Army Regulation 600–85

Personnel—General

The Army Substance Abuse Program

Rapid Action Revision (RAR) Issue Date: 2 December 2009

Headquarters
Department of the Army
Washington, DC
2 February 2009

UNCLASSIFIED

SUMMARY of CHANGE

AR 600–85
The Army Substance Abuse Program

This rapid action revision, dated 2 December 2009--

- o Delineates and defines the overarching tenets and supporting capabilities of the Army Substance Abuse Program as prevention and treatment (chap 1).

- o Updates responsibilities for several key players, including commanders at all levels (chap 2).

- o Updates the random drug testing policy and expands guidance for deployed units (chap 4).

- o Establishes policy on minimum requirements for the Army Substance Abuse Program’s clinical providers (chap 8).

- o Clarifies legal and administrative actions available to commanders (chap 10).

- o Modifies guidance concerning Army Substance Abuse Program client recordkeeping (chap 14).

- o Modifies policy for completing DD Form 2624 (Specimen Custody Document - Drug Testing), blocks 1 and 2 (app E).

- o Incorporates policies in support of the Army’s suicide prevention efforts (throughout).

- o Makes administrative changes (throughout).

- o Makes additional rapid action revision changes (throughout).

Headquarters
Department of the Army
Washington, DC
2 February 2009

*Army Regulation 600–85

Effective 17 February 2009

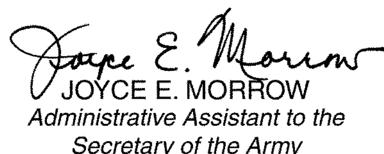
Personnel—General

The Army Substance Abuse Program

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:



JOYCE E. MORROW
Administrative Assistant to the Secretary of the Army

History. This publication is a rapid action revision (RAR). This RAR is effective 2 January 2010. The portions affected by this RAR are listed in the summary of change.

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 Active Army, the Army National Guard of the United States when in Title 10 status (National Guardsmen in Title 32 status should refer to chapter 15 of this regulation), the U.S. Army Reserve, and Department of the Army Civilian Corps Members. 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 Army Reserve and the Army National Guard, when indicated. Chapter 5 applies to Department of the Army Civilian Corps Members. Chapter 6 applies to Department of the Army Civilian Corps Members, military and civilian employee, Family members, and military retirees.

Proponent and exception authority. The proponent of this regulation is the Deputy Chief of Staff, G–1. The proponent has the authority to approve exceptions or waivers to this regulation 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 management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated (see appendix H).

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–HRS), 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 Office of the Deputy Chief of Staff, G–1 (DAPE–HRS), 300 Army Pentagon, Washington, DC 20310–0300.

Committee Continuance Approval. The Department of the Army committee management official concurs in the establishment and/or continuance of the committee(s) outlined herein. 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–ZX), 2511 Jefferson Davis Highway, 13th Floor, Taylor Building, Arlington, VA 22202–3926. 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 publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

*This regulation supersedes AR 600–85, dated 2 February 2009. This edition publishes a rapid action revision of AR 600–85.

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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, Army civilian corps members, and other personnel eligible for Army Substance Abuse Program (ASAP) services.

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibility
See chapter 2 for responsibilities.

1–5. 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 Directive (DODD) 1010.1, DODD 1010.4, and DODD 1010.9. In response to these directives, the Army conducts a comprehensive program to prevent and control the abuse of alcohol and other drugs.

1–6. Army Center Substance Abuse Program mission and objectives
The Army Center for Substance Abuse Programs (ACSAP) mission is to strengthen the overall fitness and effectiveness of the Army's workforce, to conserve manpower, and to enhance the combat readiness of Soldiers. The following are the objectives of the ACSAP:

a. Increase individual fitness and overall unit readiness.

b. Provide services which are proactive and responsive to the needs of the Army's workforce and emphasize alcohol and other drug abuse deterrence, prevention, education, and rehabilitation.

c. Implement alcohol and other drug risk reduction and prevention strategies that respond to potential problems before they jeopardize readiness, productivity, and careers.

d. Restore to duty those substance-impaired Soldiers who have the potential for continued military Service.

e. Provide effective alcohol and other drug abuse prevention and education at all levels of command, and encourage commanders to provide alcohol and drug-free leisure activities.

f. Ensure all personnel assigned to ASAP staff are appropriately trained and experienced to accomplish their missions.

g. Achieve maximum productivity and reduce absenteeism and attrition among civilian corps members by reducing the effects of the abuse of alcohol and other drugs.

h. Improve readiness by extending services to the Soldiers, civilian corps members, and Family members.

