leaders at all levels about the status of their programs and highlight issues (for example, drug abuse trends, testing rates, discrepancy rates, and so forth) that need the commanders' attention.

(2) Brief UPLs about common collection and processing issues.

(3) Modify, as needed, the local ASAP training methods or channels for disseminating prevention information and materials.

b. The DTC will maintain the following statistics:

(1) Testing days and weeks of the month by all units.

(2) Total military specimens collected by each unit for each reason for testing (IR, IU, and so forth).

(3) Discrepancy rate for the installation by unit including both FTDTL fatal and nonfatal discrepancies and DTC voids.

(4) Positive rate, by drug, for each unit and the installation.

(5) Certification dates for primary and alternate DTCs.

(6) Proof of local or DA training for additional personnel working within the DTCP.

(7) The UPL certification and recertification records.

4-18. Physical security

a. Once the UPL accepts a complete specimen from the Soldier, the specimen chain of custody begins. This chain of custody must remain continuously and forensically intact until the specimen's testing is complete at the FTDTL.

b. Proper physical security and storage of urine specimens at all levels are essential to ensure the integrity of the DTP. UA specimens will be secured using the minimum security standards for evidence storage as outlined in appendix E. Unused specimen bottles and cups must also be secured (see para 4-24).

4-19. Retesting specimens

a. Positive urine specimens may be retested if a sufficient quantity of the specimen is available and a written request for retesting is submitted by—

(1) The unit commander, the MRO, or an attorney representing the Soldier.

(2) The Soldier whose specimen tested positive, but only through their commander or attorney.

(3) Request by the president or recorder of an administrative board.

(4) An order of a court-martial or request made pursuant to the rules for court-martial.

b. A Soldier whose urine has tested positive for illicit drugs may obtain a retest at any DoD FTDTL, at no cost to the Soldier, when a sufficient quantity of the specimen is available for retesting. Only an aliquot of approximately 1-2 milliliters will be released for such testing. The original specimen and bottle will be maintained at the original DoD laboratory. The specimen must be forwarded using a chain of custody procedure and by a method that ensures the Government is not obligated to pay for the testing if the specimen is sent to a commercial laboratory.

c. A Soldier whose urine has tested positive for illegal drugs may obtain a retest at a commercial laboratory (Substance Abuse and Mental Health Service Administration approved) outside the DoD laboratory system at the Soldier's own expense when a sufficient quantity of the same specimen is available for retesting.

4-20. Requesting urinalysis documents

a. Personnel identified below may request FTDTL documents pertaining to positive UA results to use in connection with adverse administrative or disciplinary actions. All requests must identify the documents requested and must be submitted through the unit commander to the FTDTL that performed the UA. Documents will be furnished at no expense upon—

(1) Request of the installation or unit commander, a SJA office, the tested Soldier, or the tested Soldier's attorney.

(2) Request by the president or recorder of an administrative board.

(3) An order of a court-martial or request made pursuant to the rules for court-martial.

b. Documents which may be obtained from the FTDTL are a "Commander's Packet" (which includes items (1) and (2), below) or a "Documentation Packet" (which includes items (1) through (6), below). Other documents should be requested through normal military legal channels. Items available are:

(1) An affidavit cover sheet certifying the test procedures used and results found for the Soldier's specimen.

(2) Photocopy of the installation chain of custody documents with certified results.

(3) Photocopy of the intra-laboratory chain of custody documents.

- (4) A description of the analytical methodology.
 - (5) Results of the analysis of the Soldier's specimen.
 - (6) Quality control data corresponding to the Soldier's specimen.
- c. The provisions 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.

4-21. Drug testing Program software

All Army units are required to use the DoD-developed Drug Testing Computer Program as their predominant method for selecting Soldiers for testing and preparing the required testing forms and labels. Units should submit at least 95 percent of their UA specimens using the DoD DTP software.

4-22. Maintaining Drug testing Program records

ASAP files must be maintained in accordance with the Army Records Information Management System (ARIMS) which is governed by AR 25-400-2. This refers to the DD forms 2624s (Specimen Custody document – Drug Testing) and the testing ledgers will be filed per this system.

4-23. Pre-service use of drugs

a. Drug dependent persons, current problematic substance users, and persons whose pre-service drug abuse indicates a tendency to continue abuse should not be permitted to enter the Army. Recruiting procedures will include positive measures to identify and screen out problematic substance users at the point of application for enlistment, appointment, or commission. Any applicant for the Army who has a positive UA during the application process for any branch of Service at a Military Entrance Processing Station should be permanently disqualified for enlistment eligibility unless granted a waiver by the Commander, U.S. Army Recruiting Command or the Director, Army National Guard.

b. Individuals convicted of a pre-service drug-related offense are processed within the same guidelines reflected in Army enlistment policy for processing applicants with other types of criminal convictions.

c. Prior to enlistment, appointment, or induction, every officer and enlisted accession will be informed about the Army's DTP as outlined in paragraphs 4-1 and 4-2.

d. Commanders will evaluate, on a case-by-case basis, Soldiers who admit to pre-service drug abuse after denying such abuse at the time of entry. Commanders may discipline or process for separation these Soldiers for administrative separation for fraudulent enlistment. Soldiers who would otherwise have met acceptance criteria at induction may be retained with approval of the separation authority.

4-24. Drug testing supplies

a. Commanders will maintain enough drug testing supplies on hand to test 100 percent of their unit strength.

b. Installation ASAPs should maintain enough drug testing supplies to last for at least 30 days at normal consumption rates, based on demand history, in order to maximize commanders' drug testing throughout the deployment support cycle, and mitigate disruptions in the supply chain. DTCs should resupply units based on the number of specimens they turn in. UPLs must avoid supply activities that may tip off a test, such as walking through the unit area with the supplies they just received from the DTC.

c. The complete list of drug testing supplies is in appendix E.

d. Specimen collection bottles and specimen cups must be accounted for and stored in a secured facility to prevent wrongful use and to maintain the integrity of the specimen collection vessels.

Chapter 5

DA Civilian Employee Drug Testing

Section I

Army's Civilian Drug testing Program

5-1. Purpose

The Army's Civilian DTP contributes to the accomplishment of the Army's mission and the safety of the entire workforce. This chapter specifies policies of the ASAP pertaining to DA Civilians. Additional instructions and procedural guidance are provided in DA Pam 600-85.

5–2. Background

On 15 September 1986, Executive Order (EO) 12564 established the foundation for a DFW. This EO directed Federal agencies to develop a plan for achieving a DFW, while upholding the rights and protections afforded to the Government, the workforce, and the general public. In support of EO 12564, the Army implemented its civilian employee DTP.

5–3. Policy

a. Drug testing of DA Civilian employees for the purpose of gathering evidence for use in criminal proceedings will not be conducted under this regulation.

b. Any attempt by DA Civilian employees to defeat the Army’s DTP (for example, by substituting or diluting urine, chemically altering, modifying or adulterating one’s own urine, or using a device to do any of the above acts) or assisting another person who is attempting to do the same, is expressly prohibited and is a violation of this regulation. Personnel in violation of this provision will be subject to the full range of disciplinary or administrative actions, as appropriate.

c. Employees in and applicants for TDPs under DHHS and DOT rules will only be drug tested using the split-sample collection procedure.

d. In order to meet DoD guidance testing will be conducted at 50 percent per fiscal year. For an effective deterrence program random testing should be conducted monthly.

Section II

Drug-Free Workplace Program

5–4. Objectives

The goal of the Army’s DFWDTP is to ensure that Army workplaces are safe, healthful, productive, and drug-free. To achieve this goal, the Army has implemented drug testing programs for DA Civilian employees. The objectives are to:

a. Assist in maintaining public health and safety, the protection of life and property, national security, and law enforcement.

b. Deter substance abuse.

c. Identify illegal substance users.

d. Assist employees who are seeking treatment for drug use.

e. Assist in determining fitness for appointment or retention of TDPs.

5–5. Applicability

EO 12564, which established the goal of a DFW, contains provisions related to drug testing programs for civilian employees and job applicants.

5–6. Categories of Drug-free workplace drug testing

To achieve the objectives in paragraph 5–4, six categories of drug testing have been established pursuant to EO 12564. These categories are (refer to DA Pam 600–85 for detailed definitions of DFW drug testing categories)—

a. Reasonable suspicion testing.

(1) For DA Civilian employees in TDPs (see para 5–8 regarding TDPs): When there is a reasonable suspicion that a TDP employee may have used illegal drugs, whether on or off duty.

(2) Any DA Civilian employee not in a TDP: Reasonable suspicion testing may also be required of any employee in any position where there is a reasonable suspicion of on duty use or impairment.

b. Injury, accident, or unsafe practice testing. Employees may be subject to testing when there is an examination authorized by an appropriate installation or activity commander regarding an accident or unsafe practice. Accordingly, employees may be subject to testing when, based on the circumstances of the accident, their actions are reasonably suspected of having caused or contributed to an accident that results in death or personal injury requiring immediate hospitalization or in damage to Government or private property estimated to be in excess of \$20,000.

c. Voluntary testing. When an employee volunteers for drug testing, the employee will become part of a separate testing pool for volunteers, who will be randomly tested.

d. Follow-up testing. As a follow-up to treatment.

e. Applicant testing. A negative test is required prior to appointment to a TDP. (Applicant testing of non-TDP selectees is prohibited.)

f. Random testing. On a random basis after appointment to a TDP. Random drug testing will use a scientifically valid system of selecting a portion of a testing pool without individualized suspicion that a particular individual is using illicit drugs. Each employee will have an equal chance of being selected for drug testing each time this type of testing is conducted.

Note: Rehabilitation testing is not a DFW drug testing category. Rehabilitation urine testing of civilian employees or any person eligible for civilian EAP services will not be provided by the ASAP drug testing staff. Rehabilitation testing services for these populations may be provided at the discretion of the local MTF or at the expense of the individual through a private source. To ensure quality assurance, any testing performed must be done through a DHHS approved lab.

5–7. Drugs for which testing is conducted

The FTDTLs will test UA specimens of civilian employees in TDPs for validity and the drugs specified in the DHHS directive then in effect.

5–8. Drug Free Workplace Testing Designated Positions

a. Positions described by EO 12564 as sensitive positions are called TDPs (see EO 12564, Section 7, para (d)). Provided below are the sensitive positions or categories of positions that involve law enforcement, national security, the protection of life and property, or public health or safety, or other functions requiring a high degree of trust and confidence, which have been identified as TDPs across the Department of the Army. These positions have duties and responsibilities, which are consistent with the parameters established by the DHHS and the Office of National Drug Control Policy.

b. Employees in these TDPs are subject to random testing, which occurs without suspicion that a particular individual is using illegal drugs:

- (1) Positions which authorize the incumbent to carry firearms.
- (2) Positions which require the incumbent to operate a motor vehicle transporting one or more passengers on routine basis.
- (3) Operators of motor vehicles who are required to have a commercial driver's license and—
 - (a) Who drive motor vehicles weighing more than 26,001 pounds (Class A).
 - (b) Who drive motor vehicles designed to transport more than 16 passengers.
 - (c) Who drive motor vehicles that transport hazardous material.
- (4) Positions which require the incumbent to maintain a top secret clearance or have access to sensitive compartmented information in the performance of their duties.
- (5) Railroad operating crews and railroad personnel in positions in which duties include handling train movement orders, conducting safety inspections, or the maintenance and repair of signal systems.
- (6) Aviation flight crewmembers, air traffic controllers, and aviation personnel in positions in which the duties include dispatching, safety inspections, or the repair and maintenance of aircraft.
- (7) Substance Use Disorder (SUD) provider positions in which the incumbent provides direct rehabilitation and treatment services to identified alcohol or illegal drug abusers.
- (8) The PRP positions (biological duty positions, nuclear duty positions, or chemical duty positions) under the provisions of AR 50–1, AR 50–5, or AR 50–6.
- (9) Positions which require duties involving the supervision or performance of controlling and extinguishing fires, and/or rescuing of people endangered by fire.
- (10) Positions which require the handling of munitions or explosives in connection with the manufacturing, maintenance, storage, inspection, transportation, or demilitarization of these items.
- (11) Positions which require the incumbents to electroplate critical aircraft parts.
- (12) Front line law enforcement personnel with drug interdiction duties who have access to firearms.
- (13) Healthcare positions with the following job titles in the following job series where the incumbents either:
 - (a) are directly involved in patient care in which the incumbent has direct patient contact or performs diagnostic testing or therapeutic functions; or
 - (b) are directly involved in patient care in which the incumbent is required to extract or work with patient's blood, urine, and other bodily fluids or tissues; prepare patient specimens for examination; perform specialized or non-routine test on patients, bodily fluids or tissue samples; or confirm patients' test results; or
 - (c) in which the incumbent maintains, stores, safeguards, inputs, fills, or distributes drugs and medication—
 1. 0602 Physicians.
 2. 0603 Physicians Assistants.

3. 0610 Registered Nurses.
4. 0620 Licensed Practical Nurses/Licensed Veterinary Nurses.
5. 0621 Nursing Assistants.
6. 0633 Physical Therapists.
7. 0640 Health Technicians.
8. 0642 Nuclear Medical Technicians.
9. 0644 Medical Technologists.
10. 0645 Medical Technicians.
11. 0647 Diagnostic Radiation Technicians/Technologists).
12. 0648 Therapeutic Radiation Technicians/Technologists).
13. 0649 Medical Instrument Technicians.
14. 0651 Respiratory Therapist.
15. 0660 Pharmacists.
16. 0661 Pharmacy Technicians.
17. 0662 Optometrist.
18. 0668 Podiatrists.
19. 0680 Dentists.
20. 0681 Dental Technicians.
21. 0682 Dental Hygienists.

(14) Certain Biological PRP positions.

(a) Positions in the Biological Reliability Program with the following job titles and in the following series, when the incumbents require unsupervised access to biological restricted areas:

1. 0018 Safety and Occupational Health Management.
2. 0080 Security Administration.
3. 0086 Security Assistant.
4. 0301 Administrative Management.
5. 0801 General Engineer.
6. 0802 Engineering Technician.
7. 0830 Mechanical Engineer.

(b) Positions in the Biological Reliability Program with the following job title and in the following series, when the incumbents require unsupervised access to Biological Select Agents and Toxins: 2001 Supply Specialist.

(c) Positions in the Biological Reliability Program with the following job titles and in the following series, when the incumbents require unsupervised access to biological containment conditions:

1. 0401 Biological Scientist.
2. 0403 Microbiologist.
3. 0404 Biological Science Technician.
4. 0405 Pharmacologist.
5. 0414 Entomologist.
6. 0415 Toxicologist.
7. 0602 Medical Officer.
8. 0644 Medical Technologist.
9. 0646 Pathology Technician.
10. 0701 Veterinary Medical Science.
11. 0704 Animal Health Technician.
12. 1301 Physical Scientist.
13. 1311 Physical Science Technician.
14. 1320 Research Chemist.
15. 1910 Quality Assurance.
16. 5048 Animal Caretaker.

(15) Positions involving Overhead Cranes. Positions in the following pay plans/job series, where the incumbent operates, inspects, maintains, repairs, or rigs loads for, overhead cranes with a lifting capacity of twenty (20) tons or greater:

- (a) WG-5725.
- (b) WG-3359.
- (c) WG-5350.
- (d) WK-5401.

5–9. Identification of additional Testing Designated Positions

Procedures for requesting additional positions which commanders want to designate as a TDP are provided in DA Pam 600–85.

5–10. Testing Designated Positions within the U.S. Army Corps of Engineers

The approved TDP positions specific to the U.S. Army Corps of Engineers are as follows:

- a.* Positions that require the incumbent to operate any surface vessel, whether powered or not, including dredging equipment, in which the duties include operating, navigating, steering, directing, or sailing the vessel, operating the engines of a vessel while underway, or operating the spud(s) (anchor(s)) on a dredge.
- b.* Positions that require the incumbent to operate navigational locks for passage of marine surface traffic or that involve dispatching and clearing marine surface traffic in and out of narrow ship canals, to include marine traffic controllers.
- c.* Positions that require the incumbent to operate flood control gates to control water levels on waterways, to include dam operators.
- d.* Positions that require the incumbent to operate a water treatment plant to produce potable water for community and government use in which the duties include laboratory testing of water samples or the introduction of potentially hazardous chemicals and compounds into the water in the course of treatment.
- e.* U.S Army Corps of Engineers activity must be prepared to coordinate to test for reasonable suspicion, to conduct follow up testing, and test volunteers.
 - (1) Designation of the activity DTC, by name, title series, grade/rank, and telephone number must be appointed.
 - (2) A verified TDP list must contain the name, EDI–PI, gender, position title, series, pay plan (for example, GS) and supervisor.
- f.* Ensure to all employees the availability of a certified employee assistance professional (CEAP) emphasizing employee education, counseling, and referral to rehabilitation/treatment services.
- g.* Provide a safe harbor for any employee who voluntarily admits his or her drug use.

5–11. Civilian employees in critical safety or security positions

- a.* Refer to AR 380–67 and/or the supporting security office for guidelines on suspending access to classified information and/or reporting information to the U.S. DoD CAF for drug or alcohol related issues.
- b.* For detail concerning the Biological Surety Personnel Reliability Program, Chemical Surety Personnel Reliability Program, and the Nuclear Surety Personnel Reliability Program refer to AR 50–1, AR 50–5, and AR 50–6. The SUD staff should be familiar with their PRP responsibilities identified in AR 50–1, AR 50–5, and AR 50–6.
- c.* The SUD provider must ensure that potentially disqualifying information related to a PRP civilian employee’s participation in SUD evaluation and subsequent treatment will be made available promptly to the PRP certifying official for consideration. The results of a drug test of a civilian employee may only be disclosed with the employee’s written consent unless otherwise authorized under PL 100–71, Section 503(e).
- d.* Before PRP certification, all DA Civilian employees must submit to a UA for illegal drug use.

5–12. Drug testing coordinator qualifications, training, and certification

Since DTCs who conduct civilian drug testing collections perform duties that are crucial to the integrity and success of the ASAP, they must be very carefully selected, trained, and certified to perform their duties. On installations, DTCs are normally the DTC and an alternate DTC; however, other personnel may also serve as DTCs as long as they meet the requirements specified in chapter 9. DOT Split Sample Urine Collectors will be certified in accordance with DOT rules. DOT Split Sample Urine Collector certification is valid for 3 years.

5–13. Pre-collection procedures for random Testing Designated Positions testing

- a.* The DMO selects the testing date and the number of TDPs to test. This may be delegated to the DTC, but the DMO must still order the test.
- b.* The DMO randomly selects the personnel to be tested. The DMO may delegate this responsibility to the DTC. When conducting a random test, the DMO should use the DoD DTP, or another similar computer program, to randomly select the personnel in civilian TDPs to be tested. DMOs may use alternative selection methods, but whatever method the DMO uses must be provided for in writing in the installation or command substance abuse program SOP. Personnel in TDPs who are selected, but are not available for a random test, must be tested within 5 working days of their return or during the next random UA after their return.
- c.* The DMO or designee notifies the supervisors of the TDP personnel selected for the test to tell their selected employees to report to the UA collection site within 2 hours of notification. Notification of TDPs to report for testing

must be made verbally; written notification can also be provided to the employee but this will not be done in lieu of the verbal notice.

d. The DTC sets up the collection site area, preferably in a non-carpeted area, as close to the latrines as possible. The testing area should be a controlled area where only testing and ASAP personnel are present.

e. The DTC inspects the latrine(s) before the collection to remove any possible adulterants and to eliminate access to any sources of water. The DTC will ensure that testing personnel have soap and paper towels to wash their hands in full view of the DTC before and after providing a specimen.

f. The DTC sets up the holding area near the DTC's desk. Non-testing personnel are barred from the holding area. The DTC should provide water or other fluids in the holding area, and civilian employees who are unable to provide a specimen should drink 8 ounces of fluids every half hour, not to exceed 40 ounces. Civilian employees will remain in the holding area until they are ready to provide a specimen.

5–14. Collection procedures

The DTC will meet all the collection requirements prescribed by the DHHS Mandatory Guidelines for Federal Workplace DTPs. Collection procedures are provided in detail in the Urine Specimen Collection Handbook for Federal Workplace DTPs prepared by the DHHS Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention, and which is available at <https://www.samhsa.gov/sites/default/files/specimen-collection-handbook-2014.pdf>.

a. Generally, the individual to be tested will be permitted to provide a urine specimen privately in a restroom or similar enclosure so that the employee is not visually observed while providing a specimen. The DTC may collect the specimens of employees of both genders. If the DTC is not the same gender as the individual providing the specimen, the DTC will not enter the restroom during the actual collection, but will ensure the restroom is ready to be used prior to the collection and will listen for any indication that the individual being tested is attempting to adulterate their specimen.

b. Criteria for conducting an observed collection are provided in the Urine Specimen Collection Handbook for Federal Workplace DTPs and are always performed by a collector of the same gender as the employee. When an observed collection has to be conducted, the DTC will notify the supervisor that a situation exists that requires a direct observed collection, document/describe the situation, and provide a copy to the ASAP manager. If the employee refuses to undergo an observed test, the DTC will notify the supervisor by preparing a MFR concerning the refusal, and follow the guidelines in the DHHS handbook.

c. The supervisor directs the DA Civilian employee selected for the test to report to the UA collection site within 2 hours of notification; those individuals offsite locally must report to the collection site no more than 6 hours after notification. If a DA Civilian employee does not provide a specimen to the UA collection site, the DTC should follow the procedures in the DHHS Urine Specimen Collection Handbook.

5–15. Post-collection procedures

a. If the DTC suspects a civilian employee has adulterated, substituted, or diluted their specimen, the DTC will follow the procedures outlined in the DHHS Urine Specimen Collection Handbook. Other unusual circumstances are also covered in this handbook.

b. The DTC may pack several different donors' specimens into the same package for shipment to the FTDTL. The DTC will ensure the outermost package that contains civilian employee UA specimens has the red and white "CIVILIAN" label provided by the FTDTL at Ft. Meade, MD applied to it. For complete packaging instructions, see DA Pam 600–85.

c. All UA specimens will be forwarded as soon as possible to the FTDTL at Ft. Meade, MD using one of the following methods:

- (1) U.S. Postal Service by first class mail.
- (2) Hand-carried by surface transportation.
- (3) Military aircraft transportation system.
- (4) U.S. flag commercial airfreight, air express, and airfreight forwarder (for example, FedEx or UPS).
- (5) As a last resort, by foreign flag air carrier.

5–16. Medical review and reporting of drug-free workplace test results

a. The medical review serves as a critical safeguard in the UA program to ensure that positive drug tests resulting from legitimate medications and foods are not misinterpreted as illegal drug use. All laboratory results (positives and negatives) are forwarded to the MRO for review according to DHHS Mandatory Guidelines for Federal Workplace DTPs; refer also to DA Pam 600–85.

b. General medical review and reporting procedures and instructions for the MRO are provided in the DHHS MRO Manual for Federal Agency Workplace DTPs.

c. Retest procedures will follow the DHHS MRO Manual for Federal Agency Workplace DTPs.

(1) If employee initiates a retest, the MRO must request the retest, which may be performed at the Fort Meade, MD FTDTL or at any other National Laboratory Certification Program certified drug testing laboratory at no cost to the employee.

(2) For MRO-initiated retests, the MRO will not report the original test results to the installation until results from the retest are received; however, for employee-initiated retests, the MRO will report the results of the original test immediately.

d. All civilian employee tests will be reviewed by the centralized MRO unless the Commander, MEDCOM approves an exception in coordination with the Director, ARD. The ASAP office will maintain DoD CAFs and test results for 1 calendar year after the FTDTL reporting data and positive results for 3 calendar years after the FTDTL reporting date.

5–17. Statistical management

a. To assess and manage the program, the ASAP manager must collect, maintain, and analyze ASAP statistics, but must also prevent the disclosure of personal information to unauthorized personnel. The ASAP manager will use these statistics to—

(1) Brief leaders about the status of their programs and highlight issues (for example, drug abuse trends, testing rates, discrepancy rates, and so forth) that need commanders' or supervisors' attention.

(2) Modify, as needed, the local ASAP training methods or channels for disseminating prevention information and materials.

b. The DTC will maintain the following statistics:

(1) Number of TDPs by category.

(2) Number of TDP specimens collected per reason for test.

(3) Number of other DA Civilian employees (non-TDP) tested per reason for test.

(4) The TDP positive rates by drug.

(5) The TDP discrepancy rate.

(6) The TDP testing rate.

5–18. Refusal to test

When a civilian employee refuses to provide a lawfully-directed UA or alcohol breathalyzer test, the employee may be subject to administrative or disciplinary action. (See paragraph 10–31.)

5–19. Disciplinary and adverse actions

In accordance with DoDI 1010.09, any civilian employee found to be using illegal drugs or to be impaired by alcohol while on duty may be subject to disciplinary action. See paragraph 10–31.

5–20. Suspension from Testing Designated Positions and Personnel Reliability Program positions

When a civilian employee receives a confirmed positive test for illegal drugs, the employee's supervisor will consult with the CPAC and servicing legal office prior to suspending the employee from TDP duties or access to classified information pending a determination under AR 380–67. If the employee is in a PRP position, the supervisor will promptly notify the certifying official and suspend the employee from the PRP in accordance with AR 50–1, AR 50–5, or AR 50–6, pending a final determination of administrative action.

5–21. Deployed drug testing

a. Commanders will maintain their substance abuse programs to the maximum extent practical while deployed, which includes the random drug testing of civilian TDP employees within the command.

b. Commanders will not endanger civilian safety and security in deployed areas solely to conduct drug testing.

c. The BACM of any deployed unit that includes DA Civilian employees in TDPs will coordinate the following with the ARD:

(1) Training and certification for CSP to collect UA specimens from TDP personnel randomly selected for testing.

(2) Civilian employee collection kits, custody, and DoD CAF and other required supplies.

(3) The BAC to use for testing.

(4) Results reporting.

- (5) The MRE procedures.

Section III

Department of Transportation Drug and Alcohol Testing Program

5–22. Objectives

The DOT DTP is designed to help prevent accidents and injuries resulting from the misuse of alcohol or the use of controlled substances by drivers of commercial vehicles. Refer to DA Pam 600–85.

5–23. Applicability

The DOT rules at 49 CFR Part 382 applies to DA Civilian employees who operate a commercial motor vehicle in commerce in any State and who are subject to the commercial driver’s license requirements of 49 CFR Part 383.

5–24. Safety-sensitive functions

The DOT regulations define a safety-sensitive function at 49 CFR 382.107. (Refer to DA Pam 600–85 for a list of the functions performed by drivers while on duty that are considered to be safety-sensitive.)

5–25. Department of Transportation prohibitions and consequences

- a.* The DOT regulations establish prohibitions in 49 CFR Part 382, Subpart B.
- b.* The consequences for drivers engaging in substance use-related conduct are provided in 49 CFR Part 382, Subpart E. Drivers who engage in prohibited conduct must be immediately removed from safety-sensitive functions and cannot resume such duties unless the requirements for referral, evaluation and treatment under 49 CFR 382.605 have been met. Additionally, supervisor/managers having actual knowledge that a violation has occurred are prohibited from permitting the driver to perform or continue to perform safety-sensitive functions. (See DA Pam 600–85 for additional guidance regarding the consequences of engaging in prohibited conduct.)

5–26. Department of Transportation categories of drug and alcohol testing

- a.* Civilian employees to whom DOT regulations apply are subject to testing under circumstances described in 49 CFR Part 382, Subpart C. These include the following six bases for drug testing: pre-employment drug testing only; post-accident testing; reasonable suspicion testing; random testing; follow-up testing; and return-to-duty testing. While similar to the DFW drug testing categories listed in paragraph 5–6, DOT categories have different requirements (see DA Pam 600–85 for more information).
- b.* The applicability of drug testing requirements under the DOT regulations does not exempt an employee from the requirements for testing under the auspices of the DHHS DFW regulations when applicable.

5–27. Department of Transportation testing procedures and required education and training

- a.* Civilian drivers to whom DOT rules apply are subject to the testing procedures identified in 49 CFR Part 40.
- b.* The DOT regulations require supervisor training and driver education. Requirements are in 49 CFR 382.601 and 382.603.

5–28. Department of Transportation frequency of random alcohol and other drug testing

Random testing of drivers for alcohol and other drugs will occur at the minimum rates published in the Federal Register annually.

5–29. Specimen collection for Department of Transportation drug testing

Personnel who collect UA specimens from DA Civilian employees who are drug tested under DOT regulations perform duties that are crucial to the integrity and success of the ASAP. They must be very carefully selected, trained, and certified to perform their duties. On installations, these DOT drug test collectors are normally the DTC or an alternate DTC; however, other personnel may also collect DOT-regulated UA specimens as long as they meet the requirements specified in chapter 9. The collector must successfully complete required training and have met all the collection requirements prescribed by the DOT regulations at 49 CFR Part 40, Subpart B.

5–30. Medical review and the reporting of Department of Transportation drug test results

a. The medical review serves as a critical safeguard in the UA program to ensure positive drug tests resulting from legitimate medications and foods are not misinterpreted as illegal drug use. All laboratory results (positives and negatives) are forwarded to the MRO for review.

b. Qualifications, duties, and responsibilities of the MRO are contained in 49 CFR, Part 40. (The DA Pam 600–85 contains medical review reporting procedures and additional instructions.)

5–31. Alcohol testing

The IBAT will have been trained to proficiency in the operation of the evidentiary breathalyzer testing and/or the non-evidentiary breathalyzer testing used at the installation and the alcohol testing procedure in 49 CFR, Part 40.

5–32. Substance abuse professional evaluation, referral, and follow-up

The MTF SAP will evaluate any employee/driver who violated a DOT regulation associated with abuse of substances (illegal drug, controlled drug, or alcohol). If the SAP determines the employee/driver needs assistance, the SAP will recommend a course of treatment and refer the individual to an appropriate rehabilitation/treatment resource. DOT rules also require such an employee will be subject to unannounced follow-up alcohol and drug testing. Evaluation, referral, and follow-up requirements are provided in 49 CFR 382.605. Additional guidance is provided in the DOT SAP Procedures for Transportation Workplace Drug and Alcohol Testing Programs. (See DA Pam 600–85 for instructions for the EAP.)

5–33. Department of Transportation reporting requirements

a. Each Army installation, ARNG, and USAR should prepare and maintain an annual fiscal year summary of the results of its DOT alcohol and other drug testing programs. The information required is found in 49 CFR 382.403.

b. Each installation ASAP manager will ensure that the Form DOT F 1385 (U.S. Department of Transportation Drug and Alcohol Testing MIS Data Collection Form) is completed no later than the 28th of each month. Test data are to be maintained for at least 5 years.

c. ASAP managers of installation, ARNG and USAR commands will support the annual summary report by promptly forwarding the annual completed Form DOT F 1385 to the Director, ARD no later than 1 March of each year. The Director, ARD will summarize and analyze the data and forward a completed report to the Department of Health and Human Services and to Office of the Secretary of Transportation, Drug Enforcement and Program Compliance.

5–34. Statistical management

a. To assess and manage the program, the ASAP manager must collect, maintain, and analyze ASAP statistics, but must also prevent the disclosure of personal information to unauthorized personnel. The ASAP manager will use these statistics to:

(1) Brief leaders about the status of their programs and highlight issues (for example, drug abuse trends, testing rates, discrepancy rates, and so forth) that need commanders' or supervisors' attention.

(2) Modify, as needed, the local ASAP training methods or channels for disseminating prevention information and materials.

b. The DTC will maintain the following statistics:

(1) Number of personnel tested under DOT rules.

(2) Number of DOT UA specimens collected per reason for test.

(3) Number of alcohol breath tests conducted per reason for test.

(4) The DOT positive rates by drug.

(5) The DOT discrepancy rate.

(6) The DOT testing rate.

Chapter 6

DA Civilian Employee Army Substance Abuse Program Services

This chapter specifies policies of the ASAP pertaining to DA Civilians. (See chapter 7 for DA Civilian eligibility for SUD treatment.) (Additional instructions and procedural guidance are provided in DA Pam 600–85.)

6-1. General

- a.* Substance abuse is inconsistent with the high standards of performance, discipline, and readiness necessary to accomplish the Army's mission. The Army's goal is to provide a safe, healthful, productive, and secure workplace.
- b.* DA Civilian employees should take a proactive approach when dealing with substance abuse or other personal problems that affect their ability to perform their jobs or impact their well-being.
- c.* This chapter specifies policies of the ASAP pertaining to DA Civilian employees in appropriated and non-appropriated fund positions. (Additional instructions and procedural guidance are provided in DA Pam 600-85.)

6-2. Policy

- a.* Reducing or eliminating alcohol and/or drug misuse or abuse creates safe, healthful, productive, and secure workplaces.
- b.* DA Civilian employees must refrain from alcohol abuse while on duty and must refrain from illegal drug use. Substance abuse is inconsistent with the high standards of performance, discipline, and readiness necessary to accomplish the Army's mission.
- c.* All employees share the responsibility in reducing or eliminating substance abuse in the workplace.
- d.* Supervisors will consult early with CPAC when suspected problematic substance use, or other related problems may adversely affect an employee's job performance, behavior, and conduct in the workplace.
- e.* Supervisors will be encouraged to consult with the EAP coordinator, who helps employees with problems that may affect their job performance, attendance, and/or conduct. (EAP procedures are provided in DA Pam 600-85.)
- f.* DA Civilian employees eligible to receive EAP services will receive screening/assessment and/or referral services for treatment of problematic substance use and personal problems that may affect their job performance and/or well-being.
- g.* The SUDCC services will be offered to those eligible for healthcare in the military healthcare system.
- h.* Civilian employees will receive care at the MTF or a referral will be given based on space availability.
- i.* An employee's Family will be involved in treatment if appropriate and if the employee agrees to and signs releases of information for such involvement.
- j.* DA Civilian employees may be granted leave or approved absence to obtain evaluation and treatment in accordance with existing civilian personnel regulations and local union agreements.
- k.* Performance plans will not mention current or past treatment for SUD.
- l.* For further DoD EAP guidance regarding the DoD civilian employee Drug-Free Workplace Program refer to DoDI 1010.09.
- m.* Adolescent Family members of Soldier and civilian employees in Outside Continental United States (OCONUS) locations will be provided Adolescent Support and Counseling Services (ASACS) through a DoDEA school.

6-3. Purpose of the Employee Assistance Program

The Army's EAP includes a wide variety of services for various problems. These services are provided to promote productivity, reduce absenteeism, enhance job performance and/or wellbeing, and support worksite safety, in order to ensure the Army's mission is accomplished in an efficient manner.

- a.* EAP services include, but are not limited to, screening/assessment, short-term counseling, and referral for problems that may affect job performance and/or wellbeing (see DoDI 1010.09 for further guidance).
- b.* EAP services offer employees and supervisors guidance, consultation, mediation, and prevention education which promotes employee productivity and wellbeing. Supervisory services of consultation and mediation are provided to guide employees and managers in resolving issues that may impact the productivity of the civilian workforce.
- c.* Referral or short-term counseling assistance to Family members of DA Civilian employees is provided to help resolve personal concerns and enhance the employee's ability to perform their work duties.

6-4. Referral

Supervisors and management will refer to EAP those DA Civilian employees whose job performance, conduct, or attendance records may be indicative of personal problems requiring professional assistance.

- a.* EAP services are available on a voluntary basis for all eligible populations served, to include DA Civilian employees referred by supervisors due to job performance, conduct, or other work-related issues, such as a supervisor's suspicion that the employee is abusing drugs or alcohol. Refer to paragraphs 3-10 and 10-31 for special circumstances involving employees who are found to have used illegal drugs or to be impaired by alcohol while on duty.

b. With certain exceptions related to illegal drug use, supervisors will not use the employee's refusal of EAP assistance or the outcome of services rendered as the basis for taking disciplinary action. For exceptions, refer to section III of chapter 3 and paragraph 10–31.

c. Supervisors must base their disciplinary decisions and actions on the employee's job performance and/or conduct issues.

d. Supervisors should inform all DA Civilian employees who display performance and/or conduct issues that the EAP may help them address personal problems that may have the potential to affect performance and conduct.

e. Supervisors will promote EAP services as a benefit of employment. These services are not limited to worksite-related problems. (See DA Pam 600–85 for evaluation and referral procedures by the EAP coordinator.)

6–5. Family member services

Family members may participate in all aspects of the ASAP, except drug testing, within capabilities of existing resources and to the extent they are eligible under paragraph 1–9. Adolescent Family members of Soldiers and civilian employees in OCONUS locations will be provided by ASACS as directed in paragraph 6–2*m*. ASACS are provided in OCONUS DoD and designated schools with counselors available and located in these schools. Administrators, teachers, family members and students are made aware of services during student orientations and school handbooks.

6–6. Conflict of interest—Employee Assistance Program coordinator and civilian drug testing issues

At installations where the EAP coordinator is a separate position from other drug testing roles (ASAP manager, DTC, and so forth), EAP coordinators will not take part in the selection or collection process of civilian employee testing in support of the DFW to include DOT testing or the initial reporting of test results. It is a conflict of interest for the EAP coordinator to conduct these activities or to have the ability to determine testing dates for affected civilian employees. At installations where the EAP coordinator is combined with other drug testing roles (ASAP manager, DTC, and so forth) the ASAP will develop a mechanism whereby an SJA-approved neutral witness observes the selection method in accordance with DHHS guidelines for random civilian drug testing. The neutral witness must not be part of the testing pool to ensure neutrality. EAP coordinators will inform TDP of the provision of paragraph 6–7*c* at the initial intake session when reviewing the limits of confidentiality.

6–7. Confidentiality of civilian client records and information

a. The confidentiality and disclosure of records of the identity, diagnosis, prognosis, prevention, or rehabilitation of any client maintained in connection with a Federal substance abuse program is controlled by 42 USC 290dd-2 and 42 CFR Part 2. Generally, disclosure of such records is prohibited except under the following circumstances:

- (1) The client has consented in writing in accordance with 42 CFR Part 2, Subpart C.
- (2) Records are released to medical personnel to the extent necessary to meet a bona fide medical emergency.
- (3) Records are released to qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation. But such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.
- (4) If authorized by an appropriate order of a court of competent jurisdiction.

b. An employee does not have to be enrolled in the program in order to be protected by the provisions of 42 USC 290dd-2 and 42 CFR Part 2, as long as the employee is considered a "patient". A "patient" is defined in 42 CFR 2.11 as "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at federally assisted program." The act of requesting an assisted program for an alcohol or drug abuse problem places the individual under the protection of these laws.

c. The confidential nature of counseling records of civilian employees with alcohol or other drug problems will be preserved according to applicable laws, rules, and regulations. In situations where a TDP employee discloses to the EAP coordinator the current use of illegal drugs or significant alcohol abuse, and the employee has not given written permission to disclose the information, the EAP coordinator must consult with the installation ASAP manager and the servicing legal office without releasing identifying information of the TDP employee for guidance regarding disclosure to the supervisory chain for purposes of determining temporary abeyance of TDP duties.

d. During the initial encounter with EAP the client will be notified of the Federal confidentiality requirements and will be given a written summary of the Federal laws and regulations. A sample notice can be found in 42 CFR 2.22.

e. Clients may have access to their own records, including an opportunity to inspect and copy any records that the program maintains about the client. A client's written request for such access, although not required to obtain records, is encouraged.

f. Civilian EAP and SUD records will be maintained in accordance with 42 CFR 2.16; 49 CFR Part 382; AR 25–400–2; and the EAP coordinator Guidebook. EAP files will be maintained at the ASAP for a period of 5 years after file closure in accordance with the ARIMS under Record Retention Number RN 600-85a2.

g. The Privacy Act of 1974 (As Amended) (5 USC 552a) also applies to all information maintained in a system of records retrievable to an employee’s name or other personal identifiers.

h. SUD counseling records of any civilian will meet the requirements of AR 40–66 and the HIPAA.

i. The SUD clinical records for civilian employees will be maintained separate from other clinical records. EAP files will be maintained and secured (for example, in a secure room, locked file cabinet, or safe) separate from other administrative files.

6–8. Confidentiality of alcohol and drug test results

a. Release of alcohol and/or drug test results is governed by provisions of The Privacy Act of 1974 (As Amended) (5 USC 552a), and DOT regulations. Public Law 100–71, Section 503 (e) (5 USC 7301 note) further restricts the release of drug test results.

b. The results of a drug test of a civilian employee may not be disclosed without prior written consent of the employee, unless the disclosure would be—

(1) To the employee’s MRO.

(2) To the administrator of any EAP in which the employee is receiving counseling or treatment or is otherwise participating.

(3) To any supervisory or management official in the employee’s agency having authority to take adverse personnel action against the employee.

(4) Pursuant to the order of a court of competent jurisdiction where required by the Government to defend against any adverse personnel action.

c. The FTDTL will release drug test results only to the MRO.

d. Alcohol and other drug test results may be released to appropriate Army personnel for data collection and other purposes consistent with PL 100–71, Section 503(f); DOT regulations on controlled substances and alcohol abuse and testing; the DHHS Mandatory Guidelines for Federal Workplace DTPs; and other DA requirements. The disclosure may not include personal identifying information on any employee.

e. In accordance with DOT regulations, employees subject to DOT regulations are entitled, upon written request, to copies of and access to records relating to the employee’s use of alcohol or controlled substances, including records pertaining to their alcohol and controlled substance abuse test.

f. In accordance with PL 100–71, Section 503, Federal employees are entitled, upon written request, to have access to any records pertaining to their test and any records relating to the results of any relevant laboratory certification, review, or revocation of certification proceeding.

Chapter 7

Identification, Referral for Treatment

Generally, this chapter applies to Soldiers. It applies to DA Civilian employees and Family members where specifically noted.

7–1. Overview

The Army recognizes that SUDs are often preventable and treatable. While self-referral is preferred, commanders are also responsible for identifying Soldiers at risk for a SUD and for referring them to the BH clinic for a SUD evaluation and actively supporting intervention and treatment as clinically indicated. SUD treatment determinations, including level of care needed, will be made by the treating provider for the SUD treatment services.

a. *Alcohol.* Soldiers with alcohol-related discipline events (DUI, assault, UCMJ, and so on) or those identified by the commander as abusing alcohol will be referred to BH for a SUD evaluation.

b. *Other Substances.* All Soldiers, to include ARNG and USAR Soldiers ordered to AD under Title 10, who are identified as having unauthorized use of substances or suspected substance abuse, will be referred to the BH clinic for a SUD evaluation.

7–2. Methods of identification

a. Early ID is a critical aspect of the SUD evaluation process and occurs through a variety of methods—

(1) Voluntary (self) ID.

(2) Command ID.

- (3) Drug testing ID.
 - (4) Alcohol testing ID.
 - (5) Medical ID.
 - (6) Investigation/apprehension.
 - (7) Other, for example Family Advocacy Program.
- b. Commands will identify Soldiers at risk for having a SUD based upon evidence provided by these methods.

7–3. Voluntary (self) identification and referral

a. Voluntary (self) ID is the most desirable method of identifying substance use disorder. The individual whose performance, social conduct, interpersonal relations, or health becomes impaired because of these problems has the personal obligation to seek help. The Soldier's unit commander must become involved in supporting voluntary help seeking and early ID of problematic substance use. Command policies will encourage Soldiers and DA Civilian employees to voluntarily seek assistance and will avoid actions that would discourage these individuals from seeking help. Soldiers may initially request help from their commander, primary care provider, chaplain, any officer or NCO in their chain of command, or other agencies. Soldiers seeking self-referral for problematic substance use may access services through BH services for a SUD evaluation. The Limited Use Policy exists to encourage Soldiers to proactively seek help.

b. In situations where a Soldier reveals to a chaplain or chaplain assistant that they have or have had an alcohol or other drug use problem, confidential communication could limit a chaplain from notifying a Soldier's unit commander. However, the Soldier may waive the communication privilege and allow the chaplain to inform the unit commander. If the Soldier does not waive their privilege, the chaplain will inform the Soldier that treatment for a SUD is available through the BH clinic.

c. Identification resulting from a Soldier seeking emergency treatment for an actual or possible alcohol or other drug overdose, not subsequent to a traffic accident or criminal offense, is considered to be a variation of voluntary (self) ID, and therefore, the limited use policy will apply. For reporting purposes, such cases will be classified as self-referral.

d. Civilian employees will be offered screening/assessment, short-term counseling and referral for SUD treatment services, if eligible to receive care at the MTF, or to rehabilitation/treatment programs off the installation (see chapter 6). Supervisors will follow procedures outlined in DA Pam 600–85.

e. Military Family members will receive substance use disorder treatment services within their assigned MTF; if space is not available, a referral to the network for appropriate level of care will be given.

f. Commander/supervisor ID occurs when a commander/supervisor observes, suspects, or otherwise becomes aware of an individual whose job performance, social conduct, interpersonal relations, physical fitness, or health appears to be affected adversely by suspected problematic substance use. Soldiers who are identified with possible problematic substance use will be processed by their unit commander or designated representative in accordance with AR 600–85 using DA Form 8003 and referred to the BH clinic for a SUD evaluation. All referrals made with a DA Form 8003 will have a SUD evaluation performed by the BH clinic. If mandated treatment for SUD is required, the recommended frequency, length of counseling sessions, and level of treatment will be shared with the commander to solicit support.

7–4. Drug testing identification

a. Drug testing ID is accomplished through UA, which is discussed in detail in chapter 4 for Soldiers and in chapter 5 for civilian employees.

b. Any Soldier identified with a verified drug positive requires a mandatory command referral to the BH clinic for a SUD evaluation within 5 duty days of receipt of the validated positive drug test results. When this ID method applies, the commander will describe the Limited Use Policy to the Soldier. The DA Form 8003 will be marked with reason for command referral as bio-chemical.

c. Any civilian employee identified with a verified drug positive requires a mandatory referral to the EAP for an assessment.

7–5. Alcohol testing identification

a. Alcohol testing ID is accomplished through alcohol breathalyzer or blood sample alcohol testing which is discussed in chapter 3 of this regulation.

b. Any Soldier on duty whose alcohol breathalyzer or blood sample alcohol test result indicates alcohol impairment as discussed in paragraph 3–2 requires a mandatory command referral to the BH clinic for a SUD evaluation within 5 duty days of receipt of the test result.

c. When this ID method applies, the commander will describe the Limited Use Policy to the Soldier and refer the Soldier to the BH clinic for a SUD evaluation using the DA Form 8003 form as soon as possible. The DA Form 8003 will be marked with reason for referral as bio-chemical.

d. Any civilian employee subject to the DOT breath testing for employees performing duties requiring a commercial driver's license will require a mandatory referral to the ASAP EAP for screening/assessment and referral to the installation SAP if the confirmed alcohol test result is 0.04 percent or higher. Supervisors will follow procedures outlined in DA Pam 600–85, if confirmed alcohol test is 0.02 percent or higher.

7–6. Investigation/Apprehension testing identification

a. A Soldier's problematic substance use may be identified through military or civilian law enforcement investigation and/or apprehension. The unit commander will refer the Soldier for a mandatory command referral to the BH clinic for a SUD evaluation within 5 duty days of notification of apprehension. Referral for evaluation or treatment does not interfere with or preclude pending legal or administrative actions.

b. When this ID method applies, the commander will describe the Limited Use Policy to the Soldier and refer the Soldier to the BH clinic for a SUD evaluation using the DA Form 8003 as soon as possible. The DA Form 8003 will be marked with reason for referral as investigation/apprehension.

7–7. Medical identification

a. During routine or emergency medical treatment, health care providers may note problematic substance use. In such instances, health care providers will refer the Soldier to the BH clinic for a SUD evaluation. If a Soldier reveals abuse of substances (illegal drug, controlled drug, alcohol or other) to a health care provider, the health care provider will refer to BH for a SUD evaluation, if necessary. The revelation of problematic substance use, by itself, will not subject the individual to adverse administrative action. UA which may follow such disclosure will be covered under the Limited Use Policy. When this ID method applies, the commander will describe the Limited Use Policy to the Soldier as soon as possible and support the medical referral of the Soldier to the BH clinic for a SUD evaluation. The health care provider will provide information about the Soldier's alleged problematic substance use immediately to the Soldier's commander, should it appear that any of the following conditions exist:

- (1) The Soldier is acutely impaired.
- (2) Impaired judgment is evident.
- (3) Potential danger to others exists as a result of problematic substance use (for example, Chemical or Nuclear Surety Programs, flight crews).
- (4) Problematic substance use impacts the Soldier's judgment, reliability, or trustworthiness to protect classified information.

b. If a health care provider notes problematic substance use during routine or emergency medical screening of a civilian employee or Family member, the health care provider will recommend the individual for referral to BH for a SUD evaluation.

c. The evaluation, ID, and referral of health care providers with abuse of substances (illegal drug, controlled drug, alcohol or other) related problems are very sensitive issues. Health care providers are responsible for helping to identify and refer any colleague whose performance is impaired by alcohol or other drugs to the Impaired Health Care Provider Program. All health care providers will be responsible for reporting any problematic substance use concerns to the Impaired Health Care Provider Committee or chain of command. The medical health authority will manage the potentially impaired provider through the Impaired Health Care Provider Committee. When this ID method applies, the medical commander will describe the Limited Use Policy to the healthcare provider as soon as possible and support the medical referral of the Soldier to the BH clinic for a SUD evaluation.

Chapter 8

Types of Substance Use Disorder Treatment

The procedures described below are meant to assist commanders in distinguishing between mandatory enrolled substance abuse treatment and voluntary alcohol-related treatment by behavior healthcare. Soldiers who meet the criteria in paragraph 8–2a are required to enroll and participate in mandatory substance use disorder (SUD) treatment.

8–1. Types of Substance Use Disorder Treatment Services

a. Failure to progress in mandatory treatment continues to serve as a basis for administrative separation. The evaluation for mandatory treatment must include collateral information, as appropriate, and involve command consultation as permitted by DoDI 1010.04 to support the Soldier's treatment needs, including level of care.

b. Voluntary Alcohol-Related Behavioral Health Care. Soldiers who do not meet the criteria for mandatory enrolled SUD treatment described in paragraph 8–2*b* may voluntarily receive alcohol-related behavioral healthcare without enrollment in mandatory substance abuse treatment. Before the start of voluntary alcohol-related behavioral healthcare, Soldiers will be informed of the criteria for command notification and enrollment in mandatory SUD treatment.

8–2. Criteria of Substance Use Disorder Treatment Services

a. Criteria for Mandatory SUD Treatment. Behavioral health providers will conduct a complete clinical assessment to determine that a substance use disorder diagnosis is present. The Soldier will be enrolled in mandatory SUD treatment, with notification to the Soldier’s command, when any of the following conditions are present:

(1) The Soldier has a substance use disorder diagnosis related to illegal drug use, including illegal use of prescription drugs.

(2) The Soldier’s abuse of substance (alcohol) is identified through military or civilian law enforcement investigation and/or apprehension, and/or an alcohol breath or blood test indicates alcohol impairment while the Soldier is on duty, and a diagnostic assessment confirms the presence of a substance use disorder.

(3) The Soldier is receiving more extensive treatment than standard outpatient behavioral healthcare, including an addiction medicine intensive outpatient program, a partial hospitalization program, an inpatient program, or a residential treatment program.

(4) The Soldier’s substance use affects his or her judgment, reliability, or trustworthiness, or presents a clear risk to safety, security, occupational functioning, or mission. Providers will notify commanders of any concerns related to safety and/or mission readiness consistent with command notification requirements for other behavioral health conditions, in accordance with DoDI 6490.08. Commanders are responsible for notifying their security managers when these conditions arise, in accordance with DoDI 1010.04 and AR 380–67.

b. Criteria of Voluntary Alcohol-Related Behavioral Health Care. Alcohol-related behavioral healthcare will follow the procedures applicable to all other types of behavioral healthcare. The Soldier will be eligible to receive voluntary alcohol-related behavioral healthcare when the behavioral health provider conducts a complete clinical assessment and determines that an alcohol-related behavioral health condition is present, but the Soldier does not meet any of the criteria for enrollment in mandatory SUD treatment described in paragraph 2*b*. In addition, the following procedures and guidelines apply:

(1) The components of the behavioral healthcare treatment plan, such as frequency and type of visits, will be tailored by the healthcare provider in collaboration with the Soldier and to meet the Soldier’s clinical needs.

(2) If at any time a Soldier receiving voluntary alcohol-related behavioral healthcare meets any of the criteria for enrollment in mandatory SUD treatment as described in paragraph 8–2*a*, the provider will notify the Soldier’s commander and the Soldier will be enrolled in mandatory SUD treatment.

(3) Voluntary alcohol-related behavioral healthcare will not prevent subsequent placement in mandatory SUD treatment.

(4) Discontinuation of voluntary alcohol-related behavioral healthcare for any reason will not be considered a rehabilitation (treatment) failure. A history of voluntary alcohol-related behavioral healthcare, including discontinuation of this care, cannot be used as a basis for administrative separation.

c. Personnel actions. Soldiers in any type of SUD care, whether voluntary or mandatory, are subject to any personnel action their commander deems appropriate, except as noted in paragraph 8–2*b*(4).

8–3. Rehabilitation team meeting

a. Rehabilitation team meetings (RTMs) are required for all Soldiers enrolled in mandatory SUD treatment and their commander or command representative is required. Although an in-person RTM is frequently valuable in the treatment process, especially initially, a telephonic RTM is sufficient to satisfy this requirement except for in the following circumstances:

(1) Recommendation for referral to an Addiction Medicine Intensive Outpatient Program (AMIOP) or a SUD Residential Treatment Facility.

(2) If at any time a Soldier receiving voluntary care for a SUD meets any of the criteria for Mandatory Care, the provider will notify the Soldier’s commander to initiate enrollment. This includes any concern related to safety and/or mission readiness, consistent with command notification requirements for other BH conditions.

b. Soldiers in voluntary care could benefit from commander or supervisor support or input on an informal basis and are encouraged, though not required, to include them in their treatment process.

c. Any re-assessment that results in changing the level of care from voluntary non-enrolled status to mandatory enrolled status (for example, if a Soldier progresses to moderate or severe diagnosis or is involved in a substance-related indiscipline incident).

8–4. Mandatory command notifications

a. *Safety.* The command must be directly notified if at any time a Soldier is determined to be a threat to self or others.

b. *Missed appointments.* The clinical provider should immediately notify the commander or first sergeant when a Soldier “no-shows” for their appointment if in the “enrolled in mandatory treatment” category.

c. *Active intoxication or impairment.* The command must be notified and a command escort must be requested to be sent to the MTF if at any time it is suspected that a Soldier is actively intoxicated or impaired.

d. *Poor treatment adherence.* The clinical provider should notify the command if a Soldier who is enrolled in mandatory treatment fails to substantially comply with their treatment plan. Treatment noncompliance may be grounds for a separation under Chapter 9 of AR 635–200. This will be communicated to commanders through a DA Form 3822 (Report of Mental Status Evaluation), which will include a brief treatment synopsis. Officer separations will be processed in accordance with the provisions of AR 600–8–24 and AR 135–175.

Chapter 9 Prevention, Education, and Training

Section I

General

9–1. Alcohol, other drug abuse, and gambling disorder prevention, education, and training objectives

a. The objectives of alcohol, other drug abuse and gambling disorder prevention are to:

- (1) Prevent, deter, and reduce alcohol, other drug abuse, and gambling disorder.
- (2) Provide commanders, Soldiers, DA Civilian employees and Family members with substance abuse and gambling disorder prevention and awareness training as requested, to include at a minimum the following:
 - (a) The ASAP policies and services.
 - (b) Consequences of alcohol, other drug abuse and gambling disorder.
 - (c) Incompatibility of alcohol, other drug abuse, and gambling disorder with readiness, physical and mental fitness, Army Values, and the Warrior Ethos.

b. All professional staff (program specific staff, SUD, MROs, and UPLS) must train, sustain, and improve their skills, proficiency, and professionalism through:

- (1) Initial education and training courses.
- (2) Certification courses.
- (3) Professional development training programs.
- (4) Support and encouragement for the professional certification of PCs and EAP coordinators.

9–2. Policy

a. Prevention includes all measures taken to deter and reduce the abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder to the lowest possible level.

b. Prevention efforts are targeted to the total force and tailored to diverse groups and integrated with other mission-related efforts.

c. Prevention initiatives will emphasize cooperation and partnerships with the installation and local communities. Military are encouraged to get involved in the local civilian community efforts to prevent or reduce abuse of substances (illegal drug, controlled drug, alcohol and other) and gambling disorder.

d. Education and training programs must include information on the effects and consequences of abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder. These programs must also include information describing abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder services that are available at the installation and/or community.

e. Alcohol de-glamorization is an essential element of the Army prevention program. Marketing and promotion of practices which glamorize alcohol use are prohibited. All members of the military community will be provided with the information needed to make responsible decisions about personal use of alcohol.

f. Total Force is provided information to identify abuse of substances (illegal drug, controlled drug, alcohol or other) or gambling disorder. Commanders and supervisors are provided tools and skills to enable early ID of signs and symptoms of these problems.

g. Education on abuse of substances (illegal drug, controlled drug, alcohol or other) or gambling disorder will be conducted throughout the Army Training System.

h. Education on abuse of substances (illegal drug, controlled drug, alcohol or other) or gambling disorder will be compatible with the indoctrination of recruits in the standards of discipline, performance, and behavior.

i. Leaders will support prevention efforts on abuse of substances (illegal drug, controlled drug, alcohol or other) or gambling disorder to maintain readiness.

j. ARD will develop prevention products for the Total Force installation. Training products will be updated periodically.

Section II

Army Substance Abuse Program Staff and Unit Prevention Leader Training, Professional Development, and Certification

9–3. Department of the Army sponsored Army Substance Abuse Program staff training

a. The Director, ARD is responsible for developing the professional development training of the ASAP installation staff and will manage lifecycle training through the DA Civilian Training and Education Development System.

b. The Director, ARD is the proponent for ASAP manager, EAP coordinator, PC, RRPC, DTC and UPL training, and will develop a budget for all installation training requirements, with input from the HQ, IMCOM. The Director, ARD will publish a training schedule annually, which includes complete course descriptions and eligibility criteria.

c. The installation commander is responsible for resourcing the professional development training of all ASAP installation positions.

d. The ASAP personnel will attend additional appropriate professional development training as directed by IMCOM, Talent Management.

9–4. Army Substance Abuse Program staff training certifications

a. Professional and Army certifications—

(1) Establish a minimum level of competency for quality service provided by ASAP staff members and UPLs.

(2) Assure professional development for PCs, RRPCs, EAP coordinators, and suicide prevention program managers, Prevention certification is recommended for these positions, but not required as a condition of employment..

(3) Give professional recognition to assigned positions.

b. Army Substance Abuse Program (ASAP) Managers. The ASAP Manager will attend the ASAP Program Manager course within the first year of assuming the ASAP Manager duties, and must complete the refresher course every 3 years thereafter.

c. Newly hired EAP coordinators must attain CEAP status through the Employee Assistance Certification Commission established by the Employee Assistance Professionals Association within 3 years of assuming their duties.

(1) This requirement will be written into the employee's job description and be a condition of employment.

(2) Individuals will be responsible to apply for certification and training and for maintaining all professional development requirements once they are certified. This requirement will be clearly posted in all vacancy announcements for EAP coordinator positions.

(3) EAP coordinators who fail to obtain their certification within 3 years of starting in that position or who fail to maintain their EAP certification may be subject to administrative action and/or removal from these positions.

(4) ASAP Managers are encouraged to gain CEAP certification status.

(5) The EAP coordinators, who transfer to another installation and are hired as an EAP coordinator with no break in EAP coordinator service, are bound by the EAP coordinator certification start date at their first installation. The requirement to obtain certification within 3 years from the date of employment at the first installation will remain in effect.

d. The DTCs will be free of administrative proceedings and must not have had a drug or alcohol-related incident within the last 3 years. DTCs who are not certified must work under the daily direct supervision of a certified DTC. Using noncertified DTCs jeopardizes the credibility of the Army's DTP. If the installation or command does not have a certified DTC, UPLs will ship their units' specimens directly to the FTDTL for testing or the ASAP manager may request an exception to policy from the Director, ARD.

(1) Primary and alternate DTCs must be certified through the DA DTC Certification Course within 9 months of assuming their duties.

(2) Primary and alternate DTCs must be recertified every 3 years.

(3) The requirement to obtain and maintain DA DTC certification will be written into the employee's job description and be a condition of employment.

(4) DTCs who fail to obtain their certification or fail to maintain their certification may be subject to administrative actions and removal from these positions.

(5) The DTCs should attend a course of instruction that teaches proper instructional methods and skills.

(6) The ASAP managers should gain and maintain DTC certification.

(7) Additional personnel working in the Drug Test Collection Point that are not the primary or alternate DTCs will have documented training by a certified DTC and be under the direct supervision of that DTC.

(8) An ASAP manager may temporarily restrict a DTC from handling UA specimens because of an alcohol or drug-related incident or pending legal or administrative proceedings until a final determination has been made. Where the DTC is a civilian employee, the ASAP manager must first coordinate with the servicing CPAC.

9-5. Battalion/Unit Prevention Leader qualifications, training, and certification

UPL certification is crucial to the Army's DTP and unit substance abuse prevention efforts. All UPLs, regardless of component, must receive the same standardized curriculum and be certified to perform their duties. The BPL qualifications, training, and certification are the same as those for UPLs; where UPL is used in this paragraph, it applies to both UPLs and BPLs, unless otherwise stated.

a. Qualifications—military personnel.

(1) Be an officer, warrant officer, or NCO (E-5 or above for UPL, E-5 promotable or above for BPL) (recommend E-7 or above at all levels).

(2) Be designated on appointment orders by the unit commander.

(3) Successfully complete ARD standardized UPL-CTP prior to collecting any drug testing specimens.

(4) Not currently enrolled in mandatory SUD treatment.

(5) Not be under investigation for legal, administrative, or abuse of substances (illegal drug, controlled drug, alcohol or other) related offenses or incident within the last 3 years. Soldiers that have previously been in SUD treatment or completion of ADAPT should not be considered as potential UPLs for at least 36 months after release from counseling or completion of ADAPT.

(6) Commanders should request a local review of the UPL candidate's medical, personnel, and criminal records and a background check by the garrison/local ASAP for past drug positive UA test and by the MTF BH clinic for past enrollment in mandatory alcohol or drug treatment. The commander will make the final decision to appoint the candidate based on all the information received except that the requirements in paragraphs 9-5a (1) through 9-5a(5), above, are not waivable.

b. Qualifications—DA Civilian employees.

(1) If military personnel are not reasonably and consistently available to perform UPL duties, those UPL duties may be performed by a civilian employee, providing all of the following criteria are met:

(a) The employee must be at minimum a GS-5 or pay grade equivalent.

(b) The employee must be trained and certified as a UPL in accordance with AR 600-85, chapter 2 requirements and must be recertified every 18 months.

(c) The UPL duties must be annotated in the employee's position description.

(d) Trained and certified DTCs can serve as UPLs in accordance with the criteria set forth in paragraph 9-5b(1).

c. Certification. The UPLs must be certified to perform their duties by successfully completing the DA UPL CTP, a standardized course of instruction and evaluation. No other UPL certification course is authorized without the written approval of the Director, ARD. If a UPL candidate is deployed, they may be certified using the distance learning and certification procedures explained at www.asap.army.mil/. Upon successful completion of all course requirements, UPLs will receive a certificate of training and a UPL certification card. A UPL that is reassigned to another command may be appointed as a UPL in the new command with proof of a previous certification until recertification is required at the 18-month point.

d. Recertification.

(1) UPLs must be recertified every 18 months by successfully completing the UPL CTP exam. The ASAP and unit commander will initiate a new local and DAMIS background check to ensure that the UPL is still qualified in accordance with paragraphs 9-5a(1) through (6), above.

(2) If a UPL's certification expires, the UPL has up to 60 days to contact the ASAP to attend any locally-required update training, take and pass the recertification exam to be recertified for another 18 months from the date of examination. During the time between the expiration date and the exam the UPL is not authorized to collect drug testing specimens. If a UPL's certification has been expired for more than 60 days, then the UPL must retake the entire UPL certification course.

(3) The ASAP managers may revoke the ASAP certification of any UPL for an excessive number of discrepancies in drug testing collection procedures, UA specimens, or on associated forms. However, the ASAP manager must immediately notify the UPL's commander, in writing, of such revocation and the purpose for it.

e. Online certification. The online CTP for certification and recertification of deployed Soldiers is only valid for 12 months. Upon redeployment, the UPL must contact the home station ASAP before conducting any collections.

f. Instructor certificate course. UPLs are encouraged to attend an instructor certification course to enhance their ability to conduct drug and alcohol awareness training at their units.

9–6. Drug testing coordinator qualifications, training, and certification

The DTC certification is crucial to the Army's DTP and substance abuse prevention efforts. All DTCs must receive the same standardized curriculum and be certified to perform their duties. On installations, there is usually a DTC and an alternate DTC; however, other personnel who are not DTC-certified may also serve as DTCs as long as they meet the requirements specified below:

a. Qualifications.

(1) DA Civilian employee (certified DTC or GS–05 or equivalent and above), officer, warrant officer, or NCO (E–5 or above).

(2) Designated on appointment orders by the installation commander/manager.

(3) Successfully complete the ARD standardized CTP prior to collecting any drug testing specimens.

(4) Not be currently enrolled/mandatory care in the SUD treatment.

(5) Not have a conviction or other adverse finding, or be under investigation, for abuse of a substance (illegal drug, controlled drug, alcohol or other) offense or misconduct when the underlying facts occurred within the last 3 years.

b. Certification. DTCs must be certified to perform their duties by successfully completing either the DA DTC Certification Course or the DA DTC CTP, a standardized course of instruction and evaluation. No other DTC certification courses are authorized without the written approval of the Director, ARD. If a DTC candidate is deployed, they may be certified using the distance learning and certification procedures explained at <https://asap.army.mil>. Upon successful completion of all course requirements, DTCs will receive a certificate of training.

c. Recertification.

(1) The DTCs must recertify every 12 months by successfully completing the DTC CTP exam. If a DTC's certification expires while they are deployed, the DTC may recertify using the distance learning and certification procedures at para 9–6b. If a DTC fails the re-certification exam, they must retake the entire DTC CTP before retaking the exam.

(2) If a DTC's certification expires, the DTC has up to 90 days to contact the ASAP to attend any locally-required update training, take and pass the recertification exam to be recertified for another year from the date of examination. During the time between the expiration date and the exam the DTC is not authorized to collect drug testing specimens. If a DTC's certification has been expired for more than 90 days, then the DTC must retake the entire DTC certification course.

(3) The ASAP managers may revoke the certification of any DTC for an excessive number of discrepancies in drug testing collection procedures, UA specimens, or on associated forms. However, if the DTC is military, the ASAP manager must immediately notify the DTC's commander in writing of such revocation and the reasons for it.

d. The DTCs are encouraged to volunteer to be added to the random drug testing pool.

9–7. Department of Transportation Drug Test Collector, screening test technician, and installation breath alcohol technician qualifications, training, and certification

a. The DOT Drug Test Collector, STT, and IBAT certifications are crucial to the Army's DTP and substance abuse prevention efforts. On installations, DOT Drug Test Collectors are normally the DTC or an alternate DTC; however, other personnel may also serve as DOT Drug Test Collectors as long as they meet the requirements specified below.

b. DOT Drug Test Collector.

(1) Qualifications.

(a) Be a DA Civilian employee (GS–05 or equivalent and above), officer, warrant officer or NCO (E–5 or above).

(b) Be designated on appointment orders by the ASAP manager.

(c) Successfully complete the ARD standardized CTP prior to collecting any drug testing specimens.

(d) Not currently enrolled in mandatory SUD treatment, if using a Soldier or in substance abuse rehabilitation, if using a civilian.

(e) Not have a conviction or other adverse finding, or be under investigation, for abuse of substance (illegal drug, controlled drug, alcohol or other) related offenses or misconduct when the underlying facts occurred within the last 3 years.

(2) Certification. DOT Drug Test Collectors must be certified to perform their duties by successfully completing the DA DOT Drug Test Collector CTP, a standardized course of instruction and evaluation.

(3) Recertification. DOT Drug Test Collectors must recertify every 5 years by successfully completing the current DA DOT Drug Test Collector CTP.

(4) Error Correction Training.

(a) A DOT Drug Test Collector should receive error correction training within 30 days of being notified of making an error in the collection process that causes a collection to be cancelled or makes the specimen untestable. Error correction training is explained at 49 CFR, Part 40, Subpart C. If the collector does not complete error correction training within 30 days of notification, the collector is no longer authorized to conduct DOT collections until the training is completed. Error correction training must be administered by a qualified collector as explained in 49 CFR, Part 40, Subpart C. The qualified collector, who conducts the error correction training, must attest in writing that the training was completed and the mock collections were error free. The supervisor of the collector receiving the error correction training will review and retain this document for 3 years.

(b) The ASAP managers may revoke the certification of any DOT Drug Test Collector for an excessive number of discrepancies in drug testing collection procedures, UA specimens, or on associated forms. However, if the DOT Drug Test Collector is military, the ASAP manager must immediately notify their commander in writing of such revocation and the reasons for it.

c. STT and IBAT. STTs and IBATs must meet the qualification training requirements of 49 CFR, Part 40, Subpart J prior to collecting any specimens for DOT alcohol tests. Refresher training and error correction training requirements are also described in this Subpart.

d. The DOT drug test collectors, STTs, and IBATs are encouraged to volunteer to be added to the random drug testing pool.

Section III

Education and Training Requirements

9–8. Deployment training

a. The ARD and ASAPs will provide training during pre-deployment and redeployment on the topics of abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder awareness

b. Commanders of all components will ensure that they deploy with at least two certified UPLs. The commander will ensure that the UPLs receive specialized pre-deployment training, supplies, and other special instructions from the ASAP staff prior to deployment.

9–9. Leadership training and schools

a. TRADOC will ensure training on the topics of abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder awareness is conducted during initial entry, pre-commissioning and is also integrated into all other Army professional development courses.

b. All ASAP curriculum developed for TRADOC schools/courses will be reviewed and approved by the Director, ARD.

c. The ARD and AMEDDC&S staffs will be available to provide training at senior leadership training courses upon request.

9–10. Soldier substance abuse and gambling disorder awareness training

a. All newly assigned Soldiers will receive a newcomers briefing by the commander or designated representative within 30 days of reporting. At a minimum the briefing will provide information on ASAP services, the location of ASAP services, community laws, command policies, drug and alcohol free activities and the Limited Use Policy.

b. Corporals and above will receive information in professional military education from formal education institutions and from installation prevention coordinators as requested by Commanders, on the signs and symptoms of on the topics of abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder and how to refer to BH for evaluation.

c. All Regular Army Soldiers, to include National Guard and US Army Reserve Soldiers on AD/in Title 10 status, will receive training as required by commanders.

d. All unit training whether conducted by the commander, UPL, the ASAP staff, or a guest speaker will be documented using a sign-in sheet to record who attended, the topic, the date, start time, and end time of the class. A copy of the sign-in sheet will be provided to the installation ASAP staff within 5 working days.

9–11. Civilian employee substance abuse awareness training

a. All new employees will receive a substance abuse newcomers briefing by the ASAP within 60 days of entering on duty. At a minimum the briefing will provide information on the following:

- (1) ASAP services to include the EAP.
- (2) The location and hours of operation of ASAP services.
- (3) Community laws.
- (4) Command policies.
- (5) Confidentiality.
- (6) When they are subject to drug testing, including reasonable suspicion and post-accident testing.
- (7) Employees in TDPs and employees subject to DOT drug and alcohol testing will receive information on selection methods and testing procedures.
- (8) The supervisors of employees subject to DOT drug and alcohol testing will receive the required training outlined in 49 CFR 382.603.

b. All new supervisors will, within 60 days of assuming their supervisory duties, receive information on:

- (1) The supervisor's role in the recognition and documentation of employee performance and conduct problems, and the use of and responsibilities for offering EAP services.
- (2) The supervisor's responsibilities and procedures for notifying TDPs and DOT personnel of their selection for testing.
- (3) Availability of EAP services including the EAP point of contact, telephone number, address, and hours of operation.
- (4) The process of reintegrating the employee after rehabilitation into the workforce.
- (5) Confidentiality and records requirements.

c. The ASAP prevention, education, and training for civilian employees will include training provided in conjunction with existing civilian personnel orientation and training programs. Civilian employees may receive additional alcohol, other drug and gambling disorder awareness training as mission needs dictates. Employee education will address as required by position:

- (1) ASAP policies, the Army DFW Civilian DTP, DOT Controlled Substances and Alcohol Abuse and Testing regulations and requirements, and information on the availability of EAP services, to include the EAP point of contact, telephone number, address, and hours of operation.
- (2) Types, effects, signs, and symptoms of substance abuse (illegal drug, controlled drug, alcohol or other) and the hazards/effects on performance and conduct.
- (3) Program confidentiality.