1–7. Army Substance Abuse Program concept and principles
a. The ASAP is a command program that emphasizes readiness and personal responsibility. The ultimate decision regarding separation or retention of abusers is the responsibility of the Soldier's chain of command. The command role in substance abuse prevention, drug and alcohol testing, early ID of problems, rehabilitation, 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, ASAP. Deviations in clinical issues also require approval of the Commander, U.S. Army Medical Command (USAMEDCOM). In either case, approval must be obtained before establishing alternative plans for services (as required for isolated or remote areas or special organizational structures).

b. The two overarching tenets of the ASAP are Prevention and Treatment.

(1) The capabilities supporting Prevention are Education, Deterrence, Identification/Detection, Referral, and Risk Reduction.

(2) The capabilities supporting Treatment are Screening and the Rehabilitation programs.

(3) The Targeted Intervention capabilities of Army Drug and Alcohol Prevention Training (ADAPT) and Prime for Life span both Prevention and Treatment.

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

Table 1–1
Overarching tenets and supporting capabilities of ASAP

TENETS	CAPABILITY	DEFINITION
Prevention	Education and Training	Instruction for the Soldiers and other beneficiaries with increased knowledge, skills, and/or experience as the desired outcome.
Prevention	Deterrence	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/Detection	The process of identifying Soldiers and other beneficiaries as potential or actual substance abusers. This identification 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 ASAP services. Modes are self-referral and command referral.
Treatment	Screening	An in-depth individual biopsychosocial evaluation interview to determine if Soldiers and other beneficiaries need to be referred for treatment. This capability is a MEDCOM responsibility.
Prevention/Treatment	Targeted Intervention	An educational/motivational program which focuses on the adverse effects and consequences of alcohol and other drug abuse. The methods used by the Army are the Army Drug and Alcohol Prevention Training (ADAPT) program and "Prime for Life. All Soldiers and other beneficiaries screened for substance abuse issues will receive targeted intervention, whether they are enrolled in the program or not.
Treatment	Rehabilitation	Clinical intervention with the goal of returning Soldiers and other beneficiaries to full duty or identify Soldiers who are not able to be successfully rehabilitated. This capability is a MEDCOM 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.

c. The Army maintains the following principles:

(1) Abuse of alcohol or the use of illicit drugs by both military and civilian personnel is inconsistent with Army Values, the Warrior Ethos, 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 being alcohol and/or drug abusers to the ASAP. The unit commander should recommend enrollment based on the Soldier's potential for continued military service in terms of professional skills, behavior, and potential for advancement.

(3) The ASAP participation is mandatory for all Soldiers who are command referred and subsequently enrolled. Failure to attend a mandatory counseling session may constitute a violation of Article 86 of the Uniform Code of Military Justice (UCMJ).

(4) Soldiers who abuse alcohol and/or other drugs will be enrolled in the ASAP when such enrollment is clinically recommended. civilian corps members who abuse alcohol and/or other drugs may be enrolled in the ASAP when such enrollment is clinically recommended, space is available, and the employee agrees.

(5) Soldiers who fail to participate adequately in or to respond successfully to rehabilitation will be processed for administrative separation and not be provided another opportunity for rehabilitation except under the most extraordinary circumstances, as determined by the Clinical Director (CD) in consultation with the unit commander.

(6) Alcohol and other drug abuse will be addressed in a single program. Rehabilitation will generally be short term and conducted in a manner that supports the military environment.