9–12. Family member and K–12 substance abuse awareness training

a. The ASAP is encouraged to develop, support and/or sponsor anti-drug and alcohol abuse programs for community K–12 schools that are on, or formally associated with, the military installation. The ASAP prevention education and training at community schools will be addressed in the annual prevention plan.

b. The ASAP prevention education and training of Family members will be addressed as mission dictates a need. Attendance by Family members, retirees, and their families will be on a voluntary basis. Training will highlight the local laws, impact of abuse, availability of counseling, rehabilitation/treatment services, and alternatives to abuse of illegal drug, controlled drug, alcohol or other products.

9–13. Alcohol and other drug abuse prevention training

a. The ADAPT is an educational/motivational intervention which focuses on the adverse effects and consequences of problematic substance use. The ADAPT courses will consist of at least 12 hours of course material.

b. The DA-approved curricula for ADAPT will be approved by ARD. Requests for exceptions to the ADAPT curriculum or to conduct alternate curriculum research trials will be submitted in writing to the Director, ARD for approval.

c. The following personnel will attend ADAPT:

(1) Those Soldiers who have a positive UA or have had an incident that involved a substance abuse issue are required to attend and complete ADAPT at least once prior to separation of service, deployment, or permanent change of duty station.

(2) Commanders may have a Soldier attend the course for reasons related to poor performance, safety violations, high risk behaviors, and disciplinary problems.

(3) ADAPT training is authorized for civilian personnel and Family members on a space available basis.

(4) Personnel who have previously attended an ADAPT class are not required to attend the class again unless directed by the SUD provider.

d. The following personnel should attend ADAPT:

(1) Any Soldier referred by a SUD provider who deems ADAPT advisable.

(2) Personnel who wish to attend the course for informational purposes only may do so, if approved by the commander and the ASAP manager.

9–14. Risk reduction training

a. Installations may request RRP training for their IPTs and installation activities through the IMCOM ASAP manager to ARD.

b. The ARD will provide 2 to 3 days of training, based on available funding, on the use of the Risk Reduction Web portal, data analysis, IPT functions, and command briefings.

Section IV

Prevention Strategies

9–15. Prevention planning

a. The PC, in coordination with the ASAP manager and EAP coordinator, will develop ASAP initiatives within the overall Prevention Plan each fiscal year. The ASAP initiatives in the overall Prevention Plan will be a detailed plan that addresses what and how prevention will occur. The plan will at a minimum address the following:

(1) Regulatory requirements—such as mandatory training for Soldiers and civilian employees.

(2) Each prevention activity/program/campaign planned for the year describing the following:

(a) The population being targeted.

(b) The activity/program/campaign goals.

(c) The milestones to implementing the activity/program/campaign.

(d) The evaluation method.

(e) Desired outcomes.

(3) Training schedule of scheduled UPL certification courses, ADAPT classes, newcomers' briefings, pre-deployment/redeployment training, IPT meetings, and so forth.

(4) RRP milestones such as data collection and submission, report printing, IPT meetings and command briefings.

b. The ASAP initiatives in the overall Prevention Plan will include universal, selective, and indicated prevention activities to address the substance abuse prevention needs of the community.

c. The ASAP initiatives in the overall Prevention Plan is a living document that may be modified many times throughout the year based on changes in funding, IPT activities, new requirements, and so forth; however, the document will be used as a basis for all activities.

d. The ASAP initiatives in the overall Prevention Plan, activity evaluations and assessments will be used as input for the Annual Prevention Report.

Chapter 10

Legal and Administrative Procedures, and Media Relations

Section I

General

10–1. Overview

a. This chapter addresses legal and administrative actions and procedures involving problematic substance use and alcohol misuse by Soldiers and civilian employees.

b. Participation in the SUD treatment need not interfere with normal command administrative actions.

c. Legal requirements and guidelines for the ASAP must be consistent with the provisions of public laws, civil and criminal court decisions, DoD issuances, and other ARs. (Although this is a nonexclusive list, see the following examples, AR 25–22; 5 USC 552a (Privacy Act); part 2, chapter 1, title 42, CFR; the Confidentiality Law, 42 USC 290dd-2; and AR 40–66). It is essential that the legal issues of the ASAP be clearly understood by all levels of command and supervision and that legal procedures and protections be followed.

10–2. Policy

a. All attempts by any means to avoid providing a UA specimen when selected or ordered, to dilute a urine specimen to reduce the quantitative value of that specimen when confirmed by gas chromatography/mass spectrometry (GC/MS), to substitute any substance for one’s own urine, including the urine of another person, to chemically alter, adulterate, or modify one’s own urine, or to assist another Soldier or civilian employee in doing any of these actions are direct violations of the Army’s official UA policy. Soldiers who violate this paragraph are punishable under the UCMJ. Penalties for violating this paragraph include the full range of statutory and regulatory sanctions, both criminal and administrative. DA civilian employees who violate the regulations related to the Federal Drug-Free Workplace and DOT Testing Programs may be subject to the full range of disciplinary or adverse administrative actions or both.

b. Commanders may order a Soldier to provide a specimen for UA if they have probable cause to believe that illicit drugs are present within the Soldier’s body. Commanders should seek legal counsel before ordering the urine collection to help them confirm they have probable cause, but may order the collection without counsel if legal counsel is not available. Commanders should subsequently seek legal counsel to confirm that probable cause existed before using the result in any adverse action.

c. Supervisors are authorized to test a civilian employee for illegal drug use under the following additional circumstances:

(1) When there is a reasonable suspicion that any employee uses illegal drugs, but such testing may be directed for employees encumbering non-TDPs only if there is a reasonable suspicion of illegal drug use during duty hours or of performing work while impaired;

(2) When an employee is reasonably suspected of having caused or contributed to a work-related accident or unsafe practice;

(3) As a part of, or as a follow-up to, counseling or rehabilitation for illegal drug use through the EAP.

d. Supervisors should seek legal counsel before the UA collection to help them confirm there is a reasonable suspicion, but the collection may proceed without legal counsel if none is available. In those cases supervisors must subsequently seek legal counsel to confirm that reasonable suspicion existed before using the drug test result in any adverse action.

e. A commander may order a UA based upon reasonable suspicion to ensure a Soldier’s fitness for duty, even if the UA is not a valid inspection and no probable cause exists. However, the results of such a test may be used only for limited purposes.

10–3. Use of Soldiers’ confirmed positive drug test results

Table 10–1 summarizes how a Soldier’s confirmed positive drug test results may be used. This table serves as guidance only; the facts of each case will dictate the appropriate actions that a commander should pursue. Commanders should consult with their servicing legal advisor prior to initiating adverse action against a Soldier after receiving a positive drug test result. Refer to paragraph 4–5 for an explanation of the drug testing codes used in the table 10–1, below.

Table 10–1
Use of Soldiers’ confirmed positive test result

	Usable in disciplinary proceedings	Usable as basis for separation	Usable for characterization of Service
Search or seizure codes below			
-Voluntary (Member’s consent) (VO)	Yes	Yes	Yes
-Probable cause (PO)	Yes	Yes	Yes
Inspection codes below			
-Inspection Random (IR)	Yes	Yes	Yes

Table 10–1
Use of Soldiers' confirmed positive test result—Continued

-Inspection Unit (sweep) (IU)	Yes	Yes	Yes
-Inspection Other (command policy) (IO)	Yes	Yes	Yes
Medical codes below			
-General diagnostic purposes (MO)	Yes	Yes	Yes
Fitness for duty codes below			
-Competence for duty (CO)	No	Yes	No
-Mishap/safety investigation (AO)	No	Yes	No
Other (OO)	No	Yes	No
-Rehabilitation testing (RO)	No	Yes	No
-New Entrance testing (NO)	No	Yes	No

Section II

Administrative and Uniform Code of Military Justice actions for Soldiers

10–4. Administrative and Uniform Code of Military Justice options

a. Commanders must take action against Soldiers who test positive for illicit drugs or for illegal use of legal drugs when a MRO determines the Soldier has no legitimate medical purpose for taking the drug. Some possible actions include:

- (1) Administrative actions—
 - (a) Oral or written counseling/reprimand.
 - (b) Suspension of access to classified information.
- (2) UCMJ actions—
 - (a) Non-judicial punishment.
 - (b) Court martial.

b. Any legal or administrative action should be based on the substance abuse-related incident that resulted in the referral to BH for SUD evaluation; actions will not be based on screening or enrollment determinations.

c. Mandatory administrative actions include the following:

- (1) Commanders must initiate FLAGS on all Soldiers who engage in the misconduct.
- (2) The commander must initiate administrative separation. The retention/separation authority will decide if the Soldier is retained or separated.

10–5. Suspension of security clearance or duty

a. All confirmed positive tests for a drug with a possible legitimate medical use as determined by MEDCOM must be evaluated by an MRO before any adverse action is taken against a Soldier or DA Civilian employee and prior to reporting the result to DoD CAF.

b. Commanders and heads of an organization may suspend the access to classified material of any Soldier or civilian employee who has a positive drug test that has been confirmed as unauthorized/illegitimate by the MRO, when such result raises a serious question as to the individual's ability or intent to protect classified information. This includes the period of time from when a Soldier or civilian employee requests a retest of the positive result until the result of the retest has been received. If the retest does not confirm the positive result, the commander or head will reinstate access to classified material in accordance with AR 380–67.)

c. Commanders and heads of organizations will notify the certifying official promptly when one of their Soldiers or DA Civilian employees in a PRP-designated position receives a positive UA test result that is confirmed by an MRO.

10–6. Separation actions – military personnel

Illicit drug use is grounds for disciplinary action under the UCMJ and/or the initiation of administrative separation proceedings. In addition to the rules for administrative separation actions and boards (refer to AR 600–8–24 and AR 635–200), the following rules apply to administrative separation actions and boards for illicit drug use. The following policies will apply to separations initiated under provisions of AR 135–175, AR 135–178, AR 600–8–24, and AR 635–200. The basis for separation for alcohol abuse and illicit drug use and authority for retention are as follows:

a. Drug test results from an DoD FTDTL normally can be substantiated by a “Laboratory Documentation Package” alone. Counsel for the respondent will be allowed adequate opportunity to interview laboratory officials before the board date. Soldiers determined by SUD provider and informed to the commander as a rehabilitation failure, as determined in paragraph 8–4*d*, will be processed for separation in accordance with separation regulations; in addition, Soldiers with a subsequent alcohol or drug-related incident of misconduct at any time during the 12-month period following successful completion of the enrolled SUD treatment or during the 12-month period following removal from the enrolled SUD treatment, for any reason, will be processed for separation as an alcohol or drug abuse rehabilitation failure. The term “process for separation” means the separation action will be initiated and processed through the chain of command to the separation authority for appropriate action. Except for Soldiers referred to a court-martial authorized to impose a punitive discharge, commanders will process for separation all Soldiers who are—

(1) Involved in two serious incidents of alcohol-related misconduct within a 12-month period. A serious incident of alcohol-related misconduct is defined as any offense of a civil or military nature that is punishable under the UCMJ by confinement for a term exceeding 1 year.

(2) Involved in illegal trafficking, distribution, possession with intent to distribute, or sale of illegal drugs, including those listed in paragraph 4–2.

(3) Identified as an illegal drug abuser by a verified test positive for unauthorized use of controlled drugs or illegal drug use. Tested positive for illegal drugs a second time during their career.

(4) Convicted of DWI or DUI a second time during their career.

b. For Regular Army and Active Guard Reserve (AGR) Soldiers who meet separation criteria in paragraph *b*, above, but for whom commanders support retention, the retention authority will be elevated to the first GO in the chain of command with a judge advocate or legal advisor before going to the General Court Martial convening authority available in accordance with the provisions below.

(1) NCOs (corporal and above) processed for separation as provided for in paragraph above, require a retention decision from the first GO in the chain of command. All separation decisions (including retention in the Army) for specialist and below will remain with existing separation authorities.

(2) All enlisted Soldiers processed for separation as a result of drug or alcohol misconduct as provided for in paragraphs above, require a retention decision from the first GO in the chain of command.

(3) All separation actions on enlisted Soldiers with 18 or more years of qualifying service for retired pay will be submitted to HQDA for final decision in accordance with existing regulatory provisions.

c. The retention authority for enlisted Soldiers in the ARNG and the U.S. Army Reserve (non-AGR), is as follows:

(1) ARNG Soldiers, as provided in chapter 15, AR 135–178, and applicable NGB regulations.

(2) USAR Soldiers, as provided in chapter 16, AR 135–178, and applicable USARC regulations.

d. Officer separations will be processed in accordance with the provisions of AR 600–8–24 and AR 135–175.

e. Commanders must initiate FLAGS on all Soldiers who engage in the types of misconduct described in paragraphs *a* and *b*, above. Commanders will initiate and remove FLAGS using the adverse action codes as follows:

(1) For drug-related misconduct including, but not limited to, positive drug tests (in accordance with this regulation), Total Army Personnel Database code U.

(2) For alcohol-related misconduct including, but not limited to DUI, on-duty impairment due to alcohol consumption, or drunk and disorderly conduct, Total Army Personnel Database code V.

(3) Commanders will remove the flag only when—

(a) The Soldier is reassigned to the transition point for separation.

(b) The separation or retention authority (as appropriate) retains the Soldier.

(c) Until all actions are completed.

f. Illicit drug use is grounds for disciplinary action under the UCMJ and/or the initiation of administrative separation proceedings. In addition to the rules for administrative separation actions and boards (refer to AR 600–8–24 and AR 635–200), the following rules apply to administrative separation actions and boards for illicit drug use: Drug test results from an Army FTDTL normally can be substantiated by a “Laboratory Documentation Package” alone. Counsel for the respondent will be allowed adequate opportunity to interview laboratory officials before the board date.

10–7. Granting leave

Commanders may grant leave to Soldiers who have tested positive for illicit drugs. (Refer to AR 600–8–10).

10–8. Transfer to the Department of Veterans Affairs

a. Soldiers receiving SUD treatment may be transferred to a VA Treatment Facility only under the following conditions:

- (1) When within 30 days of separation. (ARNG and USAR).
- (2) On the Soldier’s written request for transfer and additional rehabilitation.

b. The request will specify the length of treatment to which the Soldier agrees. No Regular Army Soldiers will be transferred to the VA through medical channels prior to completion of separation. (Refer to AR 635–200.)

10–9. Actions before, during, and after deployments and reassignments

Deployments.

a. Legal and administrative actions against a deployed Soldier with a confirmed positive drug test may be suspended at the discretion of the separation authority until the Soldier’s unit redeployes from the theater of combat operations.

b. All independently privileged providers will profile Soldiers with a BH/SUD disorder who presents occupational impairment based on clinical judgment. Treatment in mandatory/enrolled care may render Soldiers non-deployable to certain combatant commands (COCOM), which may be waived by the COCOM surgeon.

Section III

Legal Actions for Soldiers

10–10. Law enforcement relationship to the Army Substance Abuse Program

a. It is Army policy to encourage voluntary entry into SUD treatment. The MP, USACIDC special agents, and other investigative personnel will not solicit information from patients receiving SUD care, unless the patient volunteers to provide information and assistance. If the patient volunteers, the information will not be obtained in a clinical care facility or in such a manner as to jeopardize the safety of sources of the information or compromise the confidentiality and credibility of SUD treatment (ARs 190–30 and 195–2).

b. Title 42, CFR, prohibits undercover agents from infiltrating an alcohol or other drug treatment program for the purpose of law enforcement activities. This restriction does not preclude the treatment for SUD, for treatment purposes, of MP, USACIDC, or other investigative personnel who have problematic substance use. Their law enforcement status must be made known to the treatment provider at the time of their enrollment. These measures are for the protection of the law enforcement patient and those seeking treatment within the MTF.

c. The PM and the ASAP manager 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. The ASAP manager will only release information with the BAC, UIC, EDI–PI, laboratory accession number, specimen collection date, specimen laboratory report date, test basis, and the illicit drug(s) used. The ASAP manager will not provide law enforcement with the Soldier’s complete drug and treatment history.

10–11. Limited Use Policy

The objectives of the Limited Use Policy are to facilitate early ID and care of Soldiers with substance use disorders and to maximize successful SUD treatment. When applied properly, the Limited Use Policy does not conflict with the Army’s mission or standards of discipline. It is not intended to protect a Soldier who is attempting to avoid disciplinary or adverse administrative action.

10–12. Definition of the Limited Use Policy

a. Unless waived under the circumstances listed in paragraph 10–13*d*, Limited Use Policy prohibits the use by the government of protected evidence against a Soldier in actions under the UCMJ or on the issue of characterization of service in administrative proceedings. Additionally, the policy limits the characterization of discharge to “Honorable” if protected evidence is used. Protected evidence under this policy is limited to:

(1) Results of command-directed drug or alcohol testing that are inadmissible under the MRE. Commanders are encouraged to use drug or alcohol testing when there is a reasonable suspicion that a Soldier is using a controlled substance or has a blood alcohol concentration of .05 percent or above while on duty. This information will assist a

commander in his or her determination of the need for counseling, rehabilitation, or medical treatment. Competency for duty tests may be directed if, for example, a Soldier exhibits aberrant, bizarre, or uncharacteristic behavior, but probable cause to believe the Soldier has violated the UCMJ through the abuse of alcohol or drugs is absent. Competency for duty test results may be used as a basis for administrative action to include separation, but normally may not be used as a basis for an action under the UCMJ or be used to characterize a Soldier's service.

(2) Results of a drug or alcohol test collected solely as part of a safety mishap investigation undertaken for accident analysis and the development of countermeasures as further described in paragraph 4–5.

(3) Information concerning drug or alcohol abuse or possession of drugs incidental to personal use, including the results of a drug or alcohol test, collected as a result of a Soldier's emergency medical care solely for an actual or possible alcohol or other drug overdose. To qualify for Limited Use protection, Soldiers must inform their unit commander of the facts and circumstances concerning the actual or possible overdose. The commander must receive this information as soon after receipt of the emergency treatment as is reasonably possible. If treatment takes place at a civilian facility, the Soldier must give written consent to the treating civilian physician or facility for release of information to the Soldier's unit commander concerning the emergency treatment rendered. If the medical treatment resulted from an apprehension by military or civilian law enforcement authorities, or if the admission for treatment resulted from other than abuse of alcohol or drugs, such as for injuries resulting from a traffic accident, the Limited Use Protection will not be available to the Soldier.

(4) A Soldier's self-referral to BH for SUD treatment.

(5) Admissions and other information concerning alcohol or other drug abuse or possession of drugs incidental to personal use occurring prior to the date of initial referral to treatment and provided by Soldiers as part of their initial entry into SUD treatment. This includes Soldier's admission to a physician or treating provider concerning alcohol or other drug abuse incidental to personal use occurring prior to the initial date of referral to SUD treatment.

(6) Drug or alcohol test results, if the Soldier voluntarily submits to a DoD or Army SUD treatment before the Soldier has received an order to submit for a lawful drug or alcohol test. Voluntary submission includes Soldiers communicating to a member of their chain of command that they desire to be entered into SUD treatment. This Limited Use Protection will not apply to test results, which indicate alcohol or other drug abuse occurring after the voluntary submission to the rehabilitation/treatment program. Examples: The unit commander has ordered a UA on Monday for all members of the unit (an inspection under MRE 313). Before receiving an order (or having knowledge of a pending test) to appear for the UA, a Soldier approaches the platoon sergeant, admits having used illegal drugs over the weekend, and indicates a desire to receive help. Later that day, the Soldier is ordered to and provides a specimen for the UA, which results in a positive report for cocaine use. Those results are protected by the Limited Use Policy unless there is some evidence that demonstrates the use reflected by the test occurred after the admission was made to the platoon sergeant. Later that week, the commander orders another unit inspection for the following Monday. The inspection is conducted properly under MRE 313, and the Soldier once again has a positive result for cocaine. These test results, as interpreted by an Army FTDTL expert, indicate the Soldier had used cocaine after admitting use to the platoon sergeant. This test result is not protected by the Limited Use Policy.

(7) The results of a drug or alcohol test administered solely as a required part of a DoD or Army SUD treatment program.

b. The Limited Use Policy does not prevent a provider from revealing, to the commander or appropriate authority or others having a need to know, knowledge of certain illegal acts which may compromise or have an adverse impact on mission, national security, or the health and welfare of others. The unit commander will report the information to the appropriate authority. Likewise, information that the patient presently possesses illegal drugs or that the patient committed an offense while under the influence of alcohol or illegal drugs, other than prior illegal possession incident to the prior use, is not covered under this policy. Limited use is automatic. It is not granted, and it cannot be vacated or withdrawn. It may be waived in the situations described in paragraph 10–13*d*.

c. An order from competent authority to submit to UA or breathalyzer or blood sample alcohol test is presumed a lawful order. Soldiers who fail to obey such orders may be the subject of appropriate disciplinary action under the UCMJ.

d. The Limited Use Policy does not preclude 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) has first been introduced by the Soldier. This rebuttal or impeachment may include evidence that test data indicate the presence of a controlled substance or alcohol, although not in sufficient quantity to meet the cutoff level for a positive result that has been established by DoD.

(2) The initiation of disciplinary or other action based on independently derived evidence, including evidence of continued problematic substance use after initial entry into SUD care.

e. If the command is made aware of a Soldier's illegal drug use through the Soldier's self-referral and admissions, the requirement to initiate separation proceedings pursuant to the appropriate enlisted or officer separation regulation will not apply. The unit commander may initiate a separation action; however, the information is protected by the Limited Use Policy.

10–13. Implementation of the Limited Use Policy

a. Unit commanders will explain the Limited Use Policy to Soldiers during the commander's interview as set forth in paragraph 7–6. Commanders will not make any agreement, or compromise, or expand the Limited Use Policy in any way.

b. One or more military associates of an actual or possible alcohol or 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. An assisting person may fear that adverse personal consequences could result from becoming involved. Although Limited Use Protection is not extended automatically to such a person, the availability of the following options to those Soldiers and their commanders should reduce reluctance to assist the victim:

- (1) Soldiers may seek help for their own problematic substance use at the time they help their "associate."
- (2) Their unit commander should encourage self-referral.
- (3) The physician at the MTF should encourage self-referral.
- (4) Ensure all Soldiers are aware of the rehabilitation/treatment/services available and the Limited Use Policy.
- (5) If the Soldier admits to alcohol or other drug abuse and volunteers for help, the Limited Use Policy becomes effective as of the time the Soldier asks for help.

c. Soldiers will receive an honorable discharge regardless of their overall performance of duty, if discharge is based on a proceeding where the Government initially introduces Limited Use evidence except as authorized in paragraph 10–12*d*(1). The "Government" includes the following:

- (1) The unit 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 case.
- (3) The investigating officer or recorder presenting the case before the board.
- (4) The separation authority.

d. Alternatively, if Limited Use evidence is improperly introduced by the Government before the board convenes, the elimination proceeding may be reinitiated, excluding all reference 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 may set aside the board proceeding and refer the case to a new board for rehearing. The normal rules governing hearings and permissible actions thereafter will apply in accordance with the appropriate enlisted or officer separation regulations.

e. All situations that could arise in applying the Limited Use Policy in the field cannot be foreseen. As in other instances in which regulatory guidance is applied to an actual case, the commander should seek advice from the supporting legal office.

Section IV

Confidentiality Regarding Military Personnel

10–14. Scope

a. This section prescribes policy and provides guidance on the release of information about Soldiers who have received SUD treatment. The primary intent of the references in paragraph 10–18 and of the policies in this section is to remove any fear of public disclosure of past or present SUD diagnosis and or treatment. It is also intended to encourage participation in SUD treatment.

b. The restrictions on disclosure prescribed in this section are allowed by the Freedom of Information Act (5 USC 552), 42 USC Sec 290dd-2 and 42 CFR Part 2, and the Privacy Act (5 USC 552a).

c. No person subject to the jurisdiction or control of the Secretary of the Army will divulge any information or record of identity, diagnosis, prognosis, or treatment of any patient without proper authority. This includes any information which is maintained in connection with alcohol or other drug abuse education, training, treatment, or research, except as authorized in 10–16 through 10–17, below.

10–15. Confidentiality of problematic substance use patient records

a. The release and/or discussion of information within the Army concerning a Soldier's problematic substance use is governed by the restrictions contained in 5 USC 552a, 42 USC 290dd-2), AR 40–66, and AR 25–22 and HIPAA. Such information will only be made known to those individuals who have an official need to know, and within the framework of applicable law and regulation. The restrictions on release of information outside the Army concerning Soldiers is prescribed by the laws regarding confidentiality of treatment records and information, including those cited above.

b. Limited Use Policy does not prevent a provider from revealing, to the appropriate authority, knowledge of illegal acts which may have an adverse impact on mission, national security, or the health and welfare of others.

c. SUD treatment records are protected by the restrictions contained in The Privacy Act (5 USC 552a), 42 USC 290dd-2, AR 40–66 and AR 25–22, and the HIPAA of 1996 (Public Law 104–191 Section 264) and DoD 6025.18–R Electronic DoD Health Information Privacy Regulation. These records will be maintained by the SUD treatment staff in the DoD health record system.

d. Commanders seeking information from a treatment record must make their request in accordance with procedures outlined in AR 40–66.

e. For patients in certain sensitive positions or with the PRP, medical personnel will immediately advise the commander if any information is provided by the patient which would serve to disqualify the person for continuation in any sensitive duty position. If the need to release the information is in doubt, the provider will consult with the MTF HIPAA privacy officer to determine whether to release the information to the commander.

f. Enrolled/mandatory care for SUD treatment process involves the Soldier patient, his or her unit commander and intermediate supervisors, and the SUD treatment staff. While commanders above the battalion level may on rare occasions have an official need to know the specific identity of Soldiers enrolled in SUD treatment within their commands, their knowledge of the number of enrollees is usually sufficient information. No lists of individuals from the unit who are enrolled in SUD treatment will be maintained.

g. Anyone seeking assistance for SUD treatment (mandatory/voluntary) 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 the Limited Use Policy, confidentiality, and treatment procedures.

10–16. Overview

a. 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 abuse 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 paragraphs 10–15 and 10–16, however it should not take the place of consulting with their servicing legal office.

b. In all cases where disclosure is prohibited or is authorized only with the patient's written consent, every effort should be made to avoid inadvertent disclosure. As appropriate, the reply may suggest that the inquirer contact the patient directly.

c. The disclosure that an individual is not or has not been a patient is receiving SUD treatment is fully as much subject to the prohibitions and conditions of the statutes and this regulation as a disclosure that such a person is or has been a patient. Any improper or unauthorized request for disclosure of records or information subject to the provisions of this section should be addressed as specified in paragraph 10–16*b*, above.

d. Limitations on information. Any disclosure made under this section, with or without the patient's consent, will be limited to information necessary in light of the need or purpose for the disclosure.

e. Written statements. All disclosure will be accompanied by 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 farther 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 written notice.

f. Regulations governing release of information.

(1) To the extent that the contents of this section are in conflict with any other Army 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 10–15. 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/other regulatory and statutory guidance would assist in providing an appropriate reply to an inquiry, the information may be released.

10–17. Disclosures

a. Disclosure to medical personnel, either private or governmental, to the extent necessary to meet a bona fide medical emergency, is authorized without the consent of the patient. 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, it will be documented in accordance with MTF procedures.

b. In other than emergency situations, the written consent of the patient is required (see para 10–27). Such disclosure may be made to medical personnel or to nonmedical counseling and other rehabilitative services to enable such individuals or activities to furnish services to the patient.

10–18. Disclosure to a Family member or to any person with whom the patient has a personal relationship

Written consent is required when disclosure is to a Family member or to any person with whom the patient has a personal relationship.

10–19. Disclosure to the patient's attorney

- a.* Written consent of the patient is required (see para 10–27).
- b.* A bona fide attorney-patient relationship must exist between an attorney and the patient.
- c.* The attorney must endorse DA Form 5018–R (ADAPCP Client's Consent Statement for Release of Treatment Information (LRA)).
- d.* Subject to the limitations stated by the patient in their written DA Form 5018–R, any information from the patient's treatment records may be disclosed.
- e.* Information so disclosed may not be further disclosed by the attorney, unless the patient explicitly consents in writing to the disclosure. General waivers of attorney-patient privilege or authorization to share medical information are not sufficient for this purpose.

10–20. Disclosure to patient's designee for the benefit of the patient

- a.* 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 patient.
- b.* Disclosures under the provisions of this paragraph require written consent of the patient (see para 10–27).
- c.* For the purpose of this section, the circumstances under which disclosure may be deemed for the benefit of a patient include, but are not limited to, those in which the disclosure may assist the patient in connection with any public or private—
 - (1) Claim.
 - (2) Right.
 - (3) Privilege.
 - (4) Gratuity.
 - (5) Grant.
 - (6) Or other interest accruing to, or for the benefit of, the patient or the patient's immediate Family.
- d.* Examples of the foregoing include—
 - (1) Welfare.
 - (2) Medicare.
 - (3) Unemployment.
 - (4) Workmen's compensation,
 - (5) Accident or medical insurance.
 - (6) Public or private pension or other retirement benefits.
 - (7) Any claim or defense asserted or which is an issue in any civil, criminal, administrative, or other proceeding in which the patient is party or is affected.
- e.* The criteria for approval of disclosure are the following:

(1) The statutes and implementing regulation 42 CFR provide specific criteria for disclosure in two of the circumstances under which such disclosure may be deemed for the benefit of the patient.

(2) In any other benefit situation, disclosure is authorized with the written consent of the patient if all of the following criteria are met:

(a) There is no suggestion in the written consent or the circumstances surrounding it, that the consent was not given freely, voluntarily, and without coercion.

(b) Granting the request for disclosure will not cause substantial harm to the relationship between the patient and the treating provider. Nor will it cause harm to the BH capacity to provide SUD services in general.

(c) Granting the request for disclosure will not be harmful to the patient. This determination is to be made with the advice of the program IDPH.

10–21. Disclosure to non-Department of Defense employers, employment services, or agencies

a. Written consent of the patient is required (see para 10–27).

b. Ordinarily, disclosures pursuant to this paragraph should be limited to a verification of the patient'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 patient or others or where such information is otherwise directly relevant to the employment situation.

c. Subject to the provisions of paragraphs 10–21a and 10–21b, disclosure is authorized if it is determined 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/treatment of the patient. Such information must not be disclosed for the purpose of identifying the individual as a patient 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.

10–22. Disclosures in conjunction with civilian Criminal Justice System referrals

a. Written consent of the patient is required (see para 10–27).

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 patient's supervision.

c. The patient may consent to unrestricted communication between the SUD treating provider and the individuals or agencies listed in paragraph 10–20c.

d. Such consent will expire 60 days after it is given or when there is a substantial change in the patient'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 patient 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 patient is formally charged or unconditionally released from arrest.

(2) Formally charged, when the charges have been dismissed with prejudice, or the trial of such patient has been commenced.

(3) Brought to a trial which has commenced, when such patient has been acquitted or sentenced.

e. A patient's release from confinement, probation, or parole may be conditioned upon his or her participation in SUD treatment. Such a patient 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 patient. 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.

10–23. Disclosures to the President of the United States or to Members of the United States Congress acting in response to an inquiry or complaint from the patient

a. Written consent of the patient is required (see para 10–27).

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 patient in their DA Form 5018–R.

c. This authority for disclosure from a patient'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 patient'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 paragraph 10–23c, 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 SUDCC, program facilities, techniques, or the like.

10–24. Disclosure for research, audits, and evaluations

Subject to AR 25–22, a disclosure to qualified personnel for the purpose of scientific research, management or financial audit, or program evaluation is authorized whether or not the patient gives consent.

a. 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.

b. The personnel to whom disclosure is made may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation. They may not otherwise disclose patient identities in any manner. Personnel to whom disclosure is made will be reminded that 42 CFR 2.52 and 2.53 apply.

c. In cases of scientific research, the restrictions contained in AR 25–22 applies.

10–25. Disclosure in connection with an investigation

Release of information to conduct an investigation against a civilian patient or to conduct an investigation outside the Armed Forces against a military patient is prohibited; the only exception is by order of a court of competent jurisdiction. An investigation conducted by governmental personnel in connection with a benefit to which the patient may be entitled (for example, a security investigation by a Federal Bureau of Investigation agent in conjunction with the patient's application for Government employment) is not considered to be an investigation against the patient. Hence, with the written consent of the patient, the required information may be disclosed under the provisions of paragraph 10–22.

10–26. Disclosure upon court orders

Under the provisions of 42 USC 290dd2(b)(2)(c) and 42 CFR, Chapter 1, Subpart E a court may grant relief from duty of nondisclosure of records covered by 21 USC and 42 USC and direct appropriate disclosure.

10–27. Written consent requirement

a. Where disclosure in response to a request for prohibited information is authorized with the consent of the patient, such consent must be in writing and signed by the patient.

b. The patient will be fully informed of the nature and source of the inquiry. They will be informed that their voluntary written consent is required to release information.

c. If the patient consents to the release of all or part of the requested information, they will confirm that fact by signing DA Form 5018–R or DoD equivalent.

d. The consent will be prepared in its original form and be uploaded to the electronic health record, in accordance with MTF policy.

e. The DA Form 5018–R is not a continuing document; it only applies to the specific incident noted. 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 DA Form 5018–R. Exception: Duration of consent for disclosures in conjunction with criminal justice referrals is prescribed in paragraph 10–22.

f. Where the patient's unit commander provides information for a higher HQs reply to an inquiry, the forwarding correspondence will specifically verify that the consent—

- (1) Has been signed by the patient.
- (2) Has been, or will be, filed in the patient's treatment records.

g. If the patient does not consent to the release of the requested information or if the patient limits the scope of releasable information to the extent that an adequate reply is impossible—

- (1) He or she will be encouraged to correspond directly with the originator of the inquiry.
- (2) 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 patient authorizes only the release of limited information, they will be informed that the reply will state this, and will state that they have been requested to correspond directly with the inquirer.

(3) Where the patient's unit commander provides information for a higher HQ's reply to an inquiry, forwarding correspondence will include a statement that—

(a) The patient refused to sign DA Form 5018–R or authorized the release of only limited information.

(b) The patient has been encouraged to correspond directly with the inquirer.

h. When disclosure is authorized with the consent of the patient, such consent may be given by a guardian or other person authorized under state law to act in the patient's behalf; this would only be in the case of a patient 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 patient.

i. 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 physicians may, at their discretion and with patient consent, 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 they are capable of rational communication.

10–28. Verbal inquiries

a. Telephonic inquiries.

(1) If the caller specifically requests information on a patient'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.)

(2) Inform the caller that statutes and regulations prohibit the disclosure of such information.

(3) 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.

b. 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 patient's personal privacy. The guidance on telephone inquiries (see para 10–28*a*, above) should be used for the conversation.

10–29. Authority documentation

a. Confidentiality of Records (42 USC 290dd-2).

b. 42 CFR Part 2.

c. The HIPAA of 1996 (PL 104–91, Section 164).

d. Privacy Act of 1974 (5 USC 552a).

10–30. Penalties

The provisions of this section apply to individuals responsible for any patient record and to individuals who have knowledge of the information contained in patient records. Such records include those maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research. The criminal penalties for unauthorized disclosure of information protected by Federal statutes and regulations may include a fine of up to \$5,000 for each offense under the Privacy Act and up to a \$250,000 fine and 10 years of imprisonment under the HIPAA.