(7) Separation initiation authorities, in accordance with AR 635–200 and AR 600–8–24 retain their authority to make personnel decisions except that initiation of administrative separation is mandatory for all Soldiers identified as illegal drug abusers, for all Soldiers involved in two serious incidents of alcohol-related misconduct within 12 months and for all Soldiers involved in illegal trafficking, distribution, possession, use, or sale of illegal drugs. Additionally, when a Soldier tests positive for illicit drugs a second time or is convicted of driving while intoxicated/driving under the influence a second time during his/her career, the separation authority shall administratively separate the Soldier unless the Soldier is recommended for retention by an administrative separation board or show cause board (if eligible), under the provision of AR 635–200, or is retained by the first general officer in the chain of command who has a judge advocate or legal advisor available or initiation authority for an officer show cause board under the provisions of AR 600–8–24. This authority may not be delegated and should have a prospective application, in that the regulatory provision should apply to situations in which at least 1 of a Soldier's DWI/DUI convictions or positive tests for illicit drugs occurred on or after 17 February 2009, the original effective date of the major revision to this regulation.

(8) Unit commanders retain their authority to make mission-related decisions, including field training or deployment, even though such actions may interfere with the rehabilitation plan. This includes the authority to mobilize U.S. Army Reserve (USAR) Soldiers, who have been previously ordered to AD under Title 10 United States Code (10 USC). Chapter 10 of this regulation provides further details regarding personnel actions during ASAP enrollment. The rehabilitation team, which includes the unit commander, will make decisions regarding the course of rehabilitation. If the unit commander disagrees with the decisions, the first Colonel in the Soldier's chain of command may intercede with the medical treatment facility (MTF) commander on the unit commander's behalf. In all circumstances, the MTF commander has final counseling decision authority, and the Soldier's chain of command has final administrative or command authority. If rehabilitation is indicated, the Soldier will be provided counseling until separation.

(9) Supervisors will inform all civilian corps members who display performance and/or conduct issues that the Employee Assistance Program (EAP) may help them address adult living problems that have the potential to affect performance and conduct. Supervisors will market the EAP as a benefit of employment for all eligible employees.

(10) When resources are available, ASAP rehabilitation services will be offered to eligible civilian corps members, military Family members, Family members of civilian employees, and retirees.

(11) 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 Testing Designated Position (TDP) employee discloses to the Employee Assistance Program Coordinator (EAPC) the current use of illegal drugs or significant alcohol use, and the employee has not given written permission to disclose the information, the EAPC must consult with the installation alcohol drug control officer (ADCO) and the servicing legal office without releasing identifying information of the TDP employee for guidance regarding whether or not disclosure of such information to the individual's supervisory chain would be in accordance with 42 USC 290dd-2 and 42 Code of Federal Regulation (CFR) Part 2, Subparts A–D, to determine if temporary abeyance of TDP duties would be appropriate.

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

(13) The military police (MP), U.S. Army Criminal Investigation Division Command (USACIDC) special agents, and other investigative personnel will not enroll in or otherwise infiltrate the ASAP rehabilitation program for the purpose of law enforcement activities or to solicit information from Soldiers enrolled in the ASAP.

1–8. Army Values and the Warrior Ethos

Alcohol and drug abuse by Soldiers and civilian corps members can seriously damage their physical and behavioral health, jeopardize their safety and the safety of those around them, and can lead to criminal and administrative disciplinary actions. Alcohol and drug abuse is detrimental to a unit's operational readiness and command climate and is inconsistent with Army Values and the Warrior Ethos. The Army strives to be free of all effects of alcohol and drug abuse.

1–9. Army Substance Abuse Program eligibility criteria

a. The ASAP services are authorized for personnel who are eligible to receive military medical services or are eligible for medical services under the Federal Civilian Employees Occupational Health Services Program. In addition to Soldiers, eligibility includes—

(1) United States (U.S.) citizen DOD civilian employees, to include both appropriated and nonappropriated fund employees.

(2) Foreign national employees where status of forces agreements or other treaty arrangements provide for medical services.

(3) Retired military personnel.

(4) Family members of eligible personnel when they are eligible for medical care under the provisions of AR 40–400, paragraphs 3–14 through 3–16.

(5) Members of the U.S. Navy, U.S. Marine Corps, U.S. Air Force, and U.S. Coast Guard when they are under the administrative jurisdiction of an Army commander who is subject to this regulation.

(6) Nonuniformed outside continental United States (OCONUS) personnel who are eligible to receive military medical services.