Section V

Administrative Actions for Department of the Army civilian employees

10–31. Administrative and disciplinary actions

a. Pursuant to EO 12564 supervisors shall, in addition to any appropriate personnel actions, refer any employee who is found to use illegal drugs to EAP for assessment, counseling, and referral for treatment or rehabilitation as appropriate. If the employee occupies a sensitive position as defined under DoDI 1010.09 (whether or not the position is a TDP), the supervisor must immediately remove the employee from that position and assign the employee other duties pending a decision on his or her status.

b. Supervisors must consult with their servicing CPAC before initiating any formal disciplinary or adverse action and before referring an employee to EAP. The servicing CPAC will advise the supervisor about options and responsibilities. For civilian employees found to have used illegal drugs or to be impaired by alcohol while on duty, a range of formal disciplinary actions are available from a written reprimand to removal. The severity of action chosen will

depend on the circumstances of each case. Supervisors will initiate action to discipline any employee found to have used illegal drugs, except that such action is not mandatory for an employee who voluntarily admits to illegal drug use, obtains counseling or rehabilitation through the EAP, and thereafter refrains from using illegal drugs.

c. Disciplinary action will be consistent with the requirements of any governing collective bargaining agreement and other applicable statutes, regulations, and table of penalties.

d. Supervisors generally have discretion in deciding what disciplinary measures to initiate; however, initiation of removal from Federal service is required if the employee refuses to obtain counseling or rehabilitation through the EAP after having been found to use illegal drugs, or if the employee does not refrain from using illegal drugs after a first finding of such use.

e. Verified positive test results and information developed in the course of the drug testing of the employee, subject to the limitations of 5 USC 552a, PL 100–71, 42 USC 290dd-2, and 42 CFR Part 2, may be considered in processing any adverse action against the employee or for other administrative purposes. Preliminary test results may not be used in an administrative proceeding.

f. The servicing CPAC will ensure that appropriate coordination with the labor counselor is accomplished.

g. Upon successful completion of rehabilitation, or as a part of a rehabilitation/treatment program if progress is evident and the employee poses no danger to health, safety or security, the employee may be returned to the TDP. (Refer to EO 12564, Section 5, Paragraph (c), and DoDI 1010.09)

10–32. Release of Army Substance Abuse Program information to the media

a. 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 non-abuser of alcohol or other drugs.

b. The Office of the Chief of Public Affairs, HQDA, coordinates, plans, and monitors the execution of appropriate Army information activities.

10–33. Guidelines for releasing information

a. Unclassified factual information on the following may be provided to the news media in response to queries about:

(1) The Army’s alcohol and other drug abuse program issues.

(2) The Army’s alcohol and other drug abuse prevention and rehabilitation/treatment programs.

b. Tours of facilities and discussions with treating providers must have the prior approval of the MTF commander. Such tours or discussions will not be conducted at a time or location that could result in the ID of a patient.

c. Information on quantitative results for the UA program and overall ASAP statistics will not be given until released by the Director, ARD.

d. IMCOM will ensure that command information materials receive wide distribution and will respond to queries as provided in this section.

10–34. Administration

Requests for authority to release additional information will be directed to Headquarters, Department of the Army (SAPA–PCD), 1500 Pentagon, Washington, DC 20310–1500.

Chapter 11

Drug Testing Laboratory Operations

11–1. General

The mission of the U.S. Army FTDTL is to deter drug abuse by forensically identifying drugs of abuse in DoD personnel, to assist commanders, MREs, and military lawyers in interpreting laboratory results, and to provide litigation and expert witness support for all adverse actions. The FTDTLs detect drug use by measuring the parent drug or drug metabolite concentration in Soldiers’ and DA Civilians’ urine. Each specimen will be tracked under a strict chain of custody procedure. The FTDTLs will only report as positive those specimens that meet or exceed the levels established by DoD or DHHS. FTDTLs will adhere to the operating guidance in DoDI 1010.01, 1010.16, and applicable Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, and this regulation. On average, results should be reported within the following timeline: (1) Negative military results in 4 working days; (2) Positive military results in 6 working days; (3) Negative civilian results in 1 working day; (4) Positive civilian results in 3 working days.

11–2. Litigation support

A commander or member of a legal office that requires litigation support for legal or administrative proceedings will request such support from the commander of the FTDTL that tested the specimen. Upon request of the commander or legal counsel, the FTDTL commander will provide in-person or telephonic expert witness testimony for courts martial or administrative board proceedings. If in-person testimony is required, the requesting command should provide accounting information or invitational travel orders to the FTDTL at least 10 days before the date for the testimony.

11–3. Suspected adulterated military specimens

If a military specimen appears to be adulterated, and there is sufficient sample, the FTDTL will send an aliquot to Ft. Meade FTDTL or SAMHSA certified lab, to perform validity testing in order to determine if the specimen is consistent with normal human urine. The FTDTLs are not required to determine the exact type or quantity of adulteration.

11–4. Special tests

a. If a commander desires to test a Soldier's urine for a drug that is not on the current test panel, the commander will coordinate through the FTDTL and/or the local ASAP with the ARD to request the test. If the test is approved, the request must be in writing to the respective FTDTL or AFMES, must list the requested drug(s) to test for, and must accompany the specimen to AFMES. The specimen should be on its own chain of custody document using an AFMES Form 1323 (AFMES/Division of Forensics Toxicology – Toxicological Request Form). If the specimen is sent to or through the FTDTL, the DD Form 2624 will be used.

b. If the commander desires to ensure that a Soldier is tested for one of the rotational drugs that the FTDTLs test a percentage of all specimens for, the commander will submit the request in writing to the respective FTDTL, listing the requested drug(s) to test for, with the specimen on its own chain of custody document.

c. Steroids and other Performance Enhancing Drugs (PED): Commanders must request testing for anabolic steroids and PED, as defined by sections S0–S5 of the World Antidoping Association (WADA) list. All requests for steroid and PED testing must be coordinated with the Ft. Meade FTDTL. Once approved, the commander must send a memorandum that includes the probable cause analysis requesting the test with one DD Form 2624 for one to 12 specimens submitted. If a sample is submitted for steroid/PED testing, that specimen will not also be tested for the routine panel of controlled substances. Commanders must consult with their servicing Judge Advocate regarding accountability as some substances on the WADA list may not be controlled.

Chapter 12

Risk Reduction Program

12–1. Overview

The RRP is a commander's tool designed to identify and reduce Soldiers' high-risk behaviors. High risk behaviors are behaviors that place the individual or others in danger or harms' way, for example areas of substance abuse, suicide, and crimes against property. The RRP focuses on effective use of installation resources and a coordinated effort between commanders and installation agencies to implement intervention and prevention strategy. The RRP supports the Army's ARD efforts by integrating prevention and intervention programs into a framework contributing to performance, readiness, and retention.

12–2. Objectives

The objectives of the RRP are to—

a. Provide systematic prevention and intervention methods and materials to commanders to identify risk factors and eliminate or mitigate high-risk behaviors. See table 12–1.

b. Monthly compile, analyze, and assess behavioral risk and other data to identify trends and units with high-risk profiles. Use findings to predict and address target intervention or prevention efforts.

12–3. Policy

a. All installations with 1000 or more Regular Army Soldiers will offer RRP services to the tenant units of the installation. RRP services are defined as data collection, data quality control, data analysis, commander consultation, URI or R-URI surveys and prevention and intervention services.

b. Installation RRPCs will provide risk incident data for risk factors to the ARD on a monthly basis; due by the 15th of the following month. Data will be submitted for every battalion, brigade, and major separate company by UIC and unit name.

c. Access to the RRP portal is only authorized to the RRP coordinator, agency data providers who submit the data, and commanders.

12-4. Headquarters Risk Reduction Program ad-hoc working group

a. To effectively coordinate the RRP, the organizations listed below will form a HQDA RRP Ad-hoc working group.

- (1) The DCS, G-1 (ARD).
- (2) The DCS, G-3/5/7 (Security, Force Protection and Law Enforcement Division).
- (3) TSG
- (4) DASAF
- (5) ACSIM
- (6) The HQ IMCOM (U.S. Army Family, Moral, Welfare, and Recreation and HQ IMCOM ASAP Manager)
- (7) The ACOMs, ASCCs, and DRUs

b. The working group will establish definitions, standards, and goals for risk factor incident rates for use in RRP.

c. Functional proponents will interact with other HQDA level panels and GO Steering Committees. (For example, safety coordinating panel, Army Family action plan and other HQDA agencies.)

d. Functional proponents will participate in the design, development, and delivery of IPT training.

e. Through IMCOM, functional proponents will ensure installation program providers in their functional areas participate in and assist the RRP in meeting its objectives.

f. Functional proponents will provide information for the RRP knowledge base repository in their functional areas.

12-5. Installation/command reporting requirements

a. All installations with 1000 or more Regular Army Soldiers will offer RRP services to the tenant units of the installation. RRP services are defined as data collection, data quality control, data analysis, commander consultation, URI or R-URI surveys, and prevention and intervention services. For installation that do not meet the criteria for incident reporting there are other tools available that will be more applicable for smaller populations. The current RRP tracks high-risk factors by the total number of incidents per reporting unit. Data for each factor is collected monthly, and a positive report is based on the specific definitions provided in table 12-1. The definitions allow for the collection of data to capture the number of Soldiers who have incidents instead of counting individual incidents. This gives leaders at all levels a more accurate picture of the potential risk in their unit.

b. Installation commanders will ensure installation risk factor proponents provide incident data to the RRPC in the correct format NLT 10th of each month. The data provided will include, but not be limited to the high-risk factors listed in table 12-1 below. The RRP Web portal maintains all high-risk incident data submitted from across the Army. The data contains no personally identifiable information; it is filed by UIC and indicates the number of Soldiers in the unit who experienced one or more of the identified high-risk behaviors.

c. Data providers will submit data for each month to the RRPC no later than the close of business on the 10th calendar day of the following month. The RRPC will enter the data into the web portal no later than the close of business on the 15th calendar day of each month.

d. Risk data proponents will provide/input data to the RRPC by the 10th of each month. The RRPC (or their installation or command proponents) will input the data on the Web-based system provided by ARD (<https://asap.army.mil>) by the 15th of each month.

e. Data collection population will both include and differentiate permanent party, professional military education students attending school, and initial entry training Soldiers.

**Table 12-1
High risk factors**

No.	Factor	Definition	Data proponent
1	Deaths	The number of Soldier deaths among members of the reporting unit. (DO NOT include deaths which occurred in theater.)	Casualty Assistance Office, Safety Office, Provost Marshal Office (PMO), Hospital
2	Accidents (Class C, D & E)	Class C accidents are Army accidents in which the resulting total cost of property damage is \$50,000 or more but less than \$500,000; a non-fatal injury or occupational illness that causes 1	Safety Office

**Table 12–1
High risk factors—Continued**

No.	Factor	Definition	Data proponent
		<p>or more days away from work or training beyond the day or shift on which it occurred; or disability at any time (that does not meet the definition of Class A or Class B and is a day(s)-away-from- work case).</p> <p>Class D accidents are Army accidents in which the resulting total cost of property damage is \$20,000 or more but less than \$50,000; a non-fatal injury or illness results in restricted work, transfer to another job, medical treatment greater than first aid, needle stick injuries, and cuts from sharp objects that are contaminated from another person's blood or other potentially infectious material, medical removal under medical surveillance requirements of an Occupational Safety and Health Administration standard, occupational hearing loss; or a work-related tuberculosis case.</p> <p>Class E ground accidents are Army ground accidents in which the resulting total cost of property damage is \$5,000 or more but less than \$20,000.</p> <p>Class E aviation accidents are Army aviation accidents in which the resulting total cost of property damage is \$5,000 or more but less than \$20,000. AR385–10 para3-4, AR Army Safety Program Regulation.</p>	
3	Self-harm	The number of Soldiers in the reporting unit who have committed self-inflicted, potentially injurious behavior with a non-fatal outcome for which there is evidence (either explicit or implicit) of a lack of intent to die. (Do not count ideations.)	Behavioral Health, PMO, Chaplain, G–1
4	Suicide attempts	The number of Soldiers in the reporting unit who have committed self-inflicted, potentially injurious behavior with a non-fatal outcome for which there is evidence (either explicit or implicit) of intent to die. (Do not count ideations.)	Behavioral Health, PMO, Chaplain, G–1
5	Absent without leave (AWOL)	The number of Soldiers in the reporting unit who are titled with AWOL by law enforcement.	PMO, AG, PAC, S–1, G–1
6	Drug offenses	The number of Soldiers in the reporting unit who are titled with drug offenses by law enforcement. These include, but are not limited to, possession and sale (but NOT positive urinalysis) of a controlled substance and any other prohibited substance.	PMO, DTC
7	Alcohol offenses	The number of Soldiers in the reporting unit who are titled with an alcohol-related offense by law enforcement. These include, but are not limited to, Driving Under the Influence (DUI),	PMO

**Table 12–1
High risk factors—Continued**

No.	Factor	Definition	Data proponent
		public intoxication, drunk and disorderly, reporting to work while intoxicated, alcohol-related reckless driving, possession by a minor, and consumption by a minor. (These include alcohol as a secondary or tertiary offense.)	
8	Traffic violations	The number of Soldiers in the reporting unit who are titled with a moving traffic violation by law enforcement. These include, but are not limited to, speeding, driving without a license or driving with a suspended license, failure to obey a traffic device, accidents, and non- alcohol-related reckless driving.	PMO
9	Crimes against persons	The numbers of Soldiers in the reporting unit who are titled with crimes against persons by law enforcement. These include, but are not limited to simple assault, aggravated assault, (attempted or) murder, robbery, kidnapping, harassment and threats, sodomy, rape, and adultery. (Do not include any of the drug or alcohol offenses, domestic or child abuse incidents.)	PMO
10	Crimes against property	The number of Soldiers in the reporting unit who are titled with crimes against property by law enforcement. These include, but are not limited to, house breaking/burglary, auto theft, arson, theft of government property, theft of private property, intentional damage to property, and vandalism.	PMO
11	Crimes against society	The number of Soldiers in the reporting unit who are titled with crimes against society by law enforcement. These include, but are not limited to, concealed weapon, weapons violations, gambling disorder, prostitution, curfew violations, and vagrancy.	PMO
12	Domestic violence	The number of Soldiers in the reporting unit who have cases that meet the criteria for domestic violence, as defined in AR 608–18, The Army Family Advocacy Program; applies in cases where the Soldier is identified as either the perpetrator or the victim. (This definition does not include child abuse. Also, do not count the Soldier under crimes against persons.)	Social Work Services, Behavior Health Service Line (BHSL)- Family Advocacy Program (FAP)
13	Child abuse	The number of Soldiers in the reporting unit who are identified as the alleged perpetrator in cases that meet the criteria for the following offenses, as defined in AR 608–18: child abuse, child abuse/physical maltreatment, child emotional maltreatment, child neglect, and child physical maltreatment. (Do not include the Soldier under crimes against persons.)	Social Work Services, BHSL–FAP
14	Financial problems/risk	The number of new cases of Soldiers in the reporting unit who were either (1) voluntarily or command-directed for financial problems such	ACS

Table 12–1
High risk factors—Continued

No.	Factor	Definition	Data proponent
		as writing bad checks, excessive debt, and an inability to meet current financial obligations; or (2) had a FICO score of 619 or below coupled with a debt- to-income ratio of 40 percent or more.	
15	Urinalysis samples tested	The number of urinalysis specimens tested at the Forensic Toxicology Drug Testing Laboratory (FTDTL). NOTE: The number of specimens collected might be higher than those tested at the laboratory because specimens must meet forensic specifications to be tested.	DTC, DAMIS, G–1
16	Positive urinalysis tests	The number of Soldiers in the reporting unit who have tested positive for illicit drug use (after Medical Review Officer evaluation). NOTE: This includes abuse of pharmaceuticals and legal synthetics.	BTC, DAMIS, G–1
17	Administrative disciplinary actions	The number of Soldiers in the reporting unit who have received administrative disciplinary actions (non-judicial). These include, but are not limited to, non-judicial punishment under Article 15, Uniform Code of Military Justice and Memorandums of Reprimand.	Staff Judge Advocate (SJA)
18	Administrative separations initiated	The number of Soldiers in the reporting unit who had administrative separations initiated in accordance with AR 635–200 or AR 600–8–24.	SJA, AG
19	Administrative eliminations	The number of Soldiers in the reporting unit who were approved for separation from the Army in accordance with AR 635–200) or AR 600–8–24.	SJA, AG
20	Courts martial	The number of Soldiers in the reporting unit who were tried and found guilty by court-martial.	SJA

f. Any Soldier has a potential exposure to risk and therefore to ensure accurately capturing a unit’s total potential for risk, RRPCs will report the total peak population of a given unit within the month.

12–6. Unit risk inventory and re-integration unit risk inventory

Two prominent features of the RRP are the URI and the R–URI. These command climate surveys help commanders determine the actual occurrences of high-risk behaviors, not just reported incidents, because Soldiers complete the surveys anonymously. Combined with data on actual occurrences of high-risk behaviors and the expertise of the IPT, these surveys help installation care providers target appropriate intervention strategies where they are needed most. Commanders will coordinate with the installation ASAP to administer the URI to all deploying Soldiers. To better accommodate mission requirements, the timeline for URI administration is 30 to 90 days before an operational deployment, the R–URI to redeploying Soldiers between 30 and 180 days of their return from deployment. Commanders may coordinate with the installation ASAP to administer the URI to their units at any time; however, incoming commanders should consider this a necessary action during their change of command.

12–7. Installation prevention team

a. The IPT is composed of representatives from the installation programs and supporting agencies (for example, ASAP, Safety, PM, Army Community Service/Family Advocacy, Preventive Medicine, Chaplain’s office, Behavioral Health Clinic, SJA, Community Health Promotion Program, USACIDC, and tenant commands). Installation commanders may modify team composition to meet their RRP mission requirements.

b. The IPT will meet quarterly to discuss risk reduction data for all units participating in the RRP. The IPT subject matter expert (SME) will provide analysis and recommendations for mitigating high-risk behaviors.

c. The focus of the IPT is to examine targeted areas of highest risk among individual units, and high-risk trends across the installation.

d. The RRPC or the ASAP manager has authority as the SME on high risk behaviors to act as spokesperson for the IPT and disseminate information to commanders at all levels and at the Commander's Ready and Resilient Council (CR2C).

Chapter 13

Comprehensive Assessment

13–1. Overview

a. The ASAP Comprehensive Assessment relies upon a framework of process and program evaluation. It facilitates:

(1) Enhancement of program and functional management through the continuous collection of information that monitors program performance.

(2) Establishment of accountability to funding sources and stakeholders and improves the integration of all substance abuse functions at every level of command.

(3) Determination of the efficacy and effectiveness of each substance abuse function.

b. The overall authority for this assessment effort is grounded in the Government Performance Results Act-Modernization Act (GPRA-MA) of 2010. Key overarching policy documents from the Office of the National Drug Control Policy, Department of Health and Human Services, Department of Defense, and Army HQs leadership will support the establishment of the programs goals and objectives for each function. Goals and objectives inform the development of performance indicators for use during process and program evaluation throughout the life cycle of this effort. Documenting the substance abuse performance results will occur within an Army Authoritative Database of Record (ADOR).

(1) The ARD is responsible for establishing the goals and objectives for each substance abuse function in conjunction with key stakeholders. They will be linked to the ARD Strategic Objectives. Performance indicators for each function, will be developed, nested to the appropriate functional objectives for use during the process and program evaluation stages when assessing the effectiveness of the substance abuse program.

(2) Process evaluation is the continuous and systematic collection and analysis of information (data) to provide leaders and key stakeholders with an indication as to the extent of progress against stated goals and objectives. Stakeholder's critical activities (tasks that if not completed will cause program failure) produce process and output indicators, commonly referred to as Measures of Performance (MOPs).

(a) MOPs facilitate the development of outcome indicators. Outcomes are the events, occurrences, or changes in conditions, behavior, or attitudes that indicate progress towards the substance abuse programmatic and functional goals and objectives.

(b) This requires the establishment of a continuous data collection process of performance indicators into an Army authoritative database of record.

(c) ARD is responsible for establishing and updating the process and procedures on developing and maintaining performance indicators for each FY.

(3) Program evaluation is the systematic collection of information on the substance abuse functions inputs, activities, and outputs, as well as the program's context and other key characteristics. It is a planned and periodic assessment of the substance abuse program using a common evaluation criteria of appropriateness, effectiveness, efficiency, impact and sustainability. It builds upon process evaluation and seeks to assess if medium-term outcomes and longer term impacts achieved; the intended and unintended effects of these achievements; assess approaches that worked well and those that did not; and identify the reasons for success or failure and learning from both. A level of judgment will be applied in assessing the overall value of this effort. This task will occur at a minimum of at least once every three to four years.

(4) Comprehensive assessment effort requires documentation of all program performance indicators into an ADOR. ADORs for maintaining the process and output indicators include the DAMIS, installation status report (ISR), and the Resource and Performance Report (RAPR). Annual aggregate program outcome performance measures will be maintained within the Strategic Management System and further refined down to the ACOM, ASCC, and DRU echelon.

13–2. Authority

a. Government Performance Results Act- Modernization Act (GPRA–MA) of 2010. GPRA–MA 2010 establishes a methodology framework for establishing ASAP process, output, and outcome indicators to aid all facets of the evaluation effort.

b. The ARD retains the authority to conduct all evaluations of installation ASAPs. This evaluation authority includes the following functions: deterrence, prevention, and assistance. ARD delegates the responsibility to execute substance abuse process compliance inspections to IMCOM, AMC and MEDCOM.

13–3. Process evaluation

a. Process evaluation consists of actions to monitor the implementation and execution of substance abuse efforts at all echelons. Sustaining internal controls, collecting data to on performance process and output indicators, inspections and tracking programmatic inputs by function are key components in this comprehensive assessment stage.

b. Internal controls. Use of the Process Assessment Checklist (see app D and Internal Control Evaluation (see app G) serve as an internal assessment tools at the installation. Results can also be used to inform continuous process improvement or provide valuable information for a formal program review.

c. Measures of Performance. The execution of a task (process) will result in a product or service (outputs). Collecting data on the number of processes performed is useful in assessing workload and its subsequent output. However, it does not by itself address the effectiveness of the ongoing efforts. Further information may be needed from each output to help inform if the desired effect sought (outcome) of the task was actually achieved.

(1) Collecting the right information is important and can change over time. Publication of the annual substance abuse Measures of Performance by function, will occur annually by ARD.

(2) Process, output and outcome performance indicators will be tracked down to the installation and command level function (ARD will maintain a complete list [complete with definition formula] and update every fiscal year as required). The following are not an all-inclusive performance indicator list.

d. Key functional process, output, and outcome performance indicators include:

(1) *Deterrence Process and Output Indicators.*

(a) of Required UPLs.

(b) of trained UPLs.

(c) UPL courses performed.

(d) of Soldiers completed UPL training.

(e) Soldier specimens shipped to FTDTL.

(f) Soldier specimens tested by FTDTL.

(g) Soldier specimens rejected by FTDTL (by UIC).

(h) Soldiers tested (1 x time only).

(i) Soldier specimens testing positive.

(j) Soldier specimens submitted for medical review.

(k) Soldier specimens confirmed as testing positive but legitimate use.

(l) Civilian specimens submitted for UA testing.

(m) Civilian specimens confirmed as testing positive.

(n) Civilian TDP DoT breathalyzer tests performed.

(o) Civilian TDP DoT breathalyzer tests with positive results.

(2) *Deterrence Outcome Indicators.*

(a) FY Units with two (2) or more certified UPLs Rate.

(b) FY Drug Testing Discrepancy Rate.

(c) FY Soldier/Civilian Random Testing Rate.

(d) FY Soldier Testing Rate.

(e) FY Soldier/Civilian Confirmed Illicit positive rate.

(3) *Prevention Process and Output Indicators.*

(a) Soldiers taking URI/R–URI Self Report Inventory.

(b) Companies undergoing URI/R–URI Self Report Inventories.

(4) *Prevention Outcome Indicators.*

(a) FY ADAPT Completion Rate.

(b) FY ADAPT Recidivism Rate.

(5) *Assistance Process and Output Indicators.*

(a) Soldiers enrolled in ADAPT.

(b) Soldiers self-enrolled in ADAPT.

- (c) Soldiers enrolled within 60 days of determination to attend ADAPT.
 - (d) ADAPT enrollees who complete ADAPT training.
 - (e) ADAPT graduates with no drug/alcohol relapses less than 1 year.
 - (f) Soldiers with alcohol related incidences.
 - (g) Soldier Army Retention Status at time of discharge.
 - (h) Soldiers not successfully completing assistance and discharged from assistance.
 - (i) Soldiers not successfully completing Retention Status at time of discharge.
 - (j) EAP Organizational consultations performed.
 - (k) EAP DAC mediations performed.
 - (l) DACs referred to EAP for confirmed positive for illicit drugs.
 - (m) DACs referred to EAP for DWIs self or command referred.
 - (n) DACs with other adult living problems/issues seeking EAP assistance.
 - (o) DACs assessed by EAP.
 - (p) DACs recommendations prepared by EAP.
 - (q) EAP recommendations accepted by client.
 - (r) EAP client sessions.
 - (s) EAP client cases closed.
 - (t) EAP clients still employed after 1 year.
 - (u) EAP clients performing at Satisfactory or higher level.
 - (v) EAP clients contacted through longitudinal case tracking.
- (6) *Assistance Outcome Indicators.*
- (a) FY EAP Consultation Success Rate.
 - (b) FY EAP Mediation Success Rate.
 - (c) FY EAP Client Satisfaction Rate.
- (7) *Capturing data.* The preceding list of indicators are not all inclusive. Data will be tracked harnessing the ADOR that captures the output or it will be done manually and stored in ADOR accordingly (for example DAMIS). ARD will maintain an updated copy of the performance indicator and provide access as required to all stakeholders.
- e. Inspections. Commands implementing the substance abuse programs should conduct onsite inspections only when clear negative patterns and trends arise within the functional process and performance indicators. The only required inspection will occur within the function of deterrence, specifically the sub tasks associated to drug testing.
- (1) The ARD delegates inspection authority to IMCOM and AMC to perform these inspections. Each installation or depot will be inspected at least one time in a 3-year period, commencing with revision of this regulation. Processes and procedures to be inspected includes:
- (a) Military UA collections.
 - (b) Civilian UA collections.
 - (c) DTCP operations.
 - (d) Testing Designated Position management.
 - (e) Unit Prevention Leader training.
- (2) Commands will report to ARD at the end of each FY, the number of installations/depots inspected and the resulting trends, issues, and best practices identified within drug testing.
- f. Process evaluation will rely upon each command with dedicated manpower on their force management document for substance abuse, to annually track the substance abuse programmatic inputs by function. ARD will establish a repository in an ADOR to annually track input indicators associated to the substance abuse effort by location. Input indicators measure the various resources that go into a program. At the conclusion of each FY, data compiled will be leveraged during either the process or program evaluation stage. At a minimum commands will report the following:
- (1) Financial. Budgeted and executed dollars by MDEP and function.
 - (2) Personnel. Average on hand quantity of personnel, by function, broken out by military, civil service and contractor to support.
 - (3) Personnel Professional Characteristic. Qualifications and total years' experience of functional personnel.
 - (4) Personnel Personal Characteristics. Individual characteristics of staff such as average age, gender and ethnic back ground.
 - (5) Facilities. Number of buildings used and rooms.
 - (6) Best Practices. Identified changes in processes or procedures that illustrate potential to create positive conditional change.
- g. Process evaluation is a methodical collection of information to document and assess the implementation and execution of the substance abuse. The data assists in determining if efforts are being implemented as designed and can

be used to improve the delivery and efficiency of the program. It sets the stage for a periodic program evaluation effort.

13–4. Program evaluation

a. Program evaluation will occur through the ARD Portfolio Capabilities assessment process. The purpose and intent of this effort is explained in paragraph 13–1*b* (3). While treatment is a tenet of the overall Army’s substance abuse strategy, it is executed by MEDCOM and evaluated at the MTF level. The Surgeon General has oversight of all aspects including the evaluation of SUD clinical care at all levels in accordance with 10 U.S. code § 8036 and DoDI 1010.04.

b. The effort will occur in four stages that are categorized as groundwork, formalization, implementation, utilization.

(1) Groundwork. G–1 ARD, as the proponent for the program will serve as the functional lead and appoint a team lead(s) for the evaluation advisory group. Technical support will be provided by Army Public Health Command. Army commands (IMCOM, AMC, and MEDCOM) that execute a process and provide dedicated resources for the substance abuse effort will provide one subject matter expert to serve on the advisory group during all stages. This stage ends when an evaluation plan will be drafted, with attention to how the evaluation process and findings will be used in decisions about policy and programmatic modification. At a minimum the purpose, questions, and methods used in this evaluation will be addressed.

(2) Formalization. Publication of a formal evaluation plan. Agreement will be achieved on what current output and outcome indicators that can be leveraged, new data requirements and any additional data collection tools required (for example, written surveys, telephone surveys, personal/group interviews, and so on). Prior to publication of the formal plan, all data collection tools must be developed and approved by the evaluation team. This stage ends when the evaluation plan is published.

(3) Implementation. In this stage, the program evaluation is conducted and data collection and a preliminary analysis occurs. Special attention is given to early findings and possible recommendations. A draft report is prepared and a formalization of the evaluation findings and resulting recommendations. The draft report is reviewed by the evaluation advisory group; the report is finalized with their input. This stage ends when the findings are sent to and approved by HQDA, G–1.

(4) Utilization. A review of the results will occur with additional stakeholders and a discussion will ensue on how best to use the findings. The findings can be used to modify current policy documents or the continuous process evaluation effort modify, seek additional funding, or make recommendation of possible termination of inefficient efforts. The G1, functional proponent program manager or lead will develop an action plan for subsequent implementation and monitoring until the next formal evaluation occurs.

c. ARD is responsible for maintaining all documentation associated to the program evaluation for substance abuse.

Chapter 14

Army Substance Abuse Services Information and Records Management

Section I

Introduction

14–1. Overview

a. The DAMIS is the Army’s official repository for all current and historical ASAP related information. This information is necessary for routine and special reports to program managers and decision makers. It serves as a vital reservoir of data from which research activities can take place. Computer processing and statistical analysis packages are used to develop these reports in convenient formats. The DAMIS supports the Army Health Promotion (AR 600–63) and the Health Promotion, Risk Reduction, Suicide Prevention guidance for information sharing described in DA Pam 600–24. For administrative records, DAMIS is the system of record. For medical records outlining clinical care, the Armed Forces Health Longitudinal Technology Application (AHLTA) or other medical system of record is the system of record. The total DAMIS database contains sensitive patient information, UA information, staffing and workload information, and access to personnel information for gathering data on current and former patients to determine long term success of Soldiers who have completed treatment and remain in the Army. DAMIS provides essential management information on the ASAP at each level of command. The data generated by the DAMIS provides the capability to—

(1) Measure the magnitude of alcohol and other drug abuse.

- (2) Measure the progress made in the ASAP prevention and risk education efforts.
- (3) Measure the progress made in mandatory treatment aspects.
- (4) Identify statistical trends to support requisite policy and procedural changes.
- (5) Identify funding and manpower requirements for the non-clinical tenets of ASAP.
- (6) Reply to public, media, Congressional, or other Government agency inquiries.
- (7) Perform background checks on ASAP military personnel. (Information will be released only to individuals who have an official need to know prior to appointing an individual into an ASAP-related position.)
- (8) Perform background checks on DA Civilians with prior written consent of the employee in accordance with 42 CFR 290dd-2. Information will be released only to the requesting agency designated on the consent to release form.
 - b. The data contained in the DAMIS originates from the ASAP, FTDTL, SUD clinical staff, and the Army personnel database input.
 - c. Due to confidentiality requirements cited in paragraph 14–2, below, only selected ARD, ASAP, OTSG and SUD personnel with a required need will have access to the DAMIS. See DA Pam 600–85 for ASAP access instructions.
 - d. ASAP Personnel are responsible for checking the name of individuals requiring an installation records check against the DAMIS records to identify individuals who may have had a positive drug test. This check will require the individual's consent. The background check process will consist of two separate checks, clinical and drug testing. For the drug testing check, ASAP will provide information to the commander designated entity within 5 business days on all positive UA tests results for illegal substances and any positive test that has not been adjudicated by a MRO as authorized use, SUDCC will provide information to the commander designated entity within 5 business days on dates of screening when not enrolled with the primary basis and diagnosis if one is available and the enrollment period if enrolled, with primary basis and diagnosis and success or failure of rehabilitation. The DA Form 5018–R will be used only for clinical information and an approved organizational form will be used for background check requests involving drug testing information.

14–2. Policy

The release and/or discussion of information within the Army concerning a potential or actual substance use disorder and/or abuse of other drugs is governed by the restrictions contained in the 5 USC 552a, 42 USC 290dd-2, AR 40–66, and AR 25–22.

a. For Soldiers such information will be made known to those individuals within the Army who have an official need to know. The restrictions on release of information outside the Army are prescribed by the legal authorities 42 USC 290dd-2 and 42 CFR Part 2 cited, above. For additional information refer to chapter 10. .

b. For DA Civilians, the restrictions on release of information within or outside the Army are prescribed by the legal authorities 42 USC 290dd-2 and 42 CFR Part 2 cited above. For additional information refer to chapter 6.

Section II

Reporting Procedures

14–3. Army Substance Abuse Services reports

The following are reports that will be submitted in electronic format when the data will be maintained by the DAMIS:

a. Resource and Performance Data contains primarily non-clinical tenets of ASAP management information about drug testing, EAP, risk reduction, prevention education and population served, prevention and education, manpower utilization and staffing, and obligated fund analysis:

(1) Installation ASAP managers will input resource and performance data on the last working day of the month following the period the report covers.

(2) The ARD will review the resource and performance data for accuracy and completeness and will contact the ASAP manager if data is in error or incomplete. The ASAP manager will provide the corrections to ARD within 10 duty days of notification.

b. DA Form 4465 (Patient Intake/Screening Record (PIR)) documents all Soldiers in mandatory care. DAMIS will be completed to include demographics and disposition for Soldiers in treatment by BH/SUDCC staff within 10 working days after intake and within 10 days of treatment completion. The USAR/NG ASAP manager will ensure that the DA Form 4465 are entered within 45 days after the Soldier's evaluation occurs. The SUDCC will enter release information within 10 working days from the date of release from mandatory care. In addition, patient release record will document milestones (minimum of every 90 days and program release) for Reserve Component Soldiers treated by certified and/or approved counseling or treatment agencies. The USAR/ARNG ASAP manager will ensure that release information are received and entered into DAMIS at appropriate milestones in a Soldier's treatment process.

- c. The installation EAP coordinator will input the initial counseling session into DAMIS (The EAP coordinator will report input into DAMIS all initial counseling caseload.)
- d. The MRO review data will be completed and entered into DAMIS within 15 working days of the results being posted on the FTDTL's Web portal.
- e. The ADAPT attendance records allow DAMIS to contain the complete record of a Soldier's ASAP program and allows the ARD and local ASAPs to evaluate the effectiveness of the ADAPT. The PC will submit the requested data through DAMIS within 10 days of each course completion.

14-4. Army Substance Abuse Program request to change data stored in Drug and Alcohol Management Information System

All changes of data in DAMIS must be requested in the form of MFR on letterhead addressed to the Director, ARD. The request must state the reason for change and will be accompanied with all supporting documentation and be signed by the ASAP manager. All clinical requests will be sent through the IDPH to the Regional IDPH to BHSL before sending to Director, ARD.

Section III

Reporting Requirements

14-5. Integrated Total Army Personnel Database reporting requirements

The DAMIS provides near real time access to a Soldier's assignment data through the Army Personnel Database reporting requirements if the Soldier has a DAMIS record.