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

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 Interservice Support Agreement (refer to DODI 4000.19).

d. Members of the Army National Guard (ARNG) and USAR who are not on AD are eligible to use ASAP services on a space/resource available basis.

1–10. Manpower staffing

Manpower resources for the ASAP have been provided at all levels of command. Reprogramming of manpower resources allocated for ASAP functions is not authorized.

a. Garrison Army Substance Abuse Program staff resources. Garrison ASAP staffing consists of those positions listed in paragraphs 2–18 to 2–22 of this regulation (ADCO, Prevention Coordinator (PC), Employee Assistance Program Coordinator (EAPC), Drug Testing Coordinator (DTC), and Risk Reduction Program Coordinator (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. Rehabilitation resources. Rehabilitation staff consists of CD, Counselors, Clinical Consultants (CCs), Substance Abuse Professionals, and whatever additional positions are necessary to ensure compliance with DA policies and meet local needs for effective operation of the ASAP counseling program. Army Medical Department (AMEDD) or counseling personnel will not serve as ADCOs except within USAMEDCOM activities. The ADCOs will not serve as CDs, and the two positions will not be combined. The Clinical Code of Ethics precludes dual relationships.

1–11. Labor relations

Activities must meet the applicable statutory 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 (DCS, G-1), Headquarters, Department of Army (HQDA) (DAPE–CPZ–LR), 2461 Eisenhower Avenue, Alexandria, VA 22332–0300.

Chapter 2
Responsibilities

2–1. Deputy Chief of Staff, G–1

The Deputy Chief of Staff, G–1. The DCS, G–1 will—

a. Integrate, coordinate, and approve all 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 other drug abuse in the Army.

2–2. Director of Human Resources Policy

The Director of Human Resources Policy. The DHRP will—

a. Provide guidance and leadership on all alcohol and other drug policy issues.

b. Exercise staff leadership and supervision over the ASAP.

c. Ensure the Risk Reduction Program (RRP) interfaces with related functional areas within DHRP's responsibilities (for example, well-being, suicide prevention, sexual assault, health promotion, equal opportunity, and substance abuse) and coordinate RRP activities with other related DOD, DA, and civilian agencies (for example, safety and law enforcement offices.)

d. Oversee the Army's drug and alcohol testing program.

2–3. Director, Army Substance Abuse Program

The Director, Army Substance Abuse Program. The Director, ASAP will—

a. Direct the operations of the ACSAP.

b. Develop ASAP goals and policies.

c. Review, assess, and recommend policy changes as appropriate.

d. Interpret ASAP policy in response to inquiries from Army Commands (ACOMs), Army Service Component Commands (ASCCs), and Direct Reporting Units (DRUs), their subordinate commands, other uniformed Services, DOD, and other Federal agencies.

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

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

g. Maintain liaison between the Army and the other uniformed Services, other Federal agencies, and the private sector.

h. Provide operational guidance, monitoring, and oversight of the worldwide ASAP. Coordinate management, funding, and execution of the ASAP with the Installation Management Command (IMCOM), the National Guard Bureau (NGB), the USAR Command, and commanders of ASCCs in operational areas where the IMCOM does not supervise the ASAP.

i. Consolidate all alcohol and other drug statistics and provide periodic reports to the DHRP, the Army Staff, ACOMs, ASCCs, DRUs, DOD, the Department of Health and Human Services (DHHS), and ADCOs.

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

k. Publish an Army Substance Abuse Program Evaluation Plan (ASAP EP), which will be updated every 3 years, or as ASAP changes dictate.

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

m. Develop, establish, administer, and evaluate alcohol and other drug abuse prevention, education, and training programs.

n. Develop, establish, administer, and evaluate special alcohol and other drug abuse training and educational programs for garrison ASAP staff. Establish selection criteria and provide allocations for nominees to attend special training sponsored by DA.

o. Conduct program oversight and drug testing program (DTP) inspection visits to installations at least every 2 to 3 years to assess implementation of ASAP policies and procedures.

p. Maintain staffing inventory data for the ASAP worldwide.

q. Serve as DA's lead agency on all issues related to drug demand reduction programs and alcohol abuse prevention.

r. 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.