14-6. U.S. Army Medical Command reporting requirements

a. By the 10th of each month, MEDCOM will provide the following data for both military and civilian tests to the Director, ARD for the previous month's operations of each FTDTL:

- (1) Total specimens received.
- (2) Total specimens tested by drug type.
- (3) Total specimens confirmed positive.
- (4) Total specimens confirmed positive by drug.
- (5) Total Soldiers confirmed positive.
- (6) Total specimens with discrepancies that caused the specimen not to be tested, by discrepancy category.

b. Notify the Director, ARD, and the installation ASAP manager immediately regarding any false positive results reported by the FTDTLs.

c. The MEDCOM will provide a daily download of drug testing data from the Laboratory Information Management System (LIMS) to DAMIS.

d. The MEDCOM will notify the Director, ARD of any changes in the nomenclature or naming of testing data prior to making changes within the FTDTL information system.

e. The MEDCOM will provide to the Director, ARD quarterly assistance/treatment functional capability assessment reports to inform stakeholders and Army leaders on how well the system is implementing policy designed to sustain and improve upon the personal readiness (PR) of the force. Collaboratively develop and review annually reports supporting metrics (of this report) to account for the Army's dynamic operational environment and information requirements of the Army's leadership.

14-7. Army Substance Abuse Services patient records

All SUD treatment records will be maintained in accordance with AR 40-66.

Section IV

Management Information Feedback Reports

14-8. Overview

a. Direct communication between the Director, ARD and installation ASAP manager is authorized. The ARD will maintain a historical database of ASAP data collected from resource administrative (DAMIS) and performance data, and drug testing data that will be used for program management and strategic program planning.

b. The ARD will produce management reports for each ASAP manager and IDPH/CD, Region ASAP manager, and the IMCOM Chief, ASAP/R2. This information will be derived from resource and performance data, administrative data (DAMIS) and drug testing data submitted to ARD.

14–9. The Drug and Alcohol Management Information System reports

The information retained in DAMIS allows the ASAPs to obtain reports that will allow the ASAP manager to provide accurate data on all Soldiers. Available reports include-

- a.* Repeat Positive Detail – by DoD ID number.
- b.* Repeat Positive Detail – by BAC.
- c.* Drug Detail Report.
- d.* Deployed Drug Detail Report.
- e.* Unit Drug Detail Report.
- f.* DTP Utilization.
- g.* Test Basis Positives.
- h.* MRO – Delinquent Evaluations.
- i.* Other DA specific reports.

14–10. Drug and Alcohol Management Information System metrics

The ARD will track all reporting that is required from the ASAPs and provide feedback to those ASAPs not in compliance with this chapter.

Chapter 15

Army Substance Abuse Program in the Army National Guard

Section I

General

15–1. Scope

The ASAP policies and procedures in this regulation apply to all components of the Army, including the ARNG. However, due to the different laws and conditions that affect National Guard when they are on state and federal duty, some additional or different ASAP policies and procedures may also apply. The CNGB will implement the ASAP at the State level based on program functions in the ARNG. Subject to the CNGB's discretion, the following should be considered when planning State ASAPs.

15–2. Applicability

a. This chapter applies to all ARNG Soldiers including recruits in the Recruit Sustainment Program, except for personnel in the following duty categories, who are covered by the provisions in the other chapters of this regulation:

- (1) AD of 30 days or more that is not for training, including AD in an AGR status under 10 USC.
- (2) Special tours of AD for training (ADT) of 30 days or more.
- (3) Initial AD training.
- (4) Involuntary ADT of 45 days or more.
- (5) Soldiers ordered to AD status during periods of partial, full, or total mobilization.

b. State employees and Federal technicians are not serving in a military duty status while employed in those capacities, and this chapter does not apply to them unless otherwise stated.

Section II

Subject to the Chief, National Guard Bureau's discretion, the following should be considered when planning State Army Substance Abuse Programs

15–3. Chief Surgeon, Army National Guard

- a.* Provide technical consultation on all medical aspects of the ARNG ASAP.
- b.* Coordinate with the states to ensure they have state MROs who are trained and certified by USAMEDCOM.

15–4. Chief, Substance Abuse Section

- a.* Administer, manage, and provide direction to the ARNG ASAP.

- b.* Establish requirements and prepare budget requests for ARNG funds to support the ASAP.
- c.* At CNGB's discretion provide liaison with HQDA and other agencies on ASAP matters.
- d.* Develop and provide guidance to the state MROs to ensure timely completion of medical reviews.
- e.* Develop and provide guidance to state DTCs regarding funding.
- f.* Ensure MRO findings, substance abuse training, UPL certification, and DA Form 4465 and DA Form 4466 (Patient Progress Report (PPR)) are input into the DAMIS.

15-5. State adjutants general

- a.* Provide program management and operational supervision of the ARNG ASAP within their state or territory.
- b.* Establish state ASAP policies.
- c.* Designate a state Medical Review Officers (MRO) on appointment orders.
- d.* Designate an ARNG DTC on appointment orders.
- e.* Direct the establishment of an Alcohol Drug Intervention Council (ADIC).

15-6. Drug testing coordinator

- a.* Be an E-5 or above and be appointed, in writing, to serve as the DTC by the state AG.
- b.* Be certified by the Drug Test Coordinator Certification Course within 12 months of appointment.
- c.* Must be HIPAA certified to manage confidential and medical information.
- d.* Perform day-to-day management of the state's ARNG Drug testing Program to include management of substance abuse funds.
- e.* Prepare random, mandatory testing, and other test rosters, as necessary, for use in conducting the state's UA collections.
- f.* Receive the Soldiers' drug test results from the FTDTL Web portal, and notify the commanders' or the commanders' designated representative, of the tests as soon as possible not to exceed 45 working days of retrieval. For any positive results, review the Soldier's past UA records in DAMIS to determine if they have previous positive UA results. Notify the commanders who ordered the tests of all positive UA results in the Soldier's records.
- g.* Coordinate the positive result notification process through the appropriate offices ensuring that Soldiers' personal information is protected from inadvertent disclosure until it reaches the Soldier's commander.
- h.* Coordinate all laboratory requests for the state.
- i.* Submit requests to the FTDTL for specimens to be retained for longer than 1 year, as needed.
- j.* Ensure the state's ARNG DTP is conducted according to proper procedures in a professional, controlled, and unbiased manner.
- k.* Prepare and conduct certification training for UPLs that meets the DA UPL CTP standards.
- l.* Provide staff assistance visits to state units.
- m.* Order and maintain administrative and testing supplies.
- n.* Liaison to the National Guard Bureau (NGB)-G1-HRS-SAP section.
- o.* Maintain copies of all drug testing documentation and correspondence while ensuring units are keeping originals, all in accordance with AR 25-400-2 and Privacy Act guidelines.
- p.* Maintain the state's action plan to reduce discrepancies to ensure that the state's discrepancy rate is over less than 3 percent.
- q.* Provide UPL training to personnel providing direct support to the DTC within 30 days.

15-7. Drug testing rate

Company/troop commanders will randomly test 10 percent of their Soldiers each month or the equivalent for units on alternate battle assembly cycles. All Soldiers are required to provide a valid sample for testing annually. Any Soldiers who are not selected for testing in the first three quarters, must be selected for testing in the fourth quarter using the Inspection Other (IO) in addition to the normal 10 percent monthly random selection.

15-8. State medical review officer

- a.* Be appointed on orders by the state AG.
- b.* Be eligible to serve as MRO and trained and certified to perform MRO duties by USAMEDCOM within the first 6 months of duty assignment.
- c.* Determine if positive drug results reported by the FTDTL could have resulted from the legal use of a prescription drug for medical reasons and/or for drugs administered during surgical or dental procedures. The MRO will make the determination and notify the SAP within 15 days of receiving the positive result to review.

d. If necessary, coordinate with the unit commander, who will offer the Soldier the opportunity to furnish medical evidence in the form of a medical prescription and/or statement from the Soldier's physician or dentist documenting the drug prescribed or given, date of medical or dental procedure which required prescribed drugs, and the medical reason for its use. The documentation will be marked "For Official Use Only - Personal in Nature" and will be forwarded to the MRO for evaluation. Unit commanders will not initiate an adverse action against the Soldier until the MRO had rendered an evaluation.

15–9. Specimens requiring review by a medical review officer by Department of Defense policy

Medical Review Officer (MROs) are authorized to check the State Prescription Monitoring Program (PMP) to determine Authorized Use, prior to any of these steps. If authorized use is determined, MRO will notify the ASAP office immediately. Lack of documented prescription information in the PMP cannot be used to determine Illicit Use.

- a.* Upon receipt of a presumptive positive drug result, ARNG commanders will—
 - (1) Notify Soldiers within 30 calendar days of receipt of the presumptive positive drug test result.
 - (2) Document the notification procedure used.
 - (3) Forward the documentation to the SAP office.
- b.* If unable to notify the Soldier telephonically or in person, ARNG commanders will—
 - (1) Mail the notification by certified mail, return, and/or return receipt requested.
 - (2) Complete an affidavit of mail.
 - (3) Forward the affidavit of mail and return receipt to the SAP office.
- c.* If the notification memorandum is mailed and the Soldier fails to acknowledge receipt, or fails to submit a reply within 30 calendar days of the postmarked date, administrative separation actions will proceed.
- d.* ARNG Soldiers must provide any legitimate prescription information or documentation within 30 calendar days after receiving notification on a presumptive positive drug test result to the SAP office.
- e.* Requests for an extension for good cause may be submitted to the SAP office for approval.
- f.* Unless an extension is granted, failure to deliver the proper documentation within 30 calendar days of the date of notification of a presumptive positive drug test may constitute a determination of illegitimate use and result in initiation of administrative separation actions.
- g.* The SAP office will ensure that the MRO receives test results for review and proper prescription documentation within 15 calendar days of SAP office receipt.
- h.* The MRO will provide a formal determination and complete DAMIS input and forward to the SAP office within 15 days of receiving positive test result documentation. Within 15 days of receiving the MRO determination, the SAP office will notify the Soldier's commander for action and decision.
- i.* Total process for MRO review should take no greater than 90 calendar days from result posting to completion of DAMIS input.

15–10. Military justice

Incidents involving alcohol or other drugs may also constitute a basis for violation of law and/or a military justice code. Soldiers may be processed under applicable code for disciplinary action in addition to separation and other administrative actions outlined under this regulation.

15–11. Unit risk inventories

Commanders of companies, detachments, and equivalent units should ensure that the URI and the R-URI are administered in accordance with NGB policy. The URI assesses units while at home station, and should be administered no later than 30 days prior to deployment. The R-URI assesses issues affecting unit readiness and personnel well-being that may have occurred during deployment or since returning, and should be administered at 30 to 180 days after returning home from an operational deployment.

Chapter 16

Army Substance Abuse Program in the U.S. Army Reserve

Section I

General

16–1. Scope

This chapter establishes policies, responsibilities, and specific procedures for implementing and managing the ASAP within the USAR.

16–2. Applicability

a. This chapter applies to USAR Soldiers while not on AD for 31 days or more in the following categories:

- (1) Troop Program Unit (TPU). (see AR 135–200),
- (2) Individual Mobilization Augmentee (IMA) Program.
- (3) Individual Ready Reserve (IRR).
- (4) Soldiers serving on various tours:
 - (a) ADOS
 - (b) Activate Duty Special Work (ADSM)
 - (c) ADT
 - (d) ADT–S

b. The ASAP policies and chapters apply to activated USAR Soldiers in the following status:

- (1) Active Guard Reserve (AGR)
- (2) Presidential Selected Reserve Call-up (Title 10, active), such as partial, full or total mobilization
- (3) Mobilized 31 days or more

Section II

United States Army Reserve Specific Responsibilities

16–3. Commander, U.S. Army Reserve Command

The Commander, USARC will—

- a.* Establish a Substance Abuse Program Manager (SAPM) within USARC HQ.
- b.* Appoint a Substance Abuse Program Manager, to be filled by a civilian or AGR Soldier.
- c.* Appoint a USARC ASAP manager, which should be filled by a civilian, AGR / Regular Army Field Grade Officer or above.
- d.* Designate (and/or appoint when possible) USARC MRO advisor on orders, which can be filled by a civilian, AGR, or Regular Army member.
- e.* Appoint USARC Budget Analyst.
- f.* Appoint an Employee Assistance Program Manager (EAPM).
- g.* Appoint a PC.
- h.* Appoint a Risk Reduction Program Manager (RRPM).

16–4. U.S. Army Reserve Command Substance Abuse Program Manager

- a.* Provide guidance and leadership over the Army Reserve drug policy issues.
- b.* Oversee the Army Reserve drug substance abuse program.
- c.* Prepare budget submissions, direct allocation of funds, and monitor execution of funds.
- d.* Maintain liaison between the Army and the other uniformed Services, other Federal agencies, and the private sector.
- e.* Provide operational guidance, monitoring, and oversight of the Army Reserve ASAP.
- f.* Consolidate all substance abuse statistics and provide periodic reports to higher headquarters.
- g.* Establish and maintain program-level evaluation plans, measures, data collections, analyses, and reporting procedures HQ.
- h.* Oversee the duties of the contract officer representative (COR).

16–5. Commanders of subordinate commands

The subordinate commanders (SC) commanders will—

- a. Establish a substance abuse program within their respective command.
- b. Appoint an ASAP manager to serve as the principal advisor on substance abuse prevention and training matters.
- c. Appoint an MRO and, when it is not possible to appoint a MRO from within available personnel resources, support will be provided by the USAR MRO advisor or Program Manager.
- d. Appoint an EAP coordinator, which will be filled by a DA Civilian.
- e. Appoint a Prevention Coordinator (PC), which can be filled by a 1) DA Civilian or 2) AGR, TPU or Regular Army SFC or above.
- f. Appoint a Risk Reduction Program Manager (RRPM), which can be filled by a 1) DA Civilian or 2) AGR, TPU or Regular Army SFC or above.
- g. Ensure continued support to USAR units in the execution of regulatory requirement.
- h. Will receive ASAP training in accordance with TRADOC regulations.

16–6. Subordinate Command Alcohol Drug Control Officer, to include U.S. Army Reserve Command Alcohol and Drug Control Officer/Army Substance Abuse Program manager

The SC ASAP manager will—

- a. Provide management and guidance over all USAR drug testing and prevention/education components of ASAP staff and programs.
- b. Develop and coordinate command ASAP policies and procedures.
- c. Provide data for budget and manpower planning, develop funding controls and maintain appropriate records of all ASAP resource transactions and testing within their commands.
- d. Manage and monitor the command alcohol and drug testing programs. When possible or requested by Commander the ADCO will be present at monthly battle assembly and other testing opportunities.
- e. Maintain drug testing records in accordance with ACRS (see AR 25–400–2).
- f. Monitor and evaluate the commander referral rate, and the evaluation completion rate, and provide monthly reports to the USARC Program Manager and commanders.
- g. Retrieve Soldiers' drug test results from the FTDTL Web portal, and notify the commanders, or the commanders' designated representative, of the tests as soon as possible not to exceed 45 working days of retrieval. For any positives results, review the Soldiers' past UA records in DAMIS to determine if they have previous positive UA results. Notify the commanders who ordered the tests of all positive UA results in the Soldiers' records.
- h. Be prepared to testify as an expert witness about the UA collection process during administrative separation boards.
- i. Ensure the MRO is appointed by the commander.
- j. Provide the MRO with supporting medical evidence (or the lack thereof) within 60 days after unit commander has been notified of the possible medical positive result and not to exceed the 90 day requirement.
- k. Ensure MRO findings are input into DAMIS within 45 days upon receipt of medical review, ensuring timeline from lab certification date to entry into DAMIS does not exceeding the 90 days.
- l. Assemble and disseminate information concerning substance abuse treatment at installations and certified community-based programs.
- m. Restrict notification of positive test results to the Soldier's unit commander (or commander's designated representative), the SC commander, the supporting legal office, and Security Manager(s).
- n. Ensure all mobilizing unit company-size or larger arrive at the mobilization station with at least two trained and certified UPLs and enough drug testing supplies to test 100 percent of the unit strength.
- o. Ensure that all temporary storage sites for UA specimens used by SC meet the requirements (see app E).
- p. Ensure all ASAP personnel involved in the collection or processing of UA specimens are trained and certified on the procedures established in appendix D, and that personnel who train UPLs in their collection duties are certified in accordance with paragraph 9–5c.
- q. Ensure that substance abuse training rosters are received from units and that the data is entered into DAMIS within 10 working days of receiving the roster.
- r. Enter the name, rank, and other information required on Soldiers that are certified as UPLS into DAMIS within 10 working days after a UPL certification is complete.
- s. Ensure that Soldiers who are identified as a substance abuser are screened and evaluated by a certified and/or licensed substance abuse counselor and a completed DA Form 4465 is entered into DAMIS.
- t. Ensure that Patient release records are completed on Soldiers who are enrolled into treatment at least every 90 days and/or when released from treatment. This should be entered in DAMIS within 10 days of receipt of treatment update.

- u. Serve as the coordinator of all substance abuse and risk reduction issues for the IPT, human resources council, or other similar appropriate forums.
- v. Assist commanders and supervisors in the ID and referral of individuals suspected of problematic substance use.
- w. Evaluate all prevention education and training aspects of ASAP at the end of the fiscal year, and forward through the commander, USARC Substance Abuse Program, ARD, a written report of the command prevention program activities and accomplishments.
- x. For military personnel only, restrict notification of positive drug test results with the ability to transition from using a Soldier's SSN to DoD EDI-PI, located on the Soldiers common access card. The EDI-PI will serve as the primary means for Soldiers and sample ID for military drug testing collection procedures. Drug testing laboratories will continue to accept both SSN and EDI-PI during the transition. DoD will announce when SSN will no longer be accepted in future correspondence. The notifications will be—
 - (1) The commander who ordered the test.
 - (2) The chain of command over the commander who ordered the test.
 - (3) The supporting legal office when they are acting on behalf of the commander who ordered the test.
- y. Supervise the MRO review process and ensure the review timelines are being met. Prepare and submit all required reports in DAMIS or other electronic form as specified.
- z. Ensure PCs will—
 - (1) Promote ASAP and SUDCC services using marketing, networking, and consulting strategies.
 - (2) Provide training and any other services to assist organizations in ensuring all military and civilian personnel are provided prevention education training. The DOT-designated positions and other high risk civilian positions should receive targeted training pertaining to their jobs. The PCs will track all training conducted by unit or directorate, as appropriate.
 - (3) Coordinate with the command training officer to assist in integrating the preventive education and training efforts into the overall command training program.
 - (4) Design, develop, and administer target group-oriented alcohol and other drug prevention education and training programs in coordination with the ASAP staff and other command prevention professionals.
 - (5) Maintain liaison with schools serving military Family members, civic organizations, civilian agencies, and military organizations to integrate the efforts of all community preventive education resources.
 - (6) Teach the UPL certification course, provide UPLs with education and training materials, and provide USARC with all training evaluations.
 - (7) Address military command risk levels and work toward reducing the risk factors.
 - (8) Enter into DAMIS all substance abuse training, maintain rosters for all training within the command by units and enter into DAMIS.
 - (9) Conduct pre- and post-deployment, TDY, and area of operation substance abuse training.
 - (10) Develop with ASAP staff members, a substance abuse prevention plan annually.
 - (11) Serve as the coordinator for all RRP issues and the Command Prevention Team (CPT) Human resources council or similar forum, if no RRPC is not available.
 - (12) Develop and implement a RRP policies.
 - (13) Coordinate, facilitate and collect RRP data.
 - (14) Ensure RRP data is collected from the data providers and input into the ASAP Web-based system by the 10th of the month following the previous month quarterly. The RRPC has the overall responsibility in terms of ensuring the data's accuracy.
 - (15) Coordinate with the EAP coordinator on assisting the commanders with identifying high risk units, conducting URI and R-URI surveys, and identifying appropriate intervention services.
 - (16) Ensure that the URI is administered to all Soldiers at least 30 dates before an operational deployment, annually, upon change of command, and the R-URI is administered to all Soldiers between 30 and 180 days after returning from an operational deployment.

16-7. U.S. Army Reserve medical review officers

U.S. Army Reserve MROs will—

- a. Be appointed on orders. MRO certification is valid for 3 years.
- b. Be trained and certified to perform MRO duties by USAMEDCOM within the first 6 months of duty appointment.
- c. Review positive UA drug test results on Soldiers for the drugs that require review by DoD policy. For questions contact the ASAP manager.

d. Determine if positive drug results reported by the FTDTL could have resulted from the legitimate use of a prescription drug for medical reasons and/or for drugs administered during surgical or dental procedures.

e. If necessary, coordinate with the unit commander, who will offer the Soldier the opportunity to furnish medical evidence in the form of a medical prescription statement from the Soldier's physician or dentist and the medical reason for its use, and pharmaceutical documentation prescribed or given with the date of medical or dental procedure which required prescribed medication.

f. The MRO will make the determination and notify the ASAP manager within 45 days upon receipt of medical review, ensuring timeline from lab certification date to entry into DAMIS does not exceed the 90 days receiving the positive result to review. Note: Unit commanders will not initiate any adverse action against the Soldier until the MRO has rendered a determination.

(1) There is no requirement for the MRO to have a telephonic or in-person interview with the Soldier as long as the review can be resolved by reference to the Soldier's available medical record. Soldiers will be provided the opportunity to present evidence of legitimate prescription use if the electronic or hard-copy medical records show no explanation for the positive result. If an interview does occur with the Soldier, the MRO will advise the Soldier of their rights from DA Form 3881 (Rights Warning Procedure/Waiver Certificate).

(2) If the MRO verifies legitimate use, they will notify the ASAP manager, the unit commander and the MSC military personnel officer. No further action is required.

(3) If the MRO confirms the drug use was not legitimate, the MRO will notify the ASAP manager, the unit commander and the military personnel officer. The unit commander will counsel the Soldier in accordance with paragraph 16–8 and process the Soldier for separation through the military personnel office to the separation authority.

Section III

Policies and Procedures

16–8. Policy

The objective of the USAR program is to sustain a well-disciplined, mission capable force ready for mobilization. Abuse of alcohol and other drugs is incompatible with service in the USAR.. Well organized and effective programs in UA testing and alcohol and other drug prevention and education are critical to achieving this objective. Substance abuse incidents are defined as any event in which alcohol or other drugs were involved, including positive UA for illicit drug use or non-legitimate use, DUI, domestic violence/assaults, fights, attempted suicide/gestures, unrestricted SHARP reports, arrests, and so forth.

a. Company or troop commander will conduct inspection random selection at a minimum of 10 percent monthly or 25 percent quarterly. The maximum selection rate is 40 percent of the overall unit strength per collection.

b. Commanders will not release information on positive drug results or initiate administrative actions until an MRO review is completed if one is required.

c. The USAR Soldiers identified as having a substance abuse incident will be—

(1) Counseled by the unit commander, in person or by certified mail for possible enrollment in a USAR program. Command counseling sessions will be conducted within 30 calendar days, or by the close of the next battle assembly, after the receipt of MRO-verified positive drug test report.

(2) Flagged immediately in accordance with AR 600–8–2 using DA Form 268 to suspend favorable personnel actions until separation procedures for misconduct are adjudicated, especially if a Soldier has two serious incidents for alcohol or two for drug related misconduct within in year.

(3) Processed for administrative separation. Administrative separation will be initiated and processed to the separation authority for decision on any Soldier with a positive drug test that could not have resulted from legitimate medical use of a drug.

(4) Evaluated for continued eligibility for access to classified information and reported to DoD CAF.

d. Commanders will not release information on positive drug results or initiate administrative actions until an MRO review is completed, if one is required.

e. Company or troop commanders will randomly select a minimum of 25 percent not to exceed 40 percent of their assigned strength to each month to meet the requirement of 100 percent.

f. USAR Soldiers involved in alcohol related misconduct such as drinking/impaired on duty (see para 3–2a) or operating a motor vehicle while impaired (regardless of the geographic location of the incident) will be—

(1) Counseled by the unit commander, referral to EAP coordinator, military, VA or certified community-based substance abuse treatment program for initial screening and possible treatment. Command counseling will occur within 45 calendar days of the Soldier's ID for possible alcohol related abuse, if operationally possible.

- (2) Flagged after first incident (using DA Form 268) immediately in accordance with AR 600–8–2 until separation procedures under appropriate regulations for misconduct are adjudicated.
- (3) If a Soldier has two serious incidents of alcohol related misconduct in a year.
- (4) Have their current duty assignment reviewed, and be relieved from duty if warranted. Commanders will ensure relief for cause is recorded.
- (5) Have their Service record reviewed by the Soldier’s commander to determine if one or more of the following actions are warranted:
 - (a) Administrative reduction in rank for inefficiency under the provisions of AR 600–8–19.
 - (b) Bar to reenlistment.
 - (c) Relief for Cause evaluation report.
 - (d) Administrative discharge/or disciplinary action under UCMJ, if applicable.
 - (e) General Officer Memorandum of Reprimand.
- (6) Evaluated for continued eligibility for access to classified information and reported to the DoD CAF who will determine if any formal evaluation of a security clearance is required. Note: No formal suspension of security clearance occurs at this time. In the case of a suspended separation, the Soldier will remain flagged until separation is remitted.

16–9. Funding considerations

Chapter 18 of this regulation applies to the USAR, except that—

- a. Counterdrug operation and maintenance, Army Reserve funds will be used to pay for—
 - (1) Supplies and shipping material for the collection and shipment of UA specimens to the FTDTL.
 - (2) Documentation or commanders’ packets and related costs (see para 4–19). Each Commander will submit a request for a documentation packet to the FTDTL and provide a copy of the request to the supporting reserve readiness command/regional readiness support command ASAP manager. Counterdrug operation and maintenance funds may be used for payment of expert witness’ fees when approved by the ASAP manager.
 - (3) Travel costs to Army MTFs for Soldiers on AD for 30 days or longer, who test positive for illegal substances and require screening and/or counseling.
- b. Counterdrug Pay and Allowance (VCND) funds will be used to pay for—
 - (1) ASAP training, including travel costs to conferences and seminars.
 - (2) UA collections when travel is required because no unit UPL is available.
- c. Counterdrug funds will not be used to pay for alcohol and/or other drug rehabilitation for USAR Soldiers.
- d. Substance Abuse Prevention (QAAP) funds will be used to pay for:
 - (1) Supplies in support of alcohol and drug prevention.
 - (2) Substance Abuse Related Services for Soldiers, Family members of Soldiers on AD orders for more than 31 days, and DA Civilians.
 - (3) Alcohol prevention, education (ADAPT/Prime for Life), training, materials and any associated travel cost.
 - (4) Testing requirement for DA Civilians.

16–10. Prevention

Chapter 9 applies to the USAR Soldiers and DA Civilians, except that—

- a. The USAR will establish ASAP prevention and education programs at the lowest command level which emphasize the incompatibility of substance abuse and continued service in the USAR. The USAR ASAP is a commander’s program, and commanders are encouraged to establish a form of ADIC at the lowest possible command level. The mission of the ADIC will be to outline the command’s substance abuse prevention strategies and evaluate the program’s effectiveness within the command.
- b. Commands may include USAR Soldiers’ Family members. The command’s Family readiness program manager can coordinate Family member involvement in their ADIC counterpart as well as DDR Programs.
- c. All newly assigned Soldiers will receive a newcomers’ briefing by the commander or designated representative as part of unit in-processing within 60 days of reporting. At a minimum the briefing will provide information on the ASAP policies, community laws, command policies, drug and alcohol free activities, and the Limited Use Policy.
- d. All AGR and Soldiers on orders for 31 days or more will receive training on abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder awareness. Inactive Soldiers and DA Civilians will receive training on abuse of substances (illegal drug, controlled drug, alcohol or other) and gambling disorder awareness.
- e. All unit substance abuse and gambling disorder awareness training whether conducted by the commander, UPL, the ASAP staff, or a guest speaker will be documented using a sign-in sheet to record the topic, who attended the

training, the date, start time, and end time of the class. A copy of the sign-in sheet will be provided to the ASAP staff within 45 days.

f. Commanders at all levels may include Substance Abuse Prevention and Education training on a case-by-case basis or as mission dictates a need.

16–11. Referral of alcohol and illegal drug abusers in the U.S. Army Reserve Army Substance Abuse Program

Chapter 7 applies to the USAR, except that—

a. When the unit commander believes the Limited Use Policy applies, the unit commander should consult with the ASAP manager and the supporting legal advisor. The unit commander may then explain Limited Use Policy if applicable to the particular circumstances. If the unit commander determines the Limited Use Policy does not apply, the commander should then advise the Soldier suspected of drug or alcohol abuse of the rights under UCMJ, Article 31 (b) and MRE 305, and if available ask the Soldier to sign DA Form 3881.

b. Refer the Soldier to a military, VA or certified community-based treatment program. Document the referral using DA Form 4856. The commander will provide the Soldier with a list of certified and/or approved counseling agencies that are within a reasonable commuting distance of the Soldier's residence. The USAR will not provide counseling services to include evaluation, rehabilitation/treatment and follow-up services. Additionally, Soldiers will be advised that they—

(1) Must promptly arrange for an evaluation, which should take place not later than 45 days from date of the command counseling session.

(2) Sign a consent statement for release of counseling information, which allows the counseling personnel to share necessary information with the commander or designee and the USAR ASAP manager or designated ASAP personnel. The ASAP manager and/or ASAP designated personnel must receive HIPAA training annually. The commander must be kept informed regarding the progress of rehabilitation. Soldiers must request that counseling personnel provide written monthly updates to the commander. The Soldier must also request that the rehabilitation personnel complete and forward to the USAR ASAP manager and/or designated ASAP personnel a DA Form 4465 when Soldier is evaluated and a Patient release record must be submitted a minimum of every 90 days and then at program release. Methadone maintenance and mandatory Disulfiram (Antabuse) treatment will not satisfy the rehabilitation requirements of this chapter. Soldiers may refuse to sign the consent statement. However, these Soldiers may be deemed not to be participating sufficiently in rehabilitation. Refusal to sign may result in their being processed for separation for rehabilitation failure.

(3) Must understand that failure to seek counseling, refusal to sign a consent to release information to the commander, or to participate and complete rehabilitation successfully, will result in initiation of separation proceedings under appropriate officer or enlisted separation regulations.

(4) Can only attend ASAP ADAPT (Prime for Life) after being evaluated by a certified/licensed Substance Use Disorder counselor from a military, VA or community-based substance abuse treatment program.

16–12. Rehabilitation

Chapter 8 applies to USAR members as AGRs or when extended on AD for more than 30 days.

a. The goal of the USAR ASAP rehabilitation/treatment program is to return rehabilitated Soldiers to mission readiness, upon successfully completing substance abuse treatment.

b. Commanders must be innovative and empathetic with Soldiers who are enrolled in treatment. Commanders must conduct, at a minimum, every 90 days a telephonic or in-person update with the Soldier's treatment counselor, and when possible, the Soldier (him/herself) to track his/her progress.

c. When an USAR Soldier receives medical care, after an alcohol or drug incident, at Army expense, an appropriate line of duty (LOD) determination will be made in accordance with chapter 8 or this regulation.

d. USAR Soldiers on AD orders may remain on AD until intensive in-patient/outpatient rehabilitation/treatment is completed at the discretion of the commander unless prohibited by other requirements.

16–13. Drug testing guidance

Chapter 3 and 4 applies to the USAR, except that—

a. The SC commander, unit commander, or their designated representatives will randomly identify individual Soldiers, parts of units, or entire units for random drug testing. Random drug testing quota requests will be in writing and approved by the Commander. All random drug tests will be unannounced.

b. Due to the geographical separation between USAR units and SC ASAP manager staff, all urine specimens may be shipped directly from the unit that is administering drug testing to the appropriate supporting FTDTL. Proper chain of custody procedures are required (see app E for details).

c. Command ASAP manager may establish QC operations within their respective command to include establishing QC facility.

16–14. Management information system

Chapter 14 and the following additional requirements apply to the USAR—

a. SC ASAP managers will maintain individual files on Soldiers referred to military, VA and certified community-based substance abuse treatment programs.

b. DA Form 4465 and DA Form 4466 will document and track the beginning dates, quarterly updates/completion dates, and reasons for disenrollment from rehabilitation, to include reasons for failure to meet the rehabilitation standards.

16–15. Evaluation

Parts of chapter 13 receive periodic modifications to apply to the USAR, specifically paragraphs 13–4. The operation of the USAR ASAP must include a comprehensive program of evaluation to determine program effectiveness, progress and attainment of specific goals and objectives established by the USAR Commander. Technical support and program evaluation of the USAR ASAP will be conducted through the USAR ASAP Program Manager. The USAR ASAP managers will forward a summary report of their ASAP program effectiveness to the USAR Program Manager, who will analyze for overall program effectiveness in the USAR. The USAR ASAP managers or certified DTC personnel will make periodic SAVs to the USAR units to evaluate their overall ASAP effectiveness and progress, and will further provide training assistance support to enhance the ASAP as necessary. Minimum evaluation standards should:

a. Stress the impact of the USAR’s ASAP policies, goals, and objectives on all USAR Soldiers and DA Civilians employed by the USAR.

b. Seek comparisons of the relative effectiveness concerning the various approaches on ASAP prevention and education techniques. Direct USAR ASAP managers to use evaluation questionnaires and checklists available (see app D) for assessing all functional areas of the ASAP, as deemed appropriate.

c. Obtain AARs on the effectiveness, usefulness, and efficiency of different supporting agencies.

d. Determine the overall effectiveness of various ASAP approaches to various target groups.

e. Ensure full integration on all facets of the USAR ASAP at each command. This will be for the purposes of consistency of prevention, education, and training, and substance abuse testing controls and measures for UA chain of custody procedures and reporting. The intent is to alleviate high UA dump rates at the supporting FTDTL due to inaccurate data on the chain of custody.

f. Provide feedback and recommended improvements and/or changes to the ASAP or the commanders, to include economy of funding and staffing resources, program effectiveness, program trends, and recommended changes to goals and objectives as they are met.

g. Identify possible areas for research by the USARC.

16–16. Military justice

Incidents involving abuse of substances (illegal drug, controlled drug, alcohol or other) may also constitute a basis for disciplinary, judicial, and/or non-judicial punishment(s) in accordance with the Manual for Courts-Martial, and applicable Army Regulations, orders and directives. Additionally such incidents/conduct may also constitute a basis for violations of local, state, and/or federal laws. Commanders will consult with their supporting legal office prior to initiating non-judicial punishment (Art 15, UCMJ).

16–17. Risk Reduction Program

Policies and procedures listed in chapter 12 have been modified to apply to the USAR.

a. Due to USAR being a community based organization, HQ USARC will establish an RRP Working Group from Human Resource Policy Directorates to establish key goals and risk factors, as they impact USAR.

b. Modifications have been made to command reporting requirements in an effort to support risk reduction factors for USAR.

c. Risk Reduction data will be reported quarterly (by the 15th of Oct, Jan, Apr, an Jul).

16–18. Specimens requiring review by a medical review officer based on Department of Defense policy

- a.* Upon receipt of a positive drug test result that is reviewable based on DoD policy, USAR commanders will—
 - (1) Notify Soldiers within 45 calendar days of receipt of the DoD reviewable positive drug test result.
 - (2) Document the notification procedure used.
 - (3) Upon receipt, forward the medical documentation to command ASAP manager.
- b.* If unable to notify the Soldier telephonically or in person, commanders will—
 - (1) Mail the notification by certified mail with return receipt requested.
 - (2) Complete an affidavit of mail.
 - (3) Forward the affidavit of mail and return receipt to the command ASAP manager office.
- c.* If the notification memorandum is mailed and the Soldier fails to acknowledge receipt, or to submit a reply within 45 calendar days, administrative separation actions will proceed after ASAP manager coordination with MRO.
- d.* Soldiers must provide a legitimate prescription information or medical documentation within 60 calendar days after receiving notification on a presumptive positive drug test result to the commander. The commander will forward documentation to command ASAP manager
- e.* Requests for an extension for good cause may be submitted to the ASAP manager for approval.
- f.* Unless an extension is granted, failure to deliver the proper documentation within 60 calendar days of the date of notification of a positive drug test that is reviewable based on DoD policy and the MRO will constitute a determination of illegitimate use.
- g.* MRO evaluations will be completed and entered into DAMIS within 60 calendar days of lab certification.

Chapter 17 Awards and Campaigns

Section I

Department of Defense Awards

17–1. General

The DoD and DA awards in the substance abuse field are designed to foster mission accomplishment by recognizing excellence in individuals, programs, and communities.

17–2. Army Substance Abuse Program Awards

- a.* The ASAP annual awards are designed to recognize outstanding achievements by ASAP personnel and to motivate the field to high levels of performance. An individual must occupy one of the positions in the ASAP to be eligible for consideration for the following ASAP awards:
 - (1) Army drug control officer
 - (2) Prevention coordinator
 - (3) EAP coordinator
 - (4) Risk Reduction Program coordinator
 - (5) Drug testing coordinator of the year
 - (6) MSC Army drug control officer in the USAR
 - (7) Joint Substance Abuse Program coordinators (JSAPC) in the ARNG
- b.* The award program is administered by the Director, ARD. At the end of each calendar year, the director announces by memorandum the opening of the awards program. Detailed instructions and applicant templates are included in the announcement. Completed applications are reviewed by a board comprised of employees from ARD. The director reviews the board's recommendations and selects a winner in each category.
- c.* The award eligibility criteria for each position include the following:
 - (1) Duties and achievements limited to a specific calendar year.
 - (2) Each applicant may only apply in one category.
 - (3) Accomplishments documented and quantified by measurable standards.
 - (4) All JSAPC functional areas addressed, as cited in paragraph 15–4.
 - (5) All ASAP manager Functional areas addressed, as cited in paragraph 15–5.
- d.* The installation garrison commander, the AG and NGB must endorse/sign and forward the nomination packet, which must be sent through the HQ, IMCOM Chief, ASAP /R2 to the Director, ARD.

17-3. Army Substance Abuse Program Award for Year 20/30

The Director, ARD recognizes ASAP personnel who have served within the ASAP for 20 and 30 years. Applicants must complete the applicable documentation to be considered for this award.

Section II

Secretary of Defense Awards

17-4. Community Drug Awareness Award

The Secretary of Defense Community Drug Awareness Award is presented annually to the best DDR effort for the previous year within each Service, the NGB and the Defense Agencies. The award was established in 1990 by DoD in an effort to promote community drug awareness efforts in the DoD community. The Award is presented as part of the DoD annual Red Ribbon Campaign. The primary eligibility requirement is documentation of the local Red Ribbon Campaign participation. (See the <https://asap.army.mil/web> site for details.)

17-5. Fulcrum Shield award

The Secretary of Defense Fulcrum Shield Award is an annual award designed to promote community drug awareness efforts by youth programs associated with the Military Services, Defense Agencies, and the NGB. The Award is presented as part of the DoD annual Red Ribbon Campaign. The primary eligibility requirement is documentation of the local Red Ribbon Campaign participation. (See the <https://asap.army.mil/web> site for details.)

Section III

Campaigns

17-6. General

Alcohol and other drug-related campaigns involve the community in substance abuse deterrence and awareness. Soldiers, DA Civilians and Family members are provided information on risk factors and resources in the area of substance abuse prevention. Campaigns are a collaboration of diverse resources in the local community.

17-7. Community campaigns

a. Installation ASAP managers will select a minimum of two substance abuse related campaigns a year for the ASAP staff to coordinate/support. Some campaigns may be long-term while others are time-limited.

b. Installation ASAP managers will—

- (1) Institute written SOPs designed to enhance effective local campaigns.
- (2) Evaluate campaigns regarding the potential for collaboration between local and installation resources.
- (3) Coordinate with the installation commander and other community resources regarding the implementation of a campaign.

c. The ASAP is authorized to purchase promotional items in support of substance abuse prevention campaigns. These items may be used to support local or Army-sponsored prevention campaigns. The promotional products should not indicate the Army endorses a particular product or private organization.

d. Some key community campaigns includes—

- (1) Alcohol Awareness Month.
- (2) Red Ribbon Week.
- (3) National Drunk and Drugged Driving (3D) Awareness Month.
- (4) Tie One on for Safety. For a more complete list, see the ASAP Web site at <https://asap.army.mil>.

Chapter 18

Army Substance Abuse Program Resource Management

18-1. General

The Director, ARD is responsible for the provision of resources to the ASAP. The ARD oversees MDEPs Quality Assurance QAAP, MDEP code for the ASAP funds, and the DDR Program, and the VCND which are the sources of ASAP funding. The FTDTL operations, MRO services, and clinical counseling services do not fall under the ARD director's responsibility for funding, management, or oversight.

18–2. Policy

a. The QAAP is the only source of funding in the ASAP that is authorized to pay for alcohol-related substance abuse services for Soldiers and DA Civilians. The QAAP funds may be used to cover the costs of drug-abuse related services when DoD counter-narcotics funds are insufficient or have been exhausted.

b. The U.S. Congress has restricted the use of VCND funds to DoD counter-narcotics missions. Army usage of VCND funds is restricted to providing drug abuse-related services. No VCND funds can be expended on alcohol abuse-related services or any other similar service. Army Defense Demand Reduction (DDR V Counter Narcotic Drugs (VCND)), funds are fenced and their usage is limited to the following services:

- (1) UA testing of AD Soldiers (including the costs of collection, supplies, shipment, analyses, reporting, administrative overhead, travel, civilian pay, staff training and certification, and contractual support).
- (2) UA testing of DA Civilians subject to the requirements of EO 12564 (for example, those DA Civilians in TDPs) and the requirements of DOT mandates for vehicle drivers.
- (3) UA of USAR and ARNG Soldiers using DDR operations and maintenance, Army appropriations funding.
- (4) Education and training of Soldiers and DA Civilians on the dangers of drug abuse (includes administrative overhead, civilian pay, marketing/education materials, travel, and contractual support).
- (5) In-patient and out-patient care of problematic substance users and all Soldiers who self-refer for drug abuse.

c. The VCND funds can fund demand reduction programs and initiatives directed toward the nonmilitary residents near military installations as a means of community outreach, when funds are available.

d. Installations may use VCND funds to purchase promotional items with little intrinsic value that convey an anti-drug message. Such items may include, but are not limited to balloons, pencils, pennants, ribbons, pins, stickers, and caps.

18–3. Funding sources and their uses

Two financial sources fund the ASAP: base operations support and DoD Counter-narcotics.

a. Base operations support funds include MDEPs QAAP (the ASAP). The Army proponent office for base operations support funding is the Assistant Chief of Staff, Installation Management.

b. The QAAP ASAP funds.

(1) Funds installation substance abuse program services for Soldiers and DA Civilians. Services funded include testing/ID; prevention, education and training; and counseling and rehabilitative treatment.

(2) Civilian testing requirements include DOT testing mandates for vehicle drivers and Drug-Free Workplace mandated testing of employees in TDPs. Prevention education and training includes Soldiers, leaders/supervisors, and Family members. HQDA substance abuse services include support for the RRP, the DAMIS, initial skill, and certification training for installation ASAP personnel, and product development and distribution to Soldiers designated as UPLs.

c. DoD provides VCND funds in year of execution.

d. General guidance for ASAP resource management.

(1) Fund civilian salaries in accordance with the MDEPs identified with each authorized position on the authorization document. For example, if an ASAP manager is identified on the installation's ASAP table of distribution and allowances (TDA) as a QAAP position, then that person should be paid with QAAP dollars. Dollar requirements and justifications made at Army level for civilian pay are based on TDA documentation.

(2) All DTC salaries should be funded with DoD counter-narcotics funds (VCND).

18–4. Manpower staffing

Manpower resources for the ASAP have been provided at all levels of command.

a. *Army Substance Abuse Program staff resources.* Installation ASAP staffing consists of those positions listed in paragraphs 2–17 through 2–21 (ASAP manager, prevention coordinator (PC), EAP coordinator, DTC, and RRPC, and whatever additional staff are necessary to ensure compliance with Department of the Army (DA) policies and meet local needs for effective operation of the ASAP.)

b. *Treatment resources.* Clinical staff consists of behavioral health treatment providers licensed to diagnosis and treat substance use disorders, and additional positions (for example substance abuse professionals (SAPs)) are necessary to ensure compliance with DA policies and meet local needs for effective operation of the Substance Use Disorder Clinical SUDCC services. DHA SUD providers will not serve as ASAP managers.

Appendix A

References

Section I

Required Publications

DoD publications are available at <https://www.esd.whs.mil/>.

AR 11–2

Managers' Internal Control Program (Cited in title page).

AR 25–22

The Army Privacy Program (Cited in para 10–1*c*.)

AR 25–400–2

The Army Records Information Management System (ARIMS) (Cited in para 2–17*v*.)

AR 40–66

Medical Record Administration and Health Care Documentation (Cited in para 6–7*h*.)

AR 50–1

Biological Surety (Cited in para 4–8*c*.)

AR 50–5

Nuclear Surety (Cited in para 4–8*c*.)

AR 50–6

Chemical Surety (Cited in para 4–8*c*.)

AR 135–175

Separation of Officers (Cited in para 8–4*d*.)

AR 135–178

Enlisted Administrative Separations (Cited in para 10–6.)

AR 190–5

Motor Vehicle Traffic Supervision (Cited in para 3–3*b*.)

AR 215–1

Military Morale, Welfare, and Recreation Programs and Non-appropriated Fund Instrumentalities (Cited para 3–2*c*.)

AR 380–67

Personnel Security Program (Cited in para 4–8*b*.)

AR 600–8–2

Suspension of Favorable Personnel Actions (Flag) (Cited in para 16–8*c*(2).)

AR 600–8–10

Leaves and Passes (Cited in para 10–7.)

AR 600–8–24

Officer Transfers and Discharges (Cited in para 2–28*h*.)

AR 600–63

Army Health Promotion (Cited in para 14–1*a*.)

AR 635–200

Active Duty Enlisted Administrative Separations (Cited in para 2–28*h*.)

DA Pam 40–501

Army Hearing Program (Cited in para 4–8*g*.)

DA Pam 600–24

Health Promotion, Risk Reduction, and Suicide Prevention (Cited in para 14–1*a*.)

DA Pam 600–85

Army Substance Abuse Program Civilian Services (Cited in para 2–19*a*.)

DoDI 1010.01

Military Personnel Drug Abuse Testing Program (Cited in para 1–6.)

DoDI 1010.04

Problematic Substance Use by DoD Personnel (Cited in para 1–6.)

DoDI 1010.09

DoD Civilian Employee Drug-Free Workplace Program (Cited in para 1–6.)

DoDI 1010.16

Technical Procedures for the Military Personnel Drug Abuse Testing Program (MPDATD) (Cited in para 4–4.)

DoDI 4000.19

Inter-service and Intragovernmental Support (Cited in para 1–8c.)

EO 12564

Drug-free Federal Workplace, September 15, 1986 (Cited in para 5–2.) (Available at <https://www.archives.gov/federal-register/index.html>.)

49 CFR, Part 40

Procedures for Transportation Workplace Drug and Alcohol Testing Programs (Cited in para 3–11c(3).) (Available at <http://ecfr.gov>.)

Section II**Related Publications**

A related publication is a source of additional information. The user does not have to read it to understand this publication. DoD publications are available at <https://www.esd.whs.mil/>; National Guard publications are available at www.ngbpd.c.ngb.army.mil/pubfiles; citations to the United States Code, public laws, and the Congressional Record are available at <http://www.gpoaccess.gov>; Code of Federal Regulations are available at <http://www.ecfr.gov>, and Federal Acquisition Regulations are available at <http://www.arnet.gov>; UCMJ articles are available at <https://jsc.defense.gov/portals/99/documents/ucmj%20-%2020december2019.pdf?ver=2020-01-28-083235-930>.

ADAPT Manual

Army Resiliency Directorate (Available at <https://asap.army.mil>.)

Alcohol and Drug Control Officer/Army Substance Abuse Program (ASAP) Manager Guidebook

Army Resiliency Directorate (Available on the <https://asap.army.mil>.)

AR 15–1

Department of the Army Federal Advisory Committee Management Program

AR 15–6

Procedures for Administrative Investigations and Boards of Officers

AR 25–30

Army Publishing Program

AR 40–68

Clinical Quality Management

AR 40–400

Patient Administration

AR 140–111

U.S. Army Reserve Reenlistment Program

AR 190–30

Military Police Investigations

AR 190–45

Law Enforcement Reporting

AR 350–1

Army Training and Leader Development

AR 360–1

The Army Public Affairs Program

AR 600–8–19

Enlisted Promotions and Reductions

AR 600–9

The Army Body Composition Program

AR 600–20

Army Command Policy

AR 600–105

Aviation Service of Rated Army Officers

AR 601–280

Army Retention Program

AR 623–3

Evaluation Reporting System

AR 635–8

Separation Processing and Document

AR 638–8

Army Casualty Program

Commander's Top 10 Guide

Army Resiliency Directorate (Available at <https://asap.army.mil>.)

DA Pam 25–403

Guide to Recordkeeping in the Army

DFARS 223.570

Drug-free workplace (Available at <http://www.acq.osd.mil/dpap/dars/dfars/index.htm>.)

DFARS 252.223–7004

Drug-free work force (Available at <http://www.acq.osd.mil/dpap/dars/dfars/index.htm>.)

DoDI 6025.13

Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)

Employee Assistance Program (EAP) Guidebook

Army Resiliency Directorate (Available on the <https://asap.army.mil>.)

FAR 23.5

Drug-Free Workplace (Available at <http://www.acquisition.gov/far/>.)

FAR 52.223–6

Drug-Free Workplace (May 2001) (Available at <http://www.acquisition.gov/far/>.)

Federal Employee Assistance Programs, Guiding Principles, Framework, and Definitions, September 2008

(Available at <https://www.opm.gov/policy-data-oversight/worklife/reference-materials/eapguide.pdf2008>)

Installation Biochemical Test Coordinator Guidebook

Army Resiliency Directorate (Available on the <https://asap.army.mil>.)

MRE 312

Body views and intrusions (Available at <https://www.armypubs.army.mil>) in the Manual for Courts Martial (MCM) Military Rules of Evidence at <https://www.armypubs.army.mil>.)

MRE 313

Inspections and inventories in the armed forces (Available at <https://www.armypubs.army.mil>.)

MRE 314(e)

Consent searches (Available at <https://www.armypubs.army.mil>.)

MRE 315

Probable cause searches (Available at <https://www.armypubs.army.mil>.)

PL 91–616

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970

PL 92–129

Amendments to the Military Selective Service Act of 1967

PL 92–255

Drug Abuse Treatment Act of 1972

PL 95–454

Civil Service Reform Act of 1978

PL 99–570

Federal Employees Substance Abuse Education and Treatment Act of 1986

PL 100–71, 503, 5 USC 7301 note

Supplemental Appropriations Act, 1987

PL 100–690

Anti-Drug Abuse Act of 1988

PL 102–143, Title V

Omnibus Transportation Employee Testing Act of 1991

PL 104–191, Section 264

Health Insurance Portability and Accountability Act of 1996

Prevention Coordinator Guidebook

Army Resiliency Directorate (Available on the <https://asap.army.mil>.)

UCMJ Art. 15

Commanding Officer's Non-Judicial Punishment

UCMJ Art. 86

Absent without leave

UCMJ Art. 92

Failure to obey order or regulation

UCMJ Art. 107

False official statements

UCMJ Art. 112a

Wrongful use, possession, and so on, of controlled substances

UCMJ Art. 134

General Article

5 CFR 752

Adverse Actions

5 CFR 752.203

Procedures

5 CFR 752.404

Procedures

42 CFR Chapter 1, Part 2, Subpart E

Court Orders Authorizing Disclosure and Use

42 CFR 2

Confidentiality of Alcohol and Drug Abuse Patient Records

42 CFR 2.16

Security for written records

42 CFR 2.22

Notice to patients of Federal confidentiality requirements

42 CFR 2.52

Research activities

42 CFR 2.53

Audit and evaluation activities

49 CFR

Transportation

49 CFR 40, Subpart B

Employer Responsibilities

49 CFR 40, Subpart J

Alcohol Testing Personnel

49 CFR 40.321

What is the general confidentiality rule for drug and alcohol test information?

49 CFR 40.323

May program participants release drug or alcohol test information in connection with legal proceedings?

49 CFR 40.327

When must the MRO report medical information gathered in the verification process?

49 CFR 40.329

What information must laboratories, MROs, and other service agents release to employees?

49 CFR 40.331

To what additional parties must employers and service agents release information?

49 CFR 40.333

What records must employers keep?

49 CFR 382

Controlled Substances and Alcohol Use and Testing

49 CFR 382, Subpart B

Prohibitions

49 CFR 382, Subpart C

Tests Required

49 CFR 382, Subpart E

Consequences for Drivers Engaging in Substance Use-Related Conduct

49 CFR 382.107

Definitions

49 CFR 382.403

Reporting of results in a management information system

49 CFR 382.601

Employer obligation to promulgate a policy on the misuse of alcohol and use of controlled substances

49 CFR 382.603

Training for supervisors

49 CFR 382.605

Referral, evaluation, and treatment

49 CFR 383

Commercial Driver's License Standards; Requirements and Penalties

75 CFR 22809 (2010)

Mandatory Guidelines for Federal Workplace Drug Testing Programs (Available at <https://www.samhsa.gov/workplace/resources>.)

5 USC 552

Public information; agency rules, opinions, orders, records, and proceedings

5 USC 552(a)

Records maintained on individuals

5 USC 7301

Presidential regulations

21 USC 812

Schedules of controlled substances

21 USC 1174

Transferred

42 USC 290dd-2

Confidentiality of records

Section III

Prescribed Forms

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) website (<http://armypubs.army.mil>).

DA Form 3822

Report of Mental Status Evaluation (Prescribed in para 8-4*d*.)

DA Form 5018-R

ADAPCP Client's Consent Statement for Release of Treatment Information (LRA) (Prescribed in para 10-19*c*.)

Section IV

Referenced Forms

Unless otherwise indicated, DA forms are available on the APD website (<https://armypubs.army.mil>), and DD forms are available on the Office of the Secretary of Defense (OSD) website (<https://www.esd.whs.mil/>). SFs are available at <https://www.gsa.gov/reference/forms>.

AFMES Form 1323

AFMES/Division of Forensic Toxicology – Toxicological Request Form (Available at <https://asap.army.mil>.)

DA Form 11-2

Internal Control Evaluation Certification

DA Form 268

Report to Suspend Favorable Personnel Actions (Flag)

DA Form 2028

Recommended Changes to Publications and Blank Forms

DA Form 3711

Army Substance Abuse Program (ASAP) Resource and Performance Report (RAPR)

DA Form 3881

Rights Warning Procedure/Waiver Certificate

DA Form 4833

Commander's Report of Disciplinary or Administrative Action

DA Form 4856

Developmental Counseling Form

DA Form 5019

Condition of Employment for Certain Civilian Positions Identified Critical under the Department of the Army Drug-Free Federal Workplace Program

DA Form 5513

Key Control Register and Inventory

DA Form 7412

Condition of Employment for Certain Civilian Positions Identified Safety-Sensitive under the Department of Transportation, Federal Highway Administration Rules on Drug and Alcohol Testing

DA Form 8003

Army Substance Abuse Program (ASAP) Enrollment

DD Form 2624

Specimen Custody Document-Drug Testing

Form DOT F 1380

U.S. Department of Transportation (DOT) Alcohol Testing Form (Available at http://www.randomtesting.com/alcohol_form.pdf.)

Form DOT F 1385

U.S. Department of Transportation Drug and Alcohol Testing MIS Data Collection Form (Available at <http://transit-safety.volpe.dot.gov/drugandalcohol/damis/misform/2011misform.pdf>.)

SF 66

Official Personnel Folder (Available through normal forms supply channels.)

SF 513

Medical Record - Consultation Sheet

SF 700

Security Container Information (Available through normal forms supply channels.)

SF 702

Security Container Check Sheet

Appendix B

Unit Commander's Guide to the Army Substance Abuse Program

This guide provides basic information to unit commanders about the ASAP. The following questions and figures provide a quick overview of the unit commander's responsibilities, resources, and procedures necessary to participate in and fully support the ASAP prescribed by AR 600–85.

B–1. What is the Army Substance Abuse Program?

Response 1: The Army Substance Abuse Program, or ASAP, is a comprehensive program which combines substance abuse deterrence, prevention, identification, and rehabilitation/treatment designed to strengthen the overall fitness and effectiveness of the Army and to enhance the combat readiness of its personnel and units by eliminating alcohol and/or other drug abuse. (ASAP mission and objectives are listed in para 1–7.)

B–2. What is the unit commander's role in the Army Substance Abuse Program?

Response 2: Commander's actions to prevent, deter, and reduce alcohol and other drug abuse are the keys to ASAP success. Unit commanders must observe their Soldiers' behavior and intervene early to identify possible alcohol and/or other drug abusers, refer these Soldiers for evaluation by trained medical personnel, monitor each Soldier's rehabilitation/treatment progress, and when appropriate, process Soldiers for separation. (More information on the unit commander's role in ASAP is available in paras 2–15, 2–28, 2–32, and 2–33.)

B–3. What specifically must the unit commander do?

Response 3: The major actions a unit commander must accomplish are: appointing the UPLs, establishing the unit drug testing and the prevention and education programs, and enforcing the ASAP policies. The commander will implement and maintain, even while deployed, a unit substance abuse program. (The unit commander's responsibilities is contained in para 2–28.)

a. Appoint on orders at least two officers or NCOs to be trained and certified as the UPL and alternate(s). The UPL will assist the commander in the designing and implementing the unit prevention plan, administering the unit DTP, and keeping the commander informed of trends in alcohol and other drug abuse in the unit. (See para 2–32 for a detailed list of UPL responsibilities.)

b. Ensure that the unit substance abuse program SOP and policies are up to date, reviewed annually and signed by the current unit commander.

c. Conduct random, unpredictable UA at a rate of 10 percent of the battalion's assigned and attached end strength each month. The drug and alcohol testing program facilitates early ID of substance abuse in the unit, and enables the commander to assess the security, military fitness, and good order and discipline of their unit. (See AR 600–85, chap 4 for more information on drug testing.)

d. Refer all identified drug or alcohol abusers to BH for SUD evaluation.

e. Discipline, as appropriate, all identified substance abusers, underage drinkers, and Soldiers who provide alcohol to underage Soldiers.

f. Initiate separation action on all Soldiers identified as drug abusers, those determined by their provider to be non-compliant with their SUD treatment plan or who are involved in two serious incidents of alcohol-related misconduct within 12 months.

g. Prevent, deter, and reduce the abuse of substances to the lowest extent possible through education, community involvement, and de-glamorization of alcohol (ensure that alcohol is never the focus of any unit event). While there are many prevention strategies available, the unit commander should provide education and training to Soldiers on the effects and consequences of alcohol and other drug abuse, along with the treatment which are available at the installation. (See response 4 and chap 9 for information on prevention policies and strategies.)

(1) Ensure that the required training and briefings are provided annually.

(2) Brief all newly assigned Soldiers on local and command ASAP policies and clinical services.

(3) Immediately report all offenses involving illegal possession, use, sale, or trafficking in drugs or drug paraphernalia to the PM for investigation or referral to the USACIDC. This includes all positive test results that do not require a medical review as directed by USAMEDCOM. Positive tests that require MRO review will not be reported until receipt of verified illegitimate use by the MRO.

(4) Assess programs and provide feedback to the installation RRPC and IPT for program improvements.

h. Maintain contact with both the BH/SUD and ASAP staff to stay abreast of:

(1) New training and educational materials, risk reduction data, drug and alcohol trends, and statistics within the local community or area of deployment.

- (2) The status of Soldiers enrolled in rehabilitation.
- (3) Changes in regulations or policies, programs and campaigns within the military community.
 - i. Use the RRP and work with the RRPC and the IPT to design and prevent high risk behavior and intervene when necessary.
 - j. Direct Soldiers to complete the R-URI 30 to 180 days after returning from a deployment.

B-4. Who are the Army Substance Abuse Program key players?

Response 4:

- a. Garrison ASAP.
 - (1) The commander has the key role in the ASAP (see paras 2-28 and 2-29).
 - (2) The UPL is the commander's primary POC at the unit for ASAP issues (see paras 2-31).
 - (3) The ASAP manager is in charge of garrison ASAP functions and is your primary POC for ASAP non-clinical issues (see para 2-17).
 - (4) The PC is responsible for prevention and training programs on your installation to include unit level training and the training of UPLs (see para 2-18).
 - (5) The DTC is the installation subject matter expert for drug testing procedures. The DTC operates a forensically secure installation DTP collection point, ensures quality control of the specimens sent to the FTDTL, provides technical assistance and support for the UPL CTP, and advises unit commanders on program use, test results and supplies (see para 2-20).
 - (6) The EAP coordinator is the primary POC for civilian employees in need of assistance (see para 2-19).
 - (7) The RRPC is the primary POC for the RRP statistics, URI and R-URI surveys (see para 2-21).
 - (8) The BACM supervises the ASAP program for a MSC in certain deployed areas that have been assigned a BAC (see para 4-7f).
- b. BH/SUDCC: The local MTF BH department provides the unit commander with a wide range of treatment services for alcohol and/or other drug abusers.
 - (1) The IDPH is in charge of SUD treatment and is your MTF POC.
 - (2) SUD providers evaluate Soldiers with potential substance abuse problems and provide treatment.
- c. Other personnel supporting the ASAP.
 - (1) The MRO reviews positive drug test results that could be due to authorized prescription medication or medical or dental treatment, they will determine if the use was legitimate (see para 4-14 and fig 4-2).
 - (2) The SJA is the commander's legal advisor for drug and alcohol cases (see para 2-5).
 - (3) The MP and the CID provide blotter reports and investigate drug cases.

B-5. What process should be followed if a unit commander suspects a Soldier of alcohol and/or other drug abuse?

Response 5: Figure B-1 provides an outline of the process. If a unit commander has some reasonable suspicion (the chain of command has noticed unusual or aberrant behavior by the Soldier), but not sufficient evidence for probable cause to suspect a Soldier of drug or alcohol abuse, and if the unit commander believes the Limited Use Policy applies (see paras 10-11 through 10-13), the unit commander should consult with the supporting legal advisor before discussing the Limited Use Policy with the Soldier. If appropriate, the unit commander may then explain the Limited Use Policy to the Soldier. If a unit commander has probable cause to suspect a Soldier of drug or alcohol abuse (the chain of command has good reason to suspect that drugs are within the Soldier's body), the commander should consult with the supporting legal advisor and if appropriate advise the Soldier of their rights under UCMJ Article 31(b) using DA Form 3881. The commander may then also order the Soldier to submit a probable cause (collection code PO) urine specimen. If the Soldier waives their rights, the commander may then question the Soldier about alcohol or drug abuse. If there is less than probable cause, the commander may still refer the Soldier to BH clinic for a SUD evaluation or the commander may decide that the Soldier should simply be returned to duty.

B-6. What does the unit commander do when notified that a Soldier has tested positive during a drug test?

Response 6: Figure B-2 provides an outline of the process. When a unit commander is notified that a Soldier tested positive during a UA, the unit commander's actions are determined by the type of drug identified. If the drug does not have a legitimate medical use as determined by USAMEDCOM, the commander will consult with law enforcement to determine whether law enforcement desires to conduct an investigation. The commander will also Flag the Soldier and consult with the trial counsel who supports the unit. If law enforcement declines to conduct an investigation, the commander must conduct his or her own preliminary inquiry into the alleged offense. The commander must advise

the Soldier of his or her legal rights under UCMJ Article 31 (b) using DA Form 3881. If the Soldier waives his or her rights, the commander may then question the Soldier about drug abuse. After completing the inquiry or investigation, the commander should consider the full range of actions in accordance with the Rule for Courts Martial 306 of the Manual for Court Martial. The commander must initiate administrative separation within 30 calendar days of receipt of a positive drug test report or if the case requires MRO review, within 30 calendar days of receipt of the MRO-verified positive drug test report. In cases where the chain of command has referred the matter to a trial by court-martial, administrative separation proceedings will be delayed until the completion of the court-martial process. The commander may initiate action under the UCMJ and start administrative separation processing simultaneously. Regardless of the action taken, the Soldier must be referred to BH for a SUD evaluation.

B-7. What can I expect when a Soldier is enrolled in treatment?

Response 7: When the Soldier is enrolled in the SUD treatment the SUD provider will meet with the commander to discuss the treatment plan to include required rehabilitation testing (see para 8-2a). Both the commander and the Soldier must dedicate time and effort to the process. Depending on the severity of abuse, the rehabilitation/treatment plan may include the Soldier's participation in any/all of the following:

- a. At least 12 hours of ADAPT.
- b. Weekly individual or group counseling sessions.
- c. Higher level of care.
- d. Unannounced drug or alcohol testing intended to determine if the Soldier is still abusing drugs or alcohol. The Soldier is expected to participate in normal unit operations (for example, field training exercises, charge of quarters or similar duties, and deployments) while receiving the care unless medical profiling or other guidance succeeds these activities.

B-8. How is a commander included in a Soldier's treatment when enrolled in mandatory care?

Response 8: The commander will—

- a. Participate in key meeting with BH and/or SUD provider to discuss Soldiers treatment progress.
- b. Evaluate and provide periodic feedback to the SUD provider about the Soldier's duty performance during care.
- c. Ensure the Soldier's rehabilitation testing is conducted in accordance with the rehabilitation/treatment plan.
- d. If unsuccessful, the commander will initiate separation action if it is deemed a rehabilitation failure.
- e. Understanding the components of the different SUD treatment pathways (voluntary and mandatory).

B-9. How should a unit commander prepare for a deployment?

Response 9: The commander will—

- a. Contact the installation or USAR MSC ASAP manager or JSAPO for guidance, especially on what BAC to use when testing in the deployed area.
- b. Ensure the unit has at least two trained UPLs that will deploy and two that will stay behind with the rear detachment, if necessary. Units that will be geographically dispersed in the deployment area may need additional trained UPLs.
- c. Obtain and pack enough drug testing supplies to test 100 percent of the Soldiers that will deploy. (Replacement supplies will be ordered in the deployment theater, but may take some time to reach the unit.)
- d. Deploy with the DoD DTP software, a current unit roster, and an alternate means of randomly choosing Soldiers for testing (see chap 4 for details).
- e. Ensure the UPLs know how to perform quality control, packing, and shipping procedures for the UA specimens because these tasks are usually done by a DTC or JSAPC, and the UPL will ship directly to the drug testing lab from the deployment area. Ensure the UPLs have the supplies needed to pack and ship the urine specimens.
- f. Check with the postal officer to determine how to ship UA specimens from the deployed area to the lab for testing.

B-10. What is the Limited Use Policy?

Response 10: The objective of the Limited Use Policy is to facilitate the ID of alcohol and other drug abusers by encouraging self-referral. In addition, the policy is designed to facilitate the rehabilitation of those abusers who demonstrate the potential for both rehabilitation and retention. In short, the Limited Use policy allows a Soldier to get help and make a new start without being punished for past offenses. It is not intended to protect a Soldier who is attempting to avoid disciplinary or adverse administrative action. When applied properly, the Limited Use Policy does not conflict with the Army's mission or standards of discipline. Soldiers may seek help for their own alcohol or other drug problem from their unit commander, a physician at the MTF, or any agency or individual described in chapter 7. This is a

complicated policy that your supporting legal advisor can help you apply due to the issue that positive tests can't always be used against Soldiers. Additional guidance is in paragraphs 10–11 to 10–13.

B–11. How do I get a Unit Prevention Leader certified and how do I get any needed Army Substance Abuse Program training for my unit?

Response 11:

a. Contact your ASAP manager or PC to schedule your UPL candidate to take the 40-hour UPL Certification course. Your UPL should receive a copy of the UPL CTP CD-ROM that includes all the training resources for the course. If you are deployed and need to certify a new UPL or to recertify a current UPL, contact the ARD at <https://asap.army.mil> for instructions. See paragraph 9–5 for more information.

b. Once certified, your UPL, with help from the ASAP staff, the UPL CTP CD and the ASAP Web site, should be able to provide alcohol and other drug awareness training as needed. See paragraphs 9–10, 9–11, 9–12, and 9–13 for more information.

B–12. What is smart testing?

Response 12:

a. Definition of smart testing: The process where drug testing is conducted in such a manner that it is not predictable to the tested population. If your unit is conducting random smart testing, then every Soldier should believe that they can and may be tested on any given day at any given time.

b. Why is smart testing important? The UA program is designed to be a deterrence program. If a Soldier believes that they will be tested at any time and that they will receive negative consequences for testing positive, then they will be less likely to use drugs. If a Soldier can predict when they will be tested, then they may try to beat the test, and the deterrent effect is lost.

c. DO's of smart testing:

- (1) Back-to-back testing (for example, Friday/Monday).
- (2) Weekend/Holiday testing.
- (3) During field exercises.
- (4) At the end of the duty day.
- (5) During afternoon physical training.

d. DON'Ts of smart testing:

- (1) Always testing on Mondays.
- (2) Asking for volunteers.
- (3) Listing the test on the training schedule.
- (4) Announcing the next day's test at the end of the duty day or by email.
- (5) Calling Soldiers in for an alert but telling them it's for a UA.
- (6) Calling attention to future drug testing by conspicuously handling UA supplies or preparing required forms.
- (7) Stopping collections before every Soldier selected has provided a specimen.
- (8) Printing out testing documents and labels on shared printers (see figs B–1 and B–2).