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

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

u. Provide services such as marketing, training, data processing, analysis, evaluation, guidebooks, operational guidance products and reports to DOD, DA, ACOMs, ASCCs, DRUs, and installations.

v. Administer the duties of the Contract Officer Representative (COR) to the ACSAP-contracted program.

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

x. Manage and distribute drug testing quota allocations as required.

y. Serve as the Director, U.S. Army Drug and Alcohol Technical Activity (USADATA) in accordance with AR 10–78

2–4. Deputy Chief of Staff, G–3/5/7

The 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 ACSAP and serve on a HQDA Risk Reduction Working Group.

2–5. The Surgeon General, Commander, U.S. Army Medical Command

The Surgeon General. The TSG will—

a. Develop policies, standards, and doctrine pertaining to all rehabilitation/counseling elements of the ASAP, which include medical ID, evaluation, rehabilitation/counseling, and follow-up services.

b. Program, manage, and provide adequate resources, funds, and professional services to administer the counseling elements of the ASAP at all levels.

c. Maintain residential alcohol and other drug abuse rehabilitation programs as an integral part of the health care delivery system.

d. Provide continuing education and training for assigned ASAP counseling staff.

e. Conduct credentials review and serve as approval authority for ASAP counseling staff.

f. Provide operational guidance, funding, and management the Forensic Toxicology Drug Testing Laboratory (FTDTL) that support the Army's Drug and Alcohol Testing Program.

g. Provide all necessary drug and alcohol statistical data to the Director, ASAP.

h. Exercise staff supervision over the ASAP medical and counseling elements through the specific geographic area regional medical commands (RMCs).

i. Coordinate ASAP rehabilitation and counseling policy with the Director, ASAP.

j. Evaluate rehabilitation and counseling functions and provide evaluation summaries to the Director, ASAP for integration into a total program assessment.

k. Provide medical review officer (MRO) services for military and civilian personnel drug testing.

l. Provide substance abuse professional (SAP) services for civilian Department of Transportation (DOT) alcohol and drug testing.

m. Design and furnish deployment-specific training packages for behavioral health and combat stress control medical units.

n. Ensure that all personnel who may be in a position to refer an individual for counseling have adequate training and skill to appropriately do so.

2–6. The Judge Advocate General

The Judge Advocate General. The 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.

2–7. Chief, National Guard Bureau

The Chief, National Guard Bureau. The CNGB will—

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

b. Recommend policies and operational tasks to DCS, G–1 regarding ARNG Soldiers and their families' participation in the ASAP. (See chap 15 of this regulation for specific ARNG guidance.)

c. Ensure ARNG units comply with this regulation.

d. Advise the DCS, G–1 regarding the impact of alcohol and other drug abuse and the ASAP on the ARNG.

e. Appoint a liaison to the ACSAP.

2–8. Commanders of Army Commands, Army Service Component Commands, and Direct Reporting Units

The 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 ACSAP on substance abuse issues.

b. Appoint a representative to coordinate the RRP, its policies and statistics with the ACSAP and serve on a HQDA Risk Reduction Working Group.

c. During prolonged deployments—

(1) Determine optimal number of base area codes (BACs) and their alignment.

(2) Provide detailed policy concerning random testing expectations and limitations.

d. 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 METT–TC and security, additional services should be provided.

2–9. Chief, Army Reserve

The Chief, Army Reserve. The CAR will—

a. Recommend policies and operational tasks to the DCS, G–1 regarding the participation of USAR Soldiers and their Families' in the ASAP. (See chapter 16 of this regulation for specific USAR guidance.)

b. Ensure USAR units comply with this regulation.

c. Advise the DCS, G–1 regarding the impact of alcohol and other drug abuse and the ASAP on the USAR.

d. Appoint a liaison to the ACSAP.