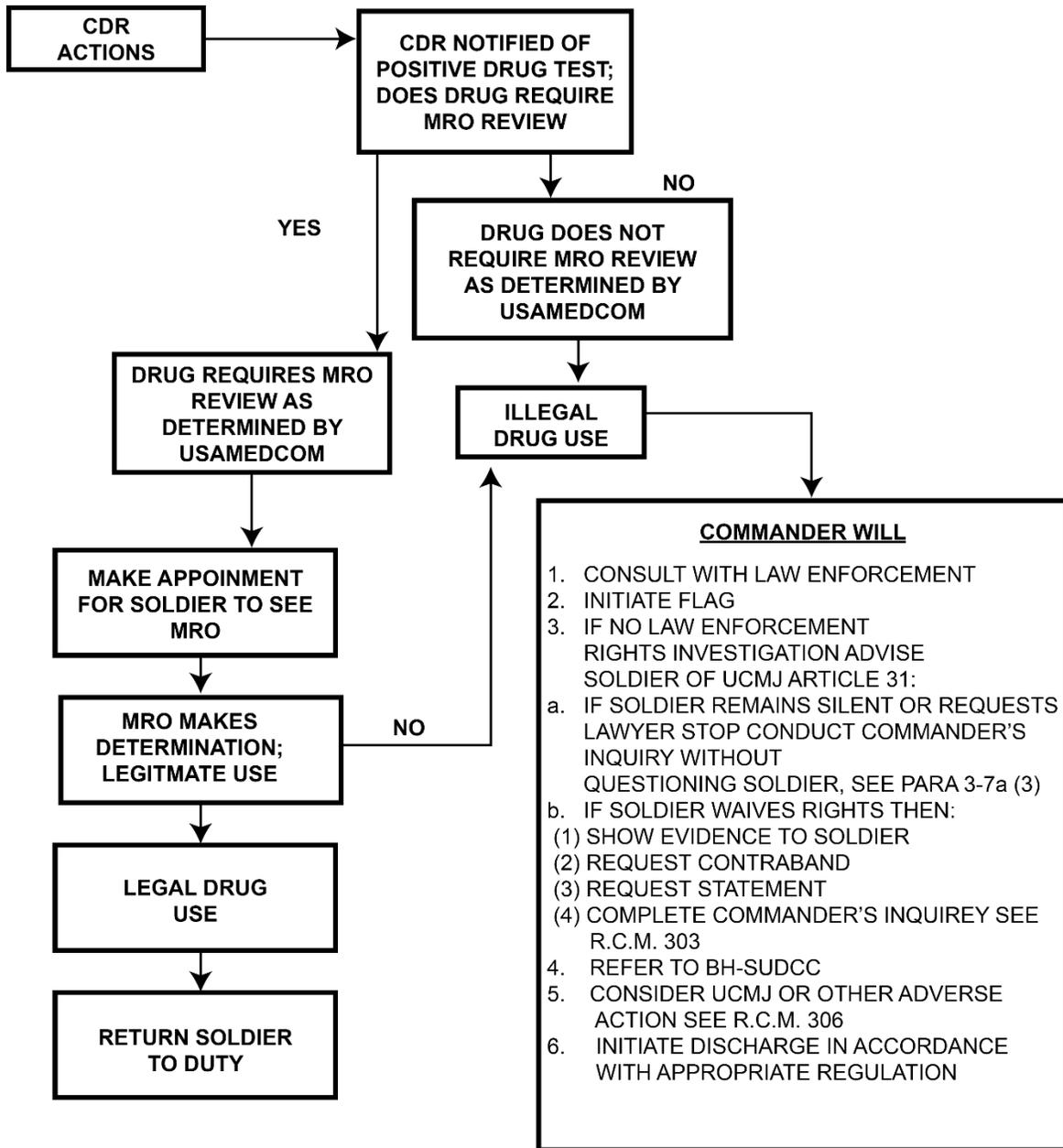


Figure B-1. Commander's actions upon receiving positive drug test results

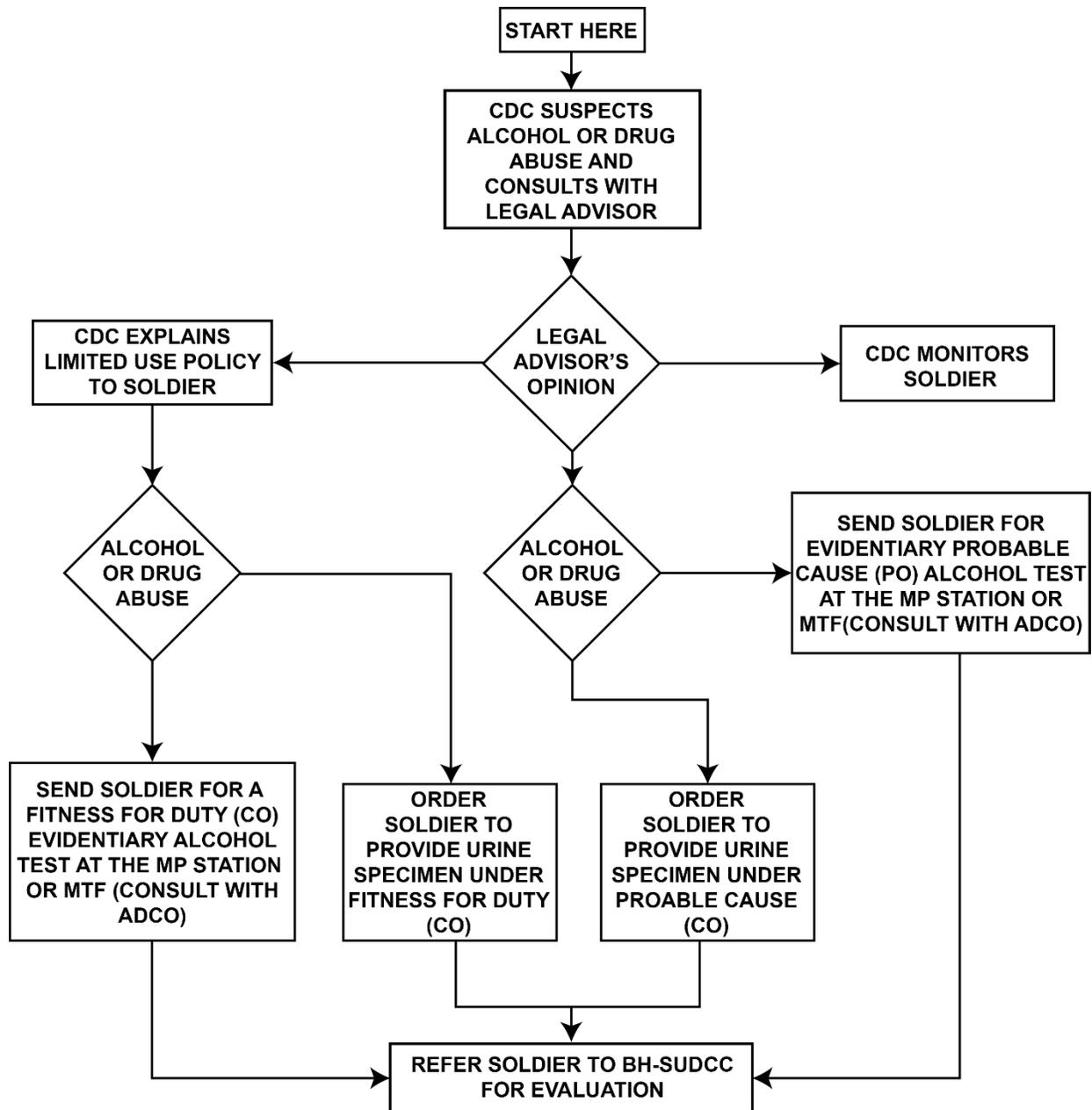


Figure B-2. A commander's action when a Soldier is suspected of abusing drugs or alcohol

Appendix C

Army Substance Abuse Program Assessment Checklist

C-1. Objective

The objective of the ASAP assessment checklist is to assist ASAP managers and CDs in evaluating the ASAP. The ASAP managers may assess a different one of the four areas of responsibility below each quarter of the fiscal year as long as all areas are assessed annually. All results of these assessments must be recorded on a MFR and retained in accordance with AR 25-400-2.

C-2. Program management

- a. Is an ASAP manager position authorized on the TDA and filled full-time to implement the ASAP?
- b. Does the ASAP manager brief the Installation or garrison commander quarterly on the overall ASAP status?
- c. Are new commanders and first sergeants briefed on the ASAP upon assuming their positions?
- d. Are appropriate reports (MP blotters, serious incident reports) reviewed by the ASAP manager on a daily/weekly basis?
- e. Has a community needs assessment survey been conducted within the last 3 years?
- f. Are DAMIS requirements completed and entered?
- g. Are DUI/UA positive reports completed and forwarded to ASAP on a quarterly basis?
- h. Are referral usage trends found in DAMIS shared with the BDE/BN chains of command, garrison and Senior Mission Commander?
- i. Are ISRs completed correctly and submitted on time?
- j. Have effective procedures been implemented to ensure that the ASAP manager is provided all data required for completion of DA Form 3711?
- k. Have monthly reports been entered in DAMIS on DA Form 3711 to provide the statistical status of the ASAP?
- l. Have local statistics been maintained and analyzed for program needs and trends?
- m. Has an IPT or human resources council or similar forum been established to review current installation issues and trends?
- n. Does the IPT (or similar forum) meet, at a minimum, on a quarterly basis?
- o. Does the ASAP manager prepare and track the garrison ASAP budget and review it with their supervisor and the garrison resource manager?
- p. Does the ASAP manager prepare an internal control evaluation (see app G)?
- q. Has the ASAP manager implemented a plan to monitor and assess command use of and satisfaction with all aspects of the program (for example, prevention, ID, and rehabilitation)?
- r. Has the ASAP manager considered nominating members of the ASAP staff for ARD Director's Awards?

C-3. Prevention/Employee Assistance Program

- a. Are elements of prevention included in the ASAP manager position description?
- b. Have goals and objectives been formulated in a written IPP?
- c. Are the following essential prevention activities fully functional? (Note: Prevention activities are based on an installation's needs assessment.)
 - (1) Educating commanders and first sergeants about the ASAP?
 - (2) Garrison ASAP professional staff development and certification?
 - (3) Civilian employee and supervisor ASAP education?
 - (4) Family member ASAP education?
 - (5) Community awareness education on the ASAP?
 - (6) Unit education programs on the ASAP includes ADAPT and others as needed.
- d. Is ADAPT implemented in accordance with AR 600-85?
- e. Is ADAPT offered a minimum of once monthly?
- f. Are "pre" and "post" tests use for ADAPT to assist in determining effectiveness of training?
- g. Have a variety of media been use d (installation newspaper, radio, television, electronic media announcements) to support and inform personnel about the ASAP and its programs?
- h. Has each civilian employee received drug/alcohol training?
- i. Are all supervisors trained at least annually on techniques for identifying abusers, the dangers of "enabling" and the referral process? Have supervisors of civilian employees in TDPs received training on civilian drug testing and how to properly notify their employees of a UA?

- j.* Were prevention campaigns conducted, such as Drunk and Drugged Driving Prevention and Red Ribbon Week?
- k.* Are evaluation forms on instructor performance and course content used for all training?
- l.* Have civilian employees occupying TDPs under the DFW received civilian drug testing training prior to being included in the TDP pool?
- m.* Is the DFW annual survey report prepared and forwarded to ASAP annually? Are all EAP files maintained and secured separately from other files? Are EAP files maintained in accordance with DCS, G1 ARD EAP coordinator guidance? Is the ADCP reviewing and recording the review of a random sampling EAP files to ensure compliance with format guidelines in the DCS, G1 ARD EAP coordinator guidance?
- n.* Is the ASAP annual prevention report completed with a copy sent to the IMCOM HQs?
- o.* Are the PC and EAP coordinator certified? Is the requirement to be certified written in their job descriptions?
- p.* Does the PC maintain a by EDI-PI list of all ADAPT attendees?
- q.* Is a data collection effort in place to capture data manually to inform the process, output and outcome performance indicators identified by ARD?
- r.* Is the data reviewed quarterly and trends/issues reported to the Community Health Promotion Council?

C-4. Risk Reduction Program

- a.* Does the installation have an IPT or human resources council or similar organization? Who coordinates the IPT meetings?
- b.* Is the IPT held as a stand-alone meeting?
- c.* Have IPT members attended IPT training?
- d.* Does the IPT meet quarterly to discuss RRP trends and to formulate recommendations for commanders to reduce high-risk behaviors?
- e.* Are minutes taken at the IPT meetings?
- f.* Who chairs the IPT meetings?
- g.* Is the IPT visible and productive on the installation?
- h.* Does the ASAP manager or a designated ASAP staff member consolidate data and enter it into the Risk Reduction Application Portal?
- i.* Do installation sources readily provide data? Is there a system in place to ensure all providers submit the required data?
- j.* Do members of the IPT have access to the Risk Reduction Web system and are they using it?
- k.* Do commanders on the installation have access to the system?
- l.* Based on the identified risk, do specific IPT members brief commanders (brigade/battalion) quarterly on risk reduction or are these briefings conducted by the ASAP manager?
- m.* Does the ASAP use unit ranking (provided in the Risk Reduction application) to determine which units are briefed and which units receive intervention?
- n.* Based on results from trend analyses, are interventions provided to units as required?
- o.* Does the ASAP manager brief the garrison commander and/or the CG on risk reduction on a quarterly basis?
- p.* How do battalion/brigade commanders respond to the RRP? Do they find it helpful in identifying high risk units?
- q.* Does the garrison commander support risk reduction?
- r.* Based on trend analysis results, can the ASAP identify the installation/brigade/battalion top three high-risk behaviors?
- s.* What other information does the ASAP use, aside from risk reduction data, to determine high-risk behaviors?
- t.* Are the risk reports useful and informative?
- u.* Does the installation use the URI?
- v.* Does the installation use the R-URI? Is there a system in place to ensure that all deployed Soldiers are administered the R-URI between 30 and 180 days after redeploying?
- w.* Does the ASAP manager compare/cross-reference data from the URIs and data?
- x.* Are there improvements that can be made to risk reduction?
- y.* Is a data collection effort in place to capture data manually to inform the process, output and outcome performance indicators identified by ARD?
- z.* Is the data reviewed quarterly and trends/issues reported to the Community Health Promotion Council?

C-5. Drug testing Procedures?

- a.* Is there a DTC and alternate DTC appointed on orders signed by the ASAP manager?
- b.* Have the DTC and alternate DTC been certified by the DTC Certification Course within the last 3 years?

- c. Are there units without two UPLs, who have been certified during the last year?
- d. Are there written installation SOPs outlining both military and civilian collections that are approved by the SJA within the last year?
- e. Is there a written SOP that covers DTC administrative and operational procedures?
- f. Has the ASAP evidence storage area passed a physical security inspection within the past 2 years?
- g. Has the ASAP passed a safety inspection within the past year?
- h. Are battalion collections inspected biannually by the DTC?
- i. Have commanders been trained in “smart testing” techniques?
- j. Is there a notification procedure for Soldiers that includes the DTC sending laboratory positives for MRO-reviewable drugs to the MRO for determination of legitimate versus not legitimate use? Do the procedures ensure that the MRO notifies the DTC of their determination, and that the DTC notifies the commander and updates DAMIS? Is the MRO appointed on orders signed by the MTF commander?
- k. Has the MRO been certified by USAMEDCOM ?
- l. Are MRO dispositions current and updated in the DAMIS?
- m. Have effective procedures been implemented to ensure that rehabilitation UA is accomplished on all Soldiers enrolled in the ASAP?
- n. Are all Soldiers in rehabilitation/treatment being periodically drug tested?
- o. Are rehabilitation drug tests properly coded on DD Form 2624?
- p. Does the civilian corps member DTP meet the DA-required testing rates?
- q. Is the EAP coordinator involved in the donor selection process and/or collection of urine samples or the initial reporting of test results in accordance with DoDI 1010.09?
- r. Has a DA Form 5019 and/or a DA Form 7412 been signed by all civilians occupying position requiring alcohol and/or other drug testing?
- s. Has the DFW Program report that provides statistical information on the civilian DTP been submitted to ARD?
- t. For military personnel, does the DTC check DAMIS and notify the commander of all previous positive UA results and rehabilitation when they notify the commander of a current positive result?
- u. Is a data collection effort in place to capture data manually to inform the process, output and outcome performance indicators identified by ARD?
- v. Is the data reviewed quarterly and trends/issues reported to the Community Health Promotion Council?

C–6. Treatment Program (to be completed by the Installation Director of Psychological Health or designee)

- a. Are all patients identified through medical channels with a drug- or alcohol-related diagnosis or related incident resulting in medical treatment referred to BH for SUD evaluation?
- b. Have effective procedures been implemented to ensure required information is entered into DAMIS?
- c. Are rehabilitation team meetings conducted with commanders for each Soldier evaluated?
- d. Is the data reviewed quarterly and trends/issues reported to the Community Health Promotion Council?

Appendix D

Standing Operating Procedures for urinalysis collection, processing, and shipping

D-1. General

This SOP provides guidance and standardizes UA collections throughout the U.S. Army. (The DTC Guidebook and Commander's Guide and UPL Handbook contain additional guidance for DA requirements. These handbooks are designed to assist the unit commander, UPL and DTC by providing detailed information on collection, handling, processing and shipping procedures for UA specimens.)

D-2. Applicability

This SOP is applicable to all UA collections conducted on all Soldiers, regardless of component.

D-3. Related material

The Commanders' Guide and UPL Handbook, ARD DTC Guidebook and DoDI 1010.16.

D-4. Pre-collection procedures

- a. The unit commander will—
 - (1) Direct that a urine test be conducted, determine periodicity and frequencies for test, identify individual Soldiers, parts of the unit, and/or the entire unit for testing, and ensure identified Soldiers are available for testing.
 - (2) Select an adequate location for testing and a holding area for Soldiers waiting to render a UA specimen.
 - (3) Ensure the UPL is certified and properly prepare documents, facilities, equipment and supplies to collect UA specimens for drug testing.
- b. The UPL obtains supplies for testing—
 - (1) The DoD prescribed urine specimen bottles with boxes.
 - (2) Optional wide mouth collection cup.
 - (3) Tamper evident tape.
 - (4) Specimen bottle labels.
 - (5) Unit ledger (unit ledger).
 - (6) DD Forms 2624.
 - (7) Disposable rubber gloves.
 - (8) Disinfectant for disinfecting specimen collection area.
 - (9) Absorbent pads, blue ink pens, black ink pens, and AAA-162 (unit personnel accountability report).
 - (10) References: AR 600-85, ACOM, ASCC, or DRU SOP, installation SOP, unit SOP, and Commander's Guide and UPL Handbook.
- c. Personnel to be tested are notified. Notification will take place no more than 2 hours prior to reporting time.
- d. Commander appoints observers, E-5 or above, of the same gender as Soldier being tested, (no more than 3 observers will be assigned to each UPL at any given time) and a holding area NCO/officer, E-5 or above, to maintain control of personnel waiting to be tested.
- e. The UPL will brief observers on their duties and responsibilities and demonstrate the observers' tasks (see fig D-4 for an example). The observers will sign an affidavit to acknowledge understanding of their duties and responsibilities as observers.
- f. The UPL will inspect latrines and post "Off Limits" signs on them; they will also post signs for "Holding Area" and "UPL Testing Station" at those locations.
- g. Commander or designated representative will brief all Soldiers selected for testing (see fig D-2 for an example).
- h. The UPL will brief the selected Soldiers on the specimen collection procedure (see fig D-3 for an example).
- i. Each Soldier will remain in the holding area until a specimen is provided unless the commander temporarily permits the Soldier to leave and an NCO or officer escorts the Soldier.
- j. If more than one UPL conducts the collection, avoid having each DD Form 2624 handled by more than one UPL (see para D-7b).

D-5. Collection procedures

All steps of this procedure must be followed in the correct sequence.

- a. The UPL puts on disposable rubber gloves.

b. Soldier approaches the UPL station with their military ID card when prepared to give a UA specimen. If the Soldier does not have an ID card in their possession, the commander (or first sergeant or executive officer) will positively identify the Soldier and verify the Soldier's EDI-PI/SSN by a reliable method (see para D-12a).

c. Soldier will remove excess outer garments such as Army combat uniform jackets, coats, or individual physical fitness uniform jackets.

d. The UPL initiates all required paperwork (if preprinted forms and labels are used, the UPL will verify all information with the military ID card). The UPL will print the DD Form 2624, unit ledger, bottle labels, and documents required to manage the Army DTP and verify all information with the military ID card. (If the military ID card does not include the Soldier's EDI-PI/SSN, the AAA-162 (unit personnel accountability report) will be used to verify the Soldier's information.) If a clerical mistake is made while filling out entries on the DD Form 2624, the specimen bottle label, or the unit ledger prior to the discrepancy inspection required by the DTC, the mistake may be corrected by its maker by lining through (single line) the mistake, placing the corrected information above the mistake, initialing and dating the corrected entry. No other method of correction is authorized except by memorandum, titled "Certificate of Correction," as described in paragraph D-8b.

(1) The UPL prepares label with the following information:

(a) Date Specimen Collected (YYYYMMDD).

(b) BAC.

(c) Soldier's EDI-PI

(d) Soldier's UIC (same UIC for the specimen batch)

(e) Blank spots for Soldier's and UPL's initials

(2) The UPL prepares a DD Form 2624 with the following information (see the Commanders' Guide and UPL Handbook for specific guidance on completing the DD Form 2624):

(a) Block 1. Submitting unit information will have name and address for the unit conducting the collection.

(b) Block 2. Additional Service Information will have the installation ASAP (in installation), state DTC (NG units in installation), RSC (USAR units in installation), or Unit Commander's official email or 10-digit DSN/phone number (all deployed units).

(c) Block 3. Base and unit ID will have the base area code (BAC) the unique code for reporting results and UIC.

(d) Block 4. Date Specimen collected (YYYYMMDD).

(e) Block 5. Unit Document Number. Begin with batch '0001' each day.

(f) Block 6. Specimen Number/Service Member's ID Number will have EDI-PI.

(g) Block 7. Test Basis for each DD Form 2624, use only one appropriate code (IR, IU, IO, CO, PO, RO, MO, AO, VO, NO, OO) (see para 4-5).

(h) Block 8. Test Information. Leave this column blank; use only as instructed by ARD ASAP.

(3) UPL prepares the unit ledger with the following information (see the Commanders Guide and UPL Handbook for specific guidance on completing the DD Form 2624):

(a) Date Specimen Collected.

(b) Batch and Specimen number (blocks 4 and 6 from DD Form 2624).

(c) Soldier's Rank.

(d) Soldier's printed name (Soldier will sign upon completion of specimen collection procedure).

(e) Soldier's EDI-PI.

(f) Test basis.

(g) Observer will print and sign their name on the unit ledger upon completion of specimen collection procedure.

(h) Comments and Disposition.

e. The UPL must first verify the information on the specimen bottle label, testing register, and DD Form 2624 matches the EDI-PI listed on the back for the Soldier's ID card (DoD ID number). The Soldier will initial the specimen bottle label indicating that all data is correct.

f. The UPL will remove a new specimen bottle from the box in front of the Soldier and replace it with the Soldier's military ID Card. The UPL will then affix the label to the specimen bottle, in full view of both the Soldier and the observer, and hand it to the Soldier. The UPL will remind the observer not to take possession of the specimen bottle and to constantly maintain direct eye contact with the bottle until the UPL places it in the collection box.

g. The Soldier will ensure that the observer has full view of the specimen bottle at all times until the UPL takes custody of the specimen. At no time will the observer take custody of the urine specimen.

h. If the Soldier requires use of the optional wide mouth collection cup, the cup will be issued to the Soldier at this time.

- i.* The Soldier and observer will move to a secure latrine; the Soldier will walk in the front with the specimen bottle held above their shoulder to keep it in full view of the observer. The observer will keep the specimen bottle in sight at all times.
- j.* Once in the latrine, the observer will direct the Soldier to wash their hands without the use of soap. The Soldier will then move to the appropriate facility (urinal or toilet) to collect the specimen.
- k.* The Soldier will remove the cap of the specimen bottle in full view of the observer, and will hold it or place it face up on a clean surface. The specimen bottle and cap must be in full view of the observer.
- l.* The Soldier will then fill the specimen bottle with at least 30 mL of urine (approximately half the specimen bottle). The observer must see urine leaving the Soldier's body and entering the specimen bottle (or collection cup). The Soldier will recap the specimen bottle in full view of the observer.
- m.* The following procedure applies to Soldiers who use the wide mouth collection cups:
 - (1) The Soldier will remove the cap from the collection cup, and provide the specimen. The observer will keep the wide mouth collection cup and the specimen bottle in full view and directly observe urine leaving the body and entering the collection cup.
 - (2) The Soldier will then open the specimen bottle, and pour the urine from the wide mouth collection cup into the specimen bottle. The Soldier will recap the specimen bottle in full view of the observer. The observer will watch this entire procedure.
- n.* The specimen bottle must contain at least 30 mL of urine (regardless of specimen volume collected, the specimen bottle must be returned to the UPL).
- o.* The Soldier should wash their hands with soap after recapping the specimen as described in steps l and m above, but the Soldier and observer must keep the specimen in full view.
- p.* The observer and the Soldier will return to the UPL's station. The Soldier will walk in front with the specimen bottle held above their shoulder. The observer will keep the specimen bottle in sight at all times.
- q.* The Soldier will hand the specimen bottle containing their specimen to the UPL; both the Soldier and observer will continue to keep the specimen bottle in sight at all times until the UPL places the specimen in the collection box.
- r.* The UPL will take the specimen bottle, verify that the cap is secure, and inspect the specimen for sufficient volume and possible adulteration. If adulteration is suspected, the UPL will secure the specimen, order the Soldier to stand fast, and ensure that the commander is notified.
- s.* The UPL will then place tamper evident tape across the specimen bottle cap. The tape will be one continuous piece that runs across the top of the specimen bottle and touches the label on both ends without obscuring any information.
- t.* The UPL will initial the specimen bottle label. The UPL's initials signify that they have received the specimen from the Soldier, checked the specimen for adulteration and sufficient volume, ensured the cap was secure, and placed tamper evident tape across the cap.
- u.* The UPL will place the specimen in the collection box and remove the Soldier's ID card. The UPL retains the Soldier's ID card until the Soldier signs the unit ledger.
- v.* The observer will then sign the unit ledger in front of the UPL and Soldier to verify their complied with the collection process and directly observed the Soldier provide the specimen and maintained eye contact with the specimen bottle from the time it was handed to the Soldier until it was placed in the collection box.
- w.* The Soldier will then sign the unit ledger in front of both the observer and UPL verifying that they provided the urine in the specimen bottle and that they observed the specimen being sealed with tamper evident tape and placed into the collection box. The UPL should check the specimen bottle label, unit ledger, and DD Form 2624 and correct errors before releasing the Soldier.
- x.* The ID card will be returned to the Soldier at this time, and the Soldier is released from testing.

D-6. Post-collection procedures

After all specimens have been collected the UPL will—

- a.* Verify that all on the unit ledgers, DD Forms 2624, and specimen bottle labels match.
- b.* Ensure that all required information, signatures, and initials are on the specimen bottle labels, unit ledgers, and DD Forms 2624.
- c.* Place each DD Form 2624 into the corresponding specimen shipping container(s).
- d.* Disinfect the specimen handling area and close down the collection station.
- e.* Transport all specimens to the DTCP as soon as possible (normally the same duty day).
- f.* If unable to transport to the DTCP immediately, the specimens, DD Forms 2624, and testing register will be placed into temporary storage at the unit. Samples submitted to the ASAP after 45 days from the collection date may require written documentation from the commander explaining the delay.

D-7. Specimen chain of custody (back side of DD Form 2624)

a. Once the UPL accepts a complete specimen from the Soldier, the specimen chain of custody begins. This chain of custody must remain continuously and forensically intact until the specimens are received by the courier/shipping agency and subsequently the drug testing laboratory (FTDTL).

b. If two or more UPLs conduct the collection, avoid having each DD Form 2624 handled by more than one UPL. A change of custody should be done only on a completed batch of specimens and its DD Form 2624. If the UPL cannot complete their batch due to an emergency, the DD Form 2624 (front) should be closed-out, and a change of custody to an alternate UPL should be initiated on the back side of the DD Form 2624. The alternate UPL should prepare a new DD Form 2624 with a new batch to collect specimens from the remaining Soldiers that were not collected by the primary UPL. The Primary UPL will transfer the chain of custody of samples by printing and signing name in 11b (released by). The new UPL will receive the samples by printing and signing name in 11c (received by).

c. Each change of custody must be annotated at the time of the occurrence; do not predate or postdate the event. When the specimens are transferred from one specimen custodian to another or to temporary storage or shipping agency, correct and complete information must be annotated in blocks 12a, b, c, and d on the back side of DD Form 2624 as following:

- (1) Block 11a-Date of specimen custody transfer (use U.S. date format YYMMDD to avoid confusions).
- (2) Block 11b-Name and signature of the person or temporary storage facility (building and room) releasing custody.
- (3) Block 11c-Name and signature of the person or temporary storage facility (building and room) accepting custody.
- (4) Block 11d-Reason for transfer/change of custody (for example, "Specimens transferred to primary UPL", "Specimens placed in Temporary Storage", "Specimens retrieved from Temporary Storage", "Specimens received by DTC", "Specimens mailed to FTDTL", and so forth).

D-8. Transfer of specimens at the drug testing collection point

a. At the DTCP, the unsealed specimen boxes will be opened by the DTC or the DTC's designated representative. The actions of the DTC outlined below may be performed by the DTC's designated representative. If there is no DTC, the actions will be performed by the person designated by the ASAP manager. The UPL (or the last person on the chain of custody before transferring specimens to the DTC) will observe the entire specimen transfer process until the DTC signs the DD Forms 2624 accepting the custody of specimens. The DTC will conduct the quality control check of the specimens.

- (1) Ensure that the information contained on the front side of each DD Form 2624 is correct.
 - (a)* Complete address of submitting unit that conducted testing and contact information (name of unit, phone number, email, and official mailing address).
 - (b)* Additional Service information (address of the installation ASAP or battalion-level command or above).
 - (c)* BAC.
 - (d)* Date specimens collected.
 - (e)* EDI-PI
 - (f)* Test basis (Correct code for the type of UA and only one code per DD Form 2624).
 - (g)* Test information is no longer used to indicate rank (see DD Form 2624 Instruction)
 - (h)* Specimen number.
 - (i)* Document batch number.
 - (j)* UIC.
- (2) Ensure that the information contained on the unit ledger is correct and corresponding with the information on the DD Form 2624:
 - (a)* Name of unit that conducted testing (block 1 on DD Form 2624 – complete address of submitting unit).
 - (b)* BAC and Unit UIC (block 4-3 on the DD Form 2624).
 - (c)* Date specimens collected.
 - (d)* Batch and specimen numbers.
 - (e)* Rank, name, EDI-PI, and signatures of the Soldiers.
 - (f)* Test basis.
 - (g)* Names and signatures of the observers.
 - (h)* Comments and disposition (unusual circumstances and/or testing status of a Soldier or specimen).
- (3) Ensure that the information contained on the specimen bottle label is correct and corresponding with information on the DD Form 2624. At a minimum, each specimen bottle label must contain the date specimen collected, EDI-PI/SSN, BAC, Soldier's initials, and UPL's initials.

(4) Ensure minimum 30 mL of urine is contained in each specimen bottle and that an unbroken piece of tamper evident tape is correctly placed on each specimen bottle.

(5) Ensure the chain of custody (back side) on the DD Form 2624 is complete and accurate. Each event of change of custody must be annotated.

(a) Correct dates of change of custody.

(b) Names and signatures of UPL or temporary storage releasing custodian.

(c) Names and Signatures of UPL or temporary storage accepting custodian.

(d) The "Purpose of change/remarks" column clearly explains each change of custody.

b. If a discrepancy is found during the check, the DTC should initiate appropriate action to correct the discrepancy or error, if possible. All discrepancies that can be corrected must be explained in a memorandum titled, "Certificate of Correction," which explains—

(1) The discrepancy.

(2) The circumstances.

(3) The corrective action taken.

(a) All personnel involved, including the person(s) who made the error and the DTC, must sign this certificate.

(b) If the error is a missed entry or an incorrect entry either on the specimen bottle label or on the DD Form 2624, corrections will not be made on the label or on the form. The evidence that a correction was made will be the memorandum titled, "Certificate of Correction" (see fig D-1).

(c) The memorandum titled "Certificate of Correction," will be attached to the original and all copies of the DD Form 2624. The memorandum titled "Certificate of Correction," will be attached to the DTC's DD Form 2624 until destruction date.

c. If no discrepancies are noted, or all discrepancies have been corrected with a memorandum titled "Certificate of Correction," the UPL will enter:

(1) The date the specimens were delivered in block 11a.

(2) Print their name and sign in block 11b.

(3) Print "Specimens released by UPL to DTC" in block 11d.

(4) Ensure that the DTC prints and signs in block 11c to document receipt of the specimens.

d. After the DD Form 2624 is completed, it will be placed in an unsealed, business-sized envelope.

e. Liquid absorbent will be placed in each specimen box (containing up to 12 specimens) to absorb any leakage that may occur. Either the UPL or the DTC may complete this step. This specimen box will be sealed with adhesive tape over all open sides, edges, and flaps. The UPL or the DTC then signs his or her signature across the tape on the bottom and top of each container, and secures the unsealed envelope, with the DD Form 2624 enclosed, to the outside of the specimen container. The BAC should be hand-written across the front of the unsealed envelope. For complete packaging instructions, see the Commander's Guide and UPL handbook.

D-9. Shipping to the Forensic Toxicology Drug Testing Laboratory

a. All UA specimens will be forwarded to the supporting FTDTL.

b. If the DTC is going to ship the specimens to the FTDTL on the day received from the UPL then they will—

(1) Sign each DD Form 2624 releasing it for shipment to the FTDL. Properly complete block 11a to 11d.

(a) Date the specimens delivered to carrier (block 11a).

(b) Name and Signature of person releasing custody to carrier (block 11b).

(c) Name of carrier/shipper if known (for example, USPS). If actual shipping mode is unknown, write "Shipper." (block 11b)

(d) Purpose of change (for example, "Specimens shipped to FTDTL by USPS") (block 11d).

(2) Prepare the specimen boxes as required for shipment.

(a) All specimen containers will be wrapped for shipping.

(b) Ensure that each DD Form 2624 remains inside an envelope taped to the specimen container.

(c) Place specimen container inside a leak proof bag.

(d) Package the outermost shipping container according to the carrier's requirements and local policy. Hand write or affix a label that says "Diagnostic Specimens" near the mailing address.

(3) Ship containers to the drug testing laboratory by transportation priority one. One of the following transportation modes will be used:

(a) Registered mail.

(b) U.S. Postal Service by First Class Mail.

(c) Hand-carried by surface transportation.

(d) Military aircraft transportation system.

- (e) U.S. flag commercial air freight, air express, and air freight forwarder.
- (f) When none of the above satisfies the movement required, by foreign flag air carrier.
- c. If the DTC is unable to ship the specimens until the next duty day, the specimens must be placed in temporary storage and the DD Form 2624 annotated. The temporary storage must be a limited access area. The facility will meet the physical security requirements for evidence storage. This will include a biennial physical security evaluation by qualified personnel, a posted access roster, and an access log to annotate all personnel entering the limited access area.

D-10. Temporary storage of urine specimens at the drug testing collection point

The following describe the minimum requirements for temporary storage of UA specimens at the installation level. This is the preferred site for temporary storage.

a. Windows to the specimen storage room that are accessible from the exterior of the room will be covered with steel or iron bars or steel mesh as follows:

(1) When bars are used, they will be at least 3/8-inch thick and vertical bars will not be more than 4-inches apart. Horizontal bars will be welded to the vertical bars and spaced so those openings do not exceed 32 square inches. Ends of the bars will be securely embedded in the wall or welded to a steel channel frame fastened securely to the window casing.

(2) Acceptable steel mesh will be made from high carbon manganese steel no less than 15/100-inch thick, with a grid of not more than 2-inches from center to center. 6-gauge steel mesh with a 2-inch diamond grid may be used when high carbon manganese steel is not readily available. The steel mesh will be welded or secured to a steel channel frame and fastened to the building by smooth headed bolts that go through the entire window casing. It will be spot welded or branded on the interior, or cemented into the structure itself to prevent easy forced entry.

(3) Air conditioners may be installed in windows or outside walls provided equivalent security measures are taken.

b. Doorways: There must be only one doorway that allows access to and from the specimen storage room.

c. Additional requirements:

(1) Method 1 (evidence room)—allows specimens to be stored inside the interior of the room, when not in full view of the specimen custodian.

(a) Construction: Walls must extend from the floor to the ceiling. Walls and ceilings may be made of masonry or wood. Walls or ceiling that are of wooden stud construction must have a combined exterior and interior thickness of at least 1-inch. Permanently installed flooring (other than masonry) may be used, if the floor cannot be breached without causing considerable damage to the building structure.

(b) Entrance into the room will require opening two successive doors.

(c) When an interior steel mesh cage is used, the door to the cage will serve as the second door. In this case, the outer door will be of solid core wood or metal.

(d) When a steel mesh cage is not used two doors hung one behind the other will be used. One door may be of steel mesh welded to a steel frame. The second door may be of solid core wood or steel; or it may be a hollow wooden door with the exterior reinforced with a steel plate not less than 1/8-inch thick.

(e) If a barred door is used, the vertical steel bars will be at least 3/8-inch thick and spaced no more than 4-inches apart. Horizontal bars will be welded to the vertical bars and spaced so that openings do not exceed 32 square inches.

(f) Either door may be hung on the outside of the doorway. They will be hung so that the doorframe is not separated from the door casing.

(g) Door hinges will be installed so that doors cannot be removed without seriously damaging the door or door jam. All exposed hinge pins will be spot welded or branded to prevent removal. This is not required when safety stud hinges are used or when the hinge pins are on the inside of the doors. (A safety hinge has a metal stud on the face of one hinge leaf and a hole in the other leaf. As the door closes, the stud enters the hole and goes through the full thickness of the leaf. This creates a “bolting” or “locking” effect).

(h) The outer door will be secured by one high security, key-opened padlock. The changeable combination padlock for the inner door will conform to requirements of military specification. This changeable combination padlock is intended only as an indoor or protected area reusable seal. It is not intended for use on the outer door or for protection against forced entry.

(i) All locks will be used with a heavy steel hasp and staple. The hasp and staple will be attached with smooth headed bolts or rivets that go through the entire thickness of the door or door jam. They will be spot welded or branded on the inside of the door. Heavy duty hasps and staples attached so that they cannot be removed when the doors are closed are acceptable.

(2) Method 2 (evidence container)—specimens must be stored within a safe or cabinet, when not in full view of the specimen custodian.

(a) One door will be hung that is made of solid core wood or metal or a barred door. The solid door will, at a minimum, have a high security dead bolt lock.

(b) Inside the room will be a safe, filing cabinet or metal wall locker that weighs at least 500 pounds or is secured to the structure of the building with a chain.

(c) If a filing cabinet is used, then a metal bar hasp will be attached to run the entire height of the cabinet. This bar will be locked with a 200 series padlock (key-opened with 2 keys, no combination lock). Note: a hasp may be welded to the top drawer, but then only the top drawer may be used for temporary storage.

(d) All opening/closing of the safe/cabinet will be annotated on a SF 702 (Security Container Check Sheet).

d. Key and combination control of the temporary storage.

(1) Only primary and alternate custodians will know the combinations of inner door locks of the evidence room. However, copies of all combinations will be recorded on SF 700 (Security Container Information) and kept in sealed envelopes (signed by the specimen custodian, across the seal) in the safe of the appropriate supervisor.

(2) Each authorized DTC/DTT is allowed a key. A spare will be kept in a lock box for the individuals certified to perform drug testing duties. Each key-operated lock will have two keys. One key to each lock will always be kept by the primary custodian. The duplicate key will be put in a separate sealed envelope (signed by the specimen custodian, across the seal) and secured in the safe of the appropriate supervisor.

(3) Lock combinations and cypher locks will be changed when the primary or alternate custodian changes. All combinations and key locks will be changed upon possible compromise.

(4) Keys will be transferred from the primary to the alternate custodian only if the primary custodian is to be absent for more than 1 duty day or 3 non-duty days. The transfer of keys will be documented on DA Form 5513 (Key Control Register and Inventory).

(5) Master key padlocks or set locks will never be used in the evidence room.

e. Each event involving temporary storage of specimens must be written on the chain of custody (back of DD Form 2624).

D-11. Temporary storage of urine specimens at the unit level (by the Unit Prevention Leader)

a. A safe, secure filing cabinet, or metal wall locker will be used to store specimens. This container must be in a lockable room or office.

b. The safe, filing cabinet, or metal wall locker must weigh at least 500 pounds or be attached to the structure of the building with a chain or heavy duty bolts.

c. If a filing cabinet is used, then a metal bar hasp will be attached to run the entire height of the cabinet. A hasp may be welded to the top drawer, but then only the top drawer may be used for temporary storage.

d. The safe or filing cabinet will have a 200 series padlock (with only 2 keys, no combination lock), which is used to secure the hasp.

e. One key will be issued to the primary UPL, the other key will be secured in a sealed envelope (signed by the UPL across the seal) and issued to the commander's safe. Both keys will be issued in accordance with key control SOPs.

f. All opening/closing of the safe/cabinet will be annotated on a SF 702.

g. Each event involving temporary storage of specimens must be written on the chain of custody (back of DD Form 2624).

h. Commanders in deployed areas where facilities are not available to fully comply with the preceding temporary storage guidelines will make every attempt to ensure that specimens requiring temporary storage are properly secured to avoid any tampering or perception thereof. This may include locking them in a foot locker or similar container using a padlock to which the primary UPL has the only key and storing that foot locker in the unit's tactical operations center or other area under constant surveillance.

D-12. Unusual circumstances

All unusual circumstances will be written on the unit ledger.

a. If the Soldier does not have an ID card in their possession, the commander (or first sergeant or executive officer) will positively identify the Soldier and verify the Soldier's EDI-PI against a reliable personnel roster or record. The UPL will write that the Soldier had no ID card and how the ID was verified in the "Remarks" section of the unit ledger and/or in a MFR that is attached to the unit ledger.

b. If less than 30 mL of urine is collected, the entire specimen will be discarded and the specimen bottle will be destroyed by crushing (after obliteration of the EDI-PI-PI/SSN on the specimen bottle label). The Soldier will be sent back to the holding area until they can provide a full specimen. The Soldier will be allowed to drink 8 ounces of water every 30 minutes but not to exceed a total volume of 40 ounces in 3 hours. The holding area NCO/officer will monitor

each Soldier's water consumption to prevent the Soldier from encountering any health hazards. When the Soldier is ready to provide a specimen, the procedure; original entries on the DD Form 2624 and unit ledger may be used for the second specimen collected.

c. If a Soldier refuses to provide a specimen, the appropriate command authority will be notified. The Soldier's chain of command should give the Soldier a direct order to provide a specimen. If the Soldier refuses, it will be a violation of a direct order, which may subject the Soldier to disciplinary action.

d. If adulteration is suspected, the UPL will secure the specimen, order the Soldier to stand fast, and send someone to notify the commander. When the commander verifies the evidence of a possible adulteration and after consulting the supporting legal advisor, they may immediately pursue testing the Soldier under "probable cause (collection code PO)" with the collection being observed by a different observer. A second specimen will be submitted for testing on a separate DD Form 2624. The first specimen will be submitted and the circumstance written on the unit ledger.

e. If the tamper evident tape breaks in such a fashion that it does not touch both sides of the specimen bottle label, apply a second piece of tamper evident tape across the bottle cap and touching the label on both sides, but not directly over the original tamper evident tape that broke. Annotate on the unit ledger that a second piece of tamper evident tape was applied and that the Soldier observed this process. Prepare a MFR and/or certificate of correction after the collection and attach it to the original DD Form 2624.

D-13. Legal provisions

The provisions of this appendix do not provide any rights or privileges as to the relevancy or admissibility of laboratory documents. In no case will failure to comply with the provisions of this appendix be used to invalidate an otherwise valid and legally sufficient adverse administrative or disciplinary action.



DEPARTMENT OF THE ARMY
ORGANIZATION
STREET ADDRESS
CITY STATE ZIP

DAPE-HRS

MEMORANDUM FOR Commander, USAF Forensic Toxicology Drug Testing Laboratories [Insert Physical Address]

SUBJECT: Certification of Correction

1. This letter is to certify the following corrections were made as indicated below for urine specimen enclosed with this shipment for testing.
2. REFERENCE: Bottle Label and/or DD Form 2624
3. DOCUMENT/BATCH: 02
4. SPECIMEN: 05
5. READ AS: [Insert Incorrect SSN]
6. CORRECTED TO READ AS: [Insert correct SSN]

UPL's Printed First, Last Name]
[UPL's Signature]
[Insert Date]

Verified By:
[Commander's Printed First, Last Name]
[Commander's Signature]
[Insert Date]

[Observer's Printed First, Last Name]
[Observer's Signature]
[Insert Date]

Figure D-1. Sample Memorandum of Certification of Correction

Commander's Briefing

Today our Unit will be drug tested for illegal substance use. The primary purpose of this test is to ensure our unit's military fitness, and that we are maintaining proper standards of readiness. Individuals in this unit have been selected on a random basis (or unit sweep) for drug testing. There is no probable cause or reasonable suspicion that anyone in the unit is using or abusing drugs or a controlled substance.

Everyone selected for testing will be tested. Anyone not present will be rescheduled for testing at a later date.

Every specimen collected will be tested for marijuana (THC), cocaine, amphetamines (which includes methamphetamines, MDMA (ecstasy), MDA, and MDEA), heroin, opiates (which includes morphine and codeine), synthetic opiates (oxycodone/oxymorphone known commonly as oxycontin), and benzodiazepines. The additional drug synthetic cannabinoids (spices) will be tested on a rotational basis and/or any additional drugs on the DOD drug testing panel.

Testing procedures outlined in AR 600-85 or DA Pam 600-85 will be followed.

All Soldiers must be aware that all verbal orders connected with the testing are lawful and are to be followed as such.

A refusal to comply with orders relating to this test; subjects the Soldier to punitive or administrative actions under AR 600-85, AR 135-18, AR 135-178, and AR 635-10.

DOES ANYONE HAVE ANY QUESTIONS?

The UPL will now provide you with details about the drug testing procedures that will be used today.

Figure D-2. Commander's UA briefing

UPL's Unit Briefing

You have four major responsibilities during the collection procedure:

1. Initial the specimen bottle label verifying your personal data is correct.
2. Provide more than 30ml of specimen.
3. Keep specimen bottle in full sight until sealed with tamper evident tape.
4. Sign your payroll signature to verify that the specimen was yours and you watch it be sealed by the UPL with tamper evident tape and placed in the collection box.

Your urine specimen will be provided in a labeled plastic bottle (an optional wide mouth collection cup is available).

Each bottle will have a label affixed to it with today's date that identifies you by your EDI- PI/SSN. Do not accept a bottle that does not have a completed label affixed with your correct EDI-PI/SSN and today's date.

Collection of the specimen will be conducted using direct observation in full view of an observer. Do not go to the UPL station until you feel you are ready to provide at least 30ml (approximately ½ bottle) of urine. If you are unable to provide a specimen or an adequate quantity of urine, you will be held in the holding area until you are able to provide a specimen.

You will be provided an adequate amount of liquid to help facilitate the collection process. You will not be released from duty today until you have provided a proper specimen.

Your tasks include:

You will provide your military ID card. If you do not have your military ID card or other photo identification, the Commander will be called to verify your identification.

Remove excess outer garments such as ACU/BDU/OCPACU jackets and coats or PT jacket.

You will initial the bottle label after you verify your EDI-PI/SSN, full name, and date on the Unit Urinalysis Ledger; verify EDI-PI/SSN on DD Form 2624; and verify the date and your EDP- ID/SSN on the bottle label. Provide a urine specimen under direct observation. Sign your payroll signature on the Unit Urinalysis Ledger verifying that the urine specimen provided was yours, the specimen was sealed with tamper evident tape and was placed into the collection box.

Note: I do not need to know if you are taking or have taken prescription medications. If your specimen result comes back from the laboratory as positive for a drug that could have been a result of prescription medication, a medical doctor will review the result before any other actions are taken. The doctor will review your medical record, any prescriptions from outside providers, and possibly interview you, prior to making a medical determination of valid prescription use or illegal use. If the doctor determines the drug positive was a result of valid prescription medication, then no actions will be taken against you. Are there any questions? Any questions about the collection procedure will be directed to me or your observer.

Figure D-3. Unit Prevention Leader's UA briefing



DEPARTMENT OF THE ARMY
ORGANIZATION
STREET ADDRESS
CITY STATE ZIP

DAPE-HRS

MEMORANDUM FOR Commander, USAF Forensic Toxicology Drug Testing Laboratories, [Insert Physical Address]

SUBJECT: Responsibilities of Observers during Drug Testing

1. Observers are a critical link in the process of collecting urine specimens to be tested for substance abuse. Instances have occurred in the past where observers did not follow proper collection procedures and positive drug test were not usable in legal and/or administrative actions. In order to prevent similar occurrences in the future, observers will read and sign this memorandum.
2. The testing procedures do not violate a Soldier's Fourth or Fifth Amendment rights, nor does the observation procedure violate the right to privacy. A refusal to produce a specimen is a violation of a direct order and may result in the Soldier being processed for separation.
3. The results of tests may be used in legal proceedings and consequently, the urine specimen may be considered as evidence. A valid chain of custody is mandatory for a successful prosecution. As an observer, you may be asked to provide testimony at legal or administrative proceedings. You may be subject to Uniform Code of Military Justice or administrative action if it is discovered that the specimen was altered in any way while it was under your control. Actions may include, but are not limited to the following:
 - a. Article 92: Knowingly failing to obey a lawful general order or regulation by not maintaining direct line of sight of the urine into the bottle.
 - b. Article 107: Making a false official statement in signing the Unit Prevention Leader's (UPL's) urinalysis ledger acknowledging the urination process was directly observed and no tampering occurred.
 - c. Article 134: False swearing by authenticating that no substitution or tampering of the urine sample occurred.
4. Criteria for observers:
 - a. Be an officer or noncommissioned officer in the rank of sergeant or above.
 - b. Be of the same gender as the Soldier being tested.
 - c. Possess sufficient maturity and integrity to preserve the dignity of the Soldier being observed
 - d. Not be currently enrolled within the ASAP Rehabilitation Program or currently be under investigation for any substance abuse related offenses.
5. Responsibilities: As outlined in AR 600-85, observers must follow the protocol below during urinalysis collection procedures.
6. Once assigned to a specific Soldier, the observer:
 - a. Controls the urine collection process at all times.

Figure D-4. Urinalysis observer's briefing and memorandum

- b. Maintains visual contact with the bottle at all times.
- c. Ensures the Soldier washes his or her hands with water only, no soap, prior to providing a specimen.
- d. Ensures that the specimen provided is not contaminated or altered.
- e. Directly observes the Soldier (one Soldier at a time per observation) voiding urine into the specimen bottle. (When the optional wide mouth specimen collection container is used, immediately after the collection and while still under direct observations of the observer, the urine must be poured into the currently approved urine specimen bottle and tightly capped by the Soldier providing the specimen.)
- f. Ensures direct observation of the flow of urine from the Soldier's body into the bottle.
- g. Supervises the Soldier tightly capping the bottle.
- h. Ensures the bottle is not reopened after the cap is tightened.
- i. Escorts the Soldier back to the UPL station and/or table with bottle in full view.
- j. Observes the UPL placing tamper evident tape over the top of the bottle and across the label. Tape must not cover printed information.
- k. Observes the UPL place the specimen in the collection box.
- l. Signs the unit ledger in front of the UPL and Soldier verifying the collection process and that direct observation was conducted.

OBSERVER AFFIDAVIT: I have read and understand this document. I will comply with the responsibilities as stated above and will report anything out of the ordinary immediately to the UPL or Commander.

[Observer's First, Last Name]
 [Observer's Signature]
 [Insert Date]

[UPL's First, Last Name]
 [UPL's Signature]

[Insert Date]

Figure D-4. Urinalysis observer's briefing and memorandum--Continued

Appendix E

Drug Testing Supplies

E-1. Required military collection supplies

The supplies listed in table E-1 are required in order to conduct a military UA collection.

Table E-1 Required military urinalysis collection supplies	
Description	National Stock Number (NSN)
Urine specimen bottles (1 case=10 boxes)	6640-00-165-5778
Specimen collection cups (female collection cups)	6530-01-048-0855
Mailing pouch, specimen (leak proof bag)	6530-01-304-9762
Liquid absorbent pouch (dry absorb packs)	6530-01-304-9754
Tape, tamper resistant, serrated red 1/2 in, 72 YYD/RO	6640-01-204-2654
Labels (Avery 5163 or other 2x4), 10 sheet/1000 box	7530-01-514-4903 and 7530-01-336-0540
Exam gloves	6515-01-149-8841 or local purchase
Envelopes, plain white (business)	Various NSNs or local purchase
Tape, gummed activated with water	Various NSNs or local purchase
Tape, masking	Various NSNs or local purchase
Pen, ball point (blue pen recommended)	Various NSNs or local purchase
Paper towels	Various NSNs or local purchase

E-2. Required civilian collection supplies

The supplies listed below in table E-2 are required in order to conduct a civilian UA collection.

Table E-2 Required civilian urinalysis collection supplies	
Description/product number	Source
Civilian collection kits (single or split)	Forensic Toxicology Drug Testing Laboratory, Fort Meade, MD 301-677-7085 Kit includes DoD CAF, collection cup, specimen container, biohazard bags with absorbent and shipping box
Blue dye tablets (100 tablets per bottle)/01657	Company used in this process 1-800-255-6499
Blue dye powder/01658	Lynn Peavey Company 1-800-255-6499

Appendix F

Army Substance Abuse Program Professional Code of Ethics

F–1. Preamble

The ASAP Professional Code of Ethics serves as a code of conduct for ASAP professionals in their behavior at work and in the community. In cooperation with military and civilian leadership, ASAP professionals' primary objective is to provide the most effective drug and alcohol services to Soldiers, civilians, and their Families suffering from emotional, behavioral, alcohol and drug-related problems. The following principles are in accord with this goal to educate ASAP professionals regarding ethical professional conduct. ASAP professionals affirm their endorsement of the Code of Ethics and commitment to uphold these principles while they perform their professional duties.

F–2. Professional responsibility

ASAP professionals help protect military and civilian leadership and the communities they serve against unethical practices by an individual or organization engaged in drug and alcohol education programs, EAPs, rehabilitation, or consultation activities. When an ASAP professional knows of an apparent ethical violation by another ASAP professional, it becomes their ethical responsibility to attempt to resolve the matter by bringing that alleged unethical behavior to the other member's attention. If a resolution of ethical matters between members is not achieved, further informal consultation with colleagues and/or civilian personnel is recommended prior to any formalized IG general or other government review of a member's complaint.

F–3. Confidentiality

All professionals treat Soldier, civilian, and Family member information as confidential. Members inform clients fully about their rights regarding the scope and limitations of confidential communications elicited during the education, assessment, referral, and treatment. They do not disclose information without client consent except where failure to disclose would violate a court order or other valid obligation to disclose under relevant law and regulations.

F–4. Professional competency

All professionals are expected to possess knowledge of the Army as a whole as well as the organizations they serve; applicable Federal, DoD, and Army policies and procedures, as well as their specific duties and responsibilities. All members acknowledge the necessity of continuing experience, education and training to maintain and enhance proficiency. While membership in any specific professional organization may not be used to suggest professional competency, attaining the status of a CEAP or certified DTC does attest to meeting the requisite standard of knowledge for competency in practice.

F–5. Client protections

ASAP professionals do not discriminate because of a client's race, religion, national origin, age, disability, sex, or other impermissible basis. ASAP professionals make full disclosure of the functions and purposes of each of their programs. ASAP professionals do not give or receive financial consideration for using certain services or products, for referring clients to particular therapists or rehabilitation/treatment programs. They do not engage in sexual conduct with clients and do not act in any manner which compromises a professional relationship.

F–6. Public responsibility and professional relations

ASAP professionals agree that all members of the ASAP, whether practitioners, including other professionals, form a partnership in providing drug and alcohol services. As such, members are responsible for educating and fostering the professional development of trainees; are encouraged to promote the ASAP to commanders and civilian leadership and to provide statements based on objective information; and are expected to work cooperatively within their professional communities. Cooperation within a professional community precludes denigrating other professionals to promote one's own interests, and requires that one's professional qualifications be presented to the public in an accurate and truthful manner. ASAP professionals are encouraged to assist another member to seek counseling if that member's professional functioning becomes impaired through the use of alcohol, drugs, and/or behavioral illness.

Appendix G

Internal Control Evaluation

G–1. Function

The function covered by this checklist is effective and efficient administration of the ASAP.

G–2. Purpose

The purpose of this checklist is to assist ASAP managers in evaluating key internal controls. It is not intended to cover all controls in accordance with AR 11–2.

G–3. Instructions

Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, sampling, simulation, or other). Answers that indicate deficiencies must be explained and the corrective action identified in supporting documentation. These internal controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2 (Internal Control Evaluation Certification). Additional questions at appendix D should be considered when evaluating the ASAP Program.

G–4. Test questions

- a. Is an ASAP manager position authorized on the TDA and filled full time to implement the ASAP?
- b. Are new commanders briefed on the ASAP upon assuming command?
- c. Have UPLs been identified and certified in accordance with paragraph 9–5?
- d. Is there a DTC and alternate DTC appointed on orders signed by the ASAP manager and are certified by the DTC Certification Course?
- e. Are there written military and civilian UA collection SOPs approved by the SJA within the last year?
- f. Is there a notification procedure for military personnel that include the DTC sending laboratory positives for MRO-reviewable drugs to the MRO for a determination of legitimate use versus not legitimate use? Do the procedures ensure that the MRO notifies the DTC of their determination, and that the DTC notifies the commander and updates DAMIS?
- g. Are commanders conducting smart testing of assigned and attached personnel on a truly random basis?
- h. Is the installation or command conducting random UA of civilian corps members in TDPs at the DA-directed testing rate? Has a DA Form 5019 and/or a DA Form 7412 been signed by all civilians occupying a position requiring alcohol and/or other drug testing?
- i. Has the ASAP manager developed and implemented a plan to monitor and assess command utilization of and satisfaction with all aspects of the program (for example, prevention, ID, and rehabilitation)?
- j. Does that plan leverage the program performance indicators (process, output and outcomes) identified by ARD?
- k. Has the ASAP manager developed and implemented a prevention education program that coordinates and tracks substance abuse prevention efforts and required annual training for Soldiers and civilian corps members?
- l. Are ASAP civilian salaries funded in accordance with the MDEPs identified with each authorization listed on the installation TDA? Is the DTC's salary funded by VCND?

G–5. Supersession

This evaluation replaces the internal control evaluation checklist previously published in AR 600–85, 28 November 2016.

G–6. Comments

Help to make this a better tool for evaluating internal controls. Submit comments to Director, ARD, 2530 Crystal Drive, Taylor Building 6th Floor, Arlington, VA 22202.

Glossary

Section I

Abbreviations

ACOM

Army command

AD

Active duty

ADAPT

Alcohol and drug abuse prevention training

ADCO

Alcohol drug control officer

ADIC

Alcohol Drug Intervention Council

ADOR

Authoritative Database of Record

ADT

Active duty for training

AFMES

Armed Forces Medical Examiner System

AG

Adjutant General

AGR

Active Guard Reserve

AHLTA

Armed Forces Health Longitudinal Technology Application

ALERTS

Army Law Enforcement Reporting and Tracking System

AMEDD

Army Medical Department

AMEDDC&S

Army Medical Department Center and School

AMIOP

Addiction Medicine Intensive Outpatient Program

AO

mishap or safety inspection (collection code)

AR

Army regulation

ARD

Army Resilience Directorate

ARIMS

Army Records Information Management System

ARNG

Army National Guard

ASACS

Adolescent Support and Counseling Services

ASAP

Army Substance Abuse Program

ASAP Manager

Army Substance Abuse Program Manager

ASCC

Army service component command

AWOL

Absent without leave

BAC

Base area code

BACM

Base area code manager

BAT

Breath alcohol technician

BHSOC

Behavioral Health System of Care

BPL

Battalion prevention leaders

CCF

Central clearance facility

CD

Clinical director

CEAP

Certified Employee Assistance Professional

CFR

Code of Federal Regulations

CID

Criminal Investigation Division

CNGB

Chief, National Guard Bureau

CO

competence for duty

CPAC

Civilian Personnel Advisory Center

CPL

conforming products list

CPOC

Civilian Personnel Operations Center

CR2C

Commander's Ready and Resilient Council

CTP

Certification Training Program

DA

Department of the Army

DAMIS

Drug and Alcohol Management Information System

DASAF
Director of Army Safety

DCS
Deputy Chief of Staff

DD
Department of Defense (Forms)

DDR
Drug demand reduction

DFARS
Defense Federal Acquisition Regulation Supplement

DFW
Drug-Free Federal Workplace

DHHS
Department of Health and Human Services

DMO
Designated management official

DoD
Department of Defense

DoD CAF
Department of Defense Consolidated Adjudications Facility

DoDD
Department of Defense directive

DoDI
Department of Defense instruction

DOT
Department of Transportation

DRU
Direct reporting unit

DSM-5
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

DSN
Defense Switched Network

DTC
Drug testing coordinator

DTCP
Drug testing collection point

DTP
Drug testing Program

DUI
Driving under the influence

DWI
Driving while intoxicated

EAP
employee assistance program

EDI-PI
Electronic data interchange-person identifier

EO
Executive Order

FAA
Federal Aviation Administration

FAP
Family Advocacy Program

FAR
Federal Acquisition Regulation

FedEx
Federal Express

FLAG
Suspension of favorable actions

FTDTL
Forensic Toxicology Drug Testing Laboratory

GO
general officer

GS
General Schedule

HIPAA
Health Insurance Portability and Accountability Act

HQ
headquarters

HQDA
Headquarters, Department of the Army

IADT
initial active duty for training

IBAT
installation breath alcohol technician

ID
Identification

IG
inspector general

IMCOM
Installation Management Command

IO
inspection other

IPP
Installation Prevention Plan

IPT
Installation prevention team

IR
inspection random

ISR
Installation status report

JSAP
Joint Substance Abuse Program

JSAPC

Joint Substance Abuse Program coordinator

JSAPO

Joint Substance Abuse Program officer

LIMS

Laboratory Information Management System

LSD

lysergic acid diethylamide

MDEP

Management decision evaluation package

MEDCOM

Medical Command

MEDDAC

Medical department activity

METT-TC

Mission, enemy, terrain, troops, time, civil considerations

MFR

memorandum for record

MO

medical examination (collection code)

MOS

Military occupational specialty

MP

Military police

MRE

Military Rules of Evidence

MRO

Medical review officer

MSC

Major subordinate command

MTF

military treatment facility

NCO

noncommissioned officer

NG/ML

nanograms per milliliter

NGB

National Guard Bureau

NO

new entrant (collection code)

NSN

National stock number

OCONUS

outside continental United States

OO

Other (collection code)

Pam
Pamphlet

PC
prevention coordinator

PL
Public Law

PM
Provost marshal

PMO
Provost marshal office

PO
probable cause (collection code only)

POC
point of contact

PRP
Personnel Reliability Program

QA
quality assurance

QAAP
management decision package code for the Army Substance Abuse Program funds

QFMD
management decision package code for adolescent substance abuse counseling services funds

RO
Rehabilitation (collection code)

RRP
Risk Reduction Program

RRPC
Risk Reduction Program coordinator

RTM
Rehabilitation Team Meeting

R-URI
Re-integration unit risk inventory

SAMHSA
Substance Abuse and Mental Health Services Administration

SAP
Substance abuse professional

SF
Standard form

SHARP
Sexual Harassment/Assault Response and Prevention

SJA
Staff judge advocate

SME
subject matter expert

SOP
Standard operation procedures

SSN
social security number

STT
screening test technician

SUD
Substance use disorder

SUDCC
Substance use disorder clinical care

TDA
Table of distribution and allowances

TDP
Testing designated position

TJAG
The Judge Advocate General

TRADOC
U.S. Army Training and Doctrine Command

TSG
The Surgeon General

U.S.
United States

UA
urinalysis

UCMJ
Uniform Code of Military Justice

UIC
unit identification code

UPL
Unit Prevention Leader

UPS
United Parcel Service

URI
Unit risk inventory

USACE
United States Army Corps of Engineers

USACIDC
U.S. Army Criminal Investigation Command

USAMEDCOM
U.S. Army Medical Command

USAR
U.S. Army Reserve

USARC
U.S. Army Reserve Command

USC
United States Code

USPS

U.S. Postal Service

VA

U. S. Department of Veterans Affairs

VCND

management decision packages code for Department of Defense Counter-narcotics funds

VO

Voluntary (member consent) (collection code)

Section II**Terms****Adulterated specimen**

A urine specimen containing a substance that is not a normal constituent or containing an endogenous substance at a concentration that is not a normal physiological concentration.

Air blank

A reading by an evidentiary breath test of ambient air containing no alcohol.

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 behavioral health, financial responsibility, or personal relationships.

Alcohol and Drug Control Officer–Army Substance Abuse Program (ASAP) Manager

The person having staff responsibility for implementing the ASAP at IMCOM, ACOM, ASCC, DRU, or installation level.

Alcohol level

The alcohol in a volume of breath expressed in terms of grams of alcohol per 210 liters of breath as indicated by an evidentiary breath test. For example, a breath alcohol concentration of 0.04 means 0.04 grams (four one-hundredths of one gram) of alcohol in 210 liters of expired deep lung air.

Alcoholism

A treatable, progressive condition or illness characterized by excessive consumption of alcohol to the extent that the individual's physical and behavioral health, personal relationships, social conduct, or job performance are impaired.

Aliquot

A fractional part of a specimen used for testing. It is taken as a sample representing the whole specimen.

Army Substance Abuse Program

A personnel program that includes deterrence, prevention, and education services. The ASAP is responsive to the chain of command and supports the combat readiness of the Army.

Army Substance Abuse Program records

Forms, records, or other documents required by this regulation. This includes any information, whether recorded or not, relating to clients (Soldiers, DA Civilians and/or Family members) who receive services in connection with any function of the ASAP.

Blood alcohol concentration

the percent of alcohol (ethyl alcohol or ethanol) in a person's blood stream. The blood alcohol concentration can be tested by blood sample and breathalyzer testing.

Career

For the purposes of this regulation, an Army career is defined as inclusive of all periods of service, including officer and enlisted Service or a combination of both, when the Soldier is subject to the UCMJ or a or territory military code of justice.

Chain of custody

Procedures to account for the integrity of each urine specimen or aliquot, by tracking, handling, and storing from point of specimen collection to the final disposition of the specimen. Documentation of this process must include the date and purpose each time a specimen or aliquot is handled or transferred and ID of each individual in the chain of custody.

Commerce

An interchange of goods or commodities.

Commercial motor vehicle

A commercial vehicle with a gross vehicle weight rating of 26,001 or more pounds; or is designed to transport 16 or more occupants (to include the driver); or is of any size and is used in the transport of hazardous materials that require the vehicle to be placarded.

Confirmation

The process of using an analytical procedure to identify the presence of a specific drug or metabolite that is independent of an initial test and which uses a different technique and chemical principle from that of an initial test in order to ensure reliability and accuracy.

Department of Transportation follow-up testing

Unannounced or alcohol testing that is required for any employee who has committed a DOT drug or alcohol regulation violation, and who seeks to resume the performance of safety-sensitive functions. At a minimum the employee must undergo six follow-up tests within the 12-month period following the employee's resuming the performance of safety-sensitive duties. These tests are not to be confused with follow-up testing that is actually part of the counseling or rehabilitative process. Other tests such as random or post-accident testing cannot be submitted for the required follow-up testing.

Designated management official

The DMO is the one person on an installation that is responsible for administering the civilian DTP. In most cases, this is the installation ASAP manager.

Director, Army Resilience Directorate

The Director of the ARD is responsible to the DCS, G-1 for the performance of the overall ASAP.

Drug abuse

The use or possession of controlled substances, or illegal drugs, or the nonmedical or improper use of other drugs (for example, prescription and over the counter drugs) that are packaged with a recommended safe dosage. This includes the use of substances for other than their intended use (for example, glue and gasoline fume sniffing or steroid use for other than that which is specifically prescribed by competent medical authority.)

Drug-Free Federal Workplace Program follow-up testing

Unannounced testing that each employee who has been referred to the EAP through the administrative channels to undergo counseling or rehabilitation/treatment for illegal drug use will be subject such testing for period of 1 year upon the completion of the counseling or rehabilitation programs. Frequency of such testing may be stipulated in the abeyance contract or at a frequency determined by the supervisor. Such testing is distinct from testing which may be imposed as part of the counseling or rehabilitation/treatment programs.

Drug-testing coordinator

The DTC is the individual trained to collect UA specimens from DA Civilians as part of the civilian DTP. The DTC is often a certified DTC, though this need not be the case. A DTC performs similar duties for DA Civilians that the UPLs perform for Soldiers.

Drug-Testing Program

The DoD DTP is software designed to manage and automate a unit-level substance abuse program. The UPL uses the software to maintain a list of personnel in the unit, randomly select Soldiers for drug testing, and print required forms and bottle labels. DTCs may also use the DoD DTP for managing civilian drug testing.

Education and training

Education is instruction with increased knowledge, skill, and/or experience as the desired outcome for the student. This is in contrast to training, where a task or performance basis is used and specific conditions and standards are used to assess individual and unit proficiency (see AR 350-1). Awareness training is training used to disseminate information that provides an individual with the basic knowledge/understanding of a policy, program, and/or system.

Employee Assistance Program short-term counseling

The process whereby the EAP coordinator provides short-term guidance, advice, education, and mediation to civilian employees for the resolution of employee problems and issues.

Enrollment into mandatory care

A formal action taken by the SUD provider based on the presence of a substance use disorder and specific criteria is met by the patient.

Evidentiary breath testing device

A device approved by the National Highway Traffic Safety Administration for the evidentiary testing of breath and placed on National Highway Traffic Safety Administration's "Conforming Products List (CPL) of Evidentiary Breath Measurement Devices."

Family member

Spouse or minor children of a Soldier, or a civilian employee. Use of term in this regulation is intended to include only persons eligible for ASAP services by law or regulation.

Forensic

The application of scientific principles and techniques to matters of criminal justice especially as related to the collection, examination, and analysis of physical evidence: in drug testing the chain of custody along with analysis must be maintained for suitability of administrative and UCMJ actions.

Gambling disorder

Is an addiction similar to substance use disorders. In addition to causing financial and legal problems, also correlated with an increase in suicide attempts, substance use disorders and other behavior health conditions.

Gas chromatography/mass spectrometry

The chemical process where a drug in urine is positively identified and quantified.

Inactive duty

USAR duty status not on active duty, includes Inactive Duty Training (IDT).

Initial test

A screening test to identify those specimens that are negative for the presence of drugs or their metabolites. When negative, these specimens need no further examination and need not undergo a more costly confirmation test.

Installation breath alcohol technician

A trained individual, who assists employees/applicants in the alcohol testing process and operates an evidentiary breath test device.

Joint Substance Abuse Program officer/Joint Substance Abuse Program coordinator

The JSAPO and JSAPC manage the ASAP for the ARNG.

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.

Medical review officer

A licensed physician responsible for receiving laboratory results generated from a drug test who has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate Soldiers'/employees'/applicants' confirmed positive tests results together with their medical histories and any other relevant biomedical information.

Prevention

Readiness involves the commitment of command resources, policies, installation organizations, and community members to create and foster conditions that promote mission readiness and enhance Army well-being.

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.

Probable cause

A reasonable ground in fact and circumstance for a belief in the existence of certain circumstances (as that an offense has been or is being committed, that a person is guilty of an offense, that a particular search will uncover contraband, that an item to be seized is in a particular place, or that a specific fact or cause of action exists).

Problematic substance abuse

The use of any substance (to include alcohol) in a manner that puts the user at risk of failing in their responsibilities to mission or family, or that is considered unlawful by regulation, policy, or law.

Professional program management

Minimum one-year paid experience in managing a clinical program and managing workload accountability, administrative accountability, personnel management, and clinical oversight. The managerial job must have included budget planning and fiduciary analysis, implementation of Office of Personnel Management standards and the Merit Systems Protection Board guidelines while conducting personnel hiring actions, supervisory training, disciplinary actions, conducting conflict and problem resolution, conducting quality control program reviews, performing workload and outcome analyses, preparation and submission of statistical reports in federal or corporate work environments, instituting and maintaining performance improvement initiatives, and the preparing and delivering formal briefings at the corporate or higher HQ levels.

Random testing

A scientifically valid system of selecting a portion of a command for drug testing without individualized suspicion that a particular individual is using illicit drugs. Each Soldier or civilian will have an equal chance of being selected for drug testing each time this type of inspection is conducted.

Reasonable suspicion

An objectively justifiable suspicion that is based on specific facts or circumstances and that justifies stopping and sometimes searching (as by frisking) a person.

Rehabilitation/treatment team

A coordinating group consisting of the Soldier, the unit commander and/or first sergeant, the treating provider, and other appropriate personnel as required. The team reviews all pertinent information about the Soldier to include rehabilitation/treatment plan that requires rehabilitation testing. It selects the appropriate rehabilitation methods and assists the commander in setting standards of behavior and goals for evaluation of the Soldier's progress in rehabilitation.

Re-integration unit risk inventory

The R-URI is an anonymous questionnaire completed by Soldiers of a unit between 90 and 180 days after returning from an operational (not training) deployment. The questionnaire is designed to identify the risky behaviors Soldiers are participating in after a deployment.

Relapse

The resumption of a pattern of substance use in an individual seeking abstinence that was previously identified as problematic substance abuse.

Reservist not on active duty and is a reservist that participates on weekend battle assembly.**Sensitive position**

Any position within DA in which the occupant could cause, by virtue of the nature of the position, a materially adverse effect on the national security.

Serious incident (of alcohol-related misconduct)

Any offense of a civil or military nature that is punishable under the UCMJ by death or confinement for a term exceeding 1 year.

Slip

A temporary or isolated resumption of substance use in an individual seeking abstinence from that substance.

Smart testing

The process where drug testing is conducted in such a manner that it is not predictable to the tested population.

Split specimen

An additional specimen collected with the original specimen to be tested in the event the original specimen tests positive.

Substance abuse professional

A person who evaluates employees who have violated a DOT drug and alcohol regulation and makes recommendations concerning education, treatment, follow-up testing, and aftercare.

Substance use disorder

Occurs when a person's use of alcohol or another substance (drug) leads to health issues or problems at work, school, or home.

Testing designated position employee

A DA employee who holds a position identified by the Army as having critical safety or security responsibilities related to the Army mission.

Unit risk inventory

An anonymous questionnaire completed by all Soldiers of a unit at any time, and is designed to identify the risky behaviors Soldiers are participating in.

Voluntary/non-enrolled care

Soldiers who have an alcohol use disorder and do not meet the criteria for mandatory care.

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