2–10. Commander, Installation Management Command

The Commander, Installation Management Command. The Commander, IMCOM will—

a. Provide guidance and leadership on all facets of the execution of the garrison Army Substance Abuse Program.

b. Resource and staff the Garrison ASAP and support installation programs to achieve the objectives of the program 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 ACSAP on substance abuse issues.

e. Establish and implement supporting and supplemental plans consistent with the objectives and procedures established by the ASAP EP.

f. Prepare IMCOM ASAP program objective memorandum (POM) and budget submissions, monitor execution of Management Decision Package (MDEPs) Management Decision Package Code for the ASAP funds (QAAP) and VCND allocated to IMCOM, and coordinate ASAP resource management with the Director, ASAP.

g. Monitor the installation Employee Assistance Programs and keep the Director, ASAP updated regarding all ASAP civilian services and related statistical data.

h. Collect and maintain necessary management information to assess program effectiveness.

i. Maintain liaison with applicable regional medical commands to promote and ensure adequate capacity for, and delivery of ASAP counseling services to installations.

j. Appoint a Risk Reduction Program Coordinator at the U.S. Army Family and Morale, Welfare, and Recreation (MWR) Command, who will serve on a HQDA Risk Reduction Working Group.

k. Ensure all installations with over 500 Active Army Soldiers appoint a representative to coordinate the RRP policies and statistics with the ACSAP.

l. Serve as an information resource to ACOMs, ASCCs, and DRUs on substance abuse issues for their units.

m. Ensure all other applicable provisions of AR 600–85 are met.

n. Serve as liaison between ADCOs and the Director, ASAP on matters pertaining to ASAP manpower, budget, and administration.

o. Ensure that installation programs are executing their responsibilities to provide substance abuse prevention, education, and training to prevent, deter and reduce alcohol and drug abuse and sustain and improve the skills and abilities of the installations' ASAP staffs in accordance with chapter 9 of this regulation.

p. Allocate and monitor utilization of all available urinalysis quotas within the IMCOM, as required.

2–11. Commander, U.S. Army Criminal Investigation Division Command

The Commander, U.S. Army Criminal Investigation Division Command. The USACIDC will—

a. Conduct and support operations, programs, and activities designed to deter, prevent, and suppress traffic in controlled substances in conjunction with appropriate state, Federal, host country, and international law enforcement agencies.

b. Provide periodic drug assessment reports to the Director, ASAP for both worldwide and specific regions or commands for use in determining resource requirements and developing drug deterrence, enforcement and prevention strategies. (Refer to AR 195–2 for specific responsibilities pertaining to the investigation of drug offenses and crime prevention surveys.)

c. Ensure subordinate commands coordinate with the local ADCO concerning urinalysis results and related trends before threat assessments are presented to IMCOM, installation commanders, or deployed commanders.

2–12. Commander, U.S. Army Corps of Engineers

The Commander, U.S. Army Corps of Engineers. The 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 AR 600–85 to fit the unique organizational structure of the Corps. Prior to publication, the USACE regulation will be submitted to the Director, ASAP for review and approval.

2–13. Director of Army Safety

The Director of Army Safety. The DASF will appoint a representative to coordinate Risk Reduction Program (RRP) policy and statistics with the Army Center for Substance Abuse Programs and serve on a HQDA Risk Reduction working group.

2–14. Commanders of Regional Medical Commands

The commanders of Regional Medical Commands. The commanders of RMCs —

a. Provide oversight for the ASAP counseling centers staffed by the Medical Department Activity (MEDDAC) and/or Medical Centers (MEDCENs) within the RMC's area of responsibility.

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

c. Ensure that a sufficient number of Professional Officer Filler System (PROFIS) providers eligible to serve as medical review officers in accordance with MEDCOM Reg 40–51 are trained and certified prior to deployment.

2–15. Commanders of medical department activities and medical centers

The commanders of medical department activities and medical centers. The commanders of MEDDACs/MEDCENs will—

a. Provide adequate and appropriate administrative support, medical services, counseling support, and consultation services necessary for quality counseling services in support of the ASAP counseling centers as a separate entity from other clinical services.

b. Ensure the ASAP counseling centers in their areas of responsibility comply with appropriate medical guidance for accreditation.

c. Exercise staff supervision and management of counseling staff assigned to the ASAP.

d. Appoint on orders a physician as CC to provide medical and counseling consultation and to ensure the quality of all counseling services in the area of addiction medicine.

e. Designate a full-time civilian Clinical Director, who will be rated by the CC, with formal, written input from the ADCO, and senior rated by the Deputy Commander for Clinical Services. The ADCO's input should address command satisfaction (with counseling center hours of operation, timeliness of services/appointments, professional setting/atmosphere, responsiveness to command requests, professional staff appearance), rehabilitation team meetings, and coordination with the garrison ASAP staff. The Clinical Director position will not be combined with the Chief of Family Advocacy Program, the Chief of Behavioral Health, or any other service.

f. Designate a qualified SAP to be responsible for duties identified in Department of Transportation/Federal Highway Administration (DOT/FHWA) guidance in 49 CFR, Parts 40 and 382, governing alcohol and other drug testing of civilians requiring commercial driver's licenses.

g. Ensure close coordination of the counseling and garrison ASAP staffs and that ASAP counseling staff provides support/technical assistance for prevention classes, as resources permit.

h. Appoint on orders sufficient MROs to ensure completion of medical reviews within 5 working days in accordance with paragraph 4–14. Ensure that appointed MROs are eligible in accordance with Medical Command (MEDCOM) Regulation 40–51 and that they have completed MEDCOM-sponsored MRO training within 6 months of appointment.

i. Ensure clinical staffs provide installation ADCOs with manpower performance information, monthly clinical budget information, rehabilitation enrollment and counseling completions and other required statistical data.

2–16. Commanders of Corps, Divisions, and Brigades

The commanders of Corps, Divisions, and Brigades. The commanders of Corps, Divisions, and Brigades will—

a. Ensure subordinate commanders execute the military DTP, in accordance with chapter 4 of this regulation, 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 the battalion prevention leader (BPL) and alternate UPL to perform the duties listed in paragraph 2–34 of this regulation.

c. Ensure that units are prepared to conduct drug testing while deployed as required in paragraph 4–7 of this regulation.

d. Consider participating in and directing subordinate commanders to participate in RRP command consultations provided by the installation RRPC or installation prevention plan (IPT) members.

e. Bring or designate a representative to bring Risk Reduction Program-related issues or requests to the attention of the installation or garrison commander.

f. Ensure that the Unit Risk Inventory (URI) is administered to all Soldiers at least 90 days before an operational deployment and the Reintegration Unit Risk Inventory (R–URI) is administered to all Soldiers between 90 and 180 days after returning from an operational deployment (see para 12–6 of this regulation).

g. Recommend subordinate commanders use the Unit Risk Inventory 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 2–19*a* of this regulation.

i. Ensure subordinate commanders refer Soldiers to the ASAP for screening within 5 days of notification that the Soldiers received positive urinalysis results for illicit drug use or were involved in alcohol-related misconduct.

j. During extended deployments—

(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.

2–17. Installation or Garrison Commanders

The installation or garrison commanders. The installation or garrison commanders will—

a. Establish a local Command ASAP and ensure that the full range of ASAP services are available to all eligible

personnel. The garrison and counseling elements of the ASAP should be operationally integrated and will be co-located to achieve maximum command/Soldier readiness.

b. Designate each of the following positions:

(1) An ADCO to function as the installation ASAP single point of contact (POC) for administrative functions of the Garrison ASAP and to work with the ASAP Clinical Director to provide effective and efficient integration of the Garrison and counseling components of the ASAP.

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

(3) An EAPC 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 (CONUS), Hawaii, Alaska, and Puerto Rico) to instruct and assist individuals in the alcohol testing process and to operate an evidentiary breath testing device in accordance with DOT guidelines.

(6) A Risk Reduction Program Coordinator, when required by paragraph 12–3a of this regulation, to facilitate risk reduction activities.

c. Establish an installation prevention team, human resource 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 installation prevention plan (IPP) to address the issues identified. Serve as chairperson of the IPT/Human Resources Council and ensure the following are represented: chaplain, preventive medicine, MEDDAC, community behavioral health, installation safety office, Risk Reduction Program Coordinator, Provost Marshal (PM), ADCO, CD, PC, social work services, and legal suicide prevention. The Garrison 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 ADCO through the Director, Human Resources.

e. Appoint an installation designated management official (DMO) on orders to manage the civilian DTP.

f. Notify the local MTF commander of any indications that ASAP counseling functions are not being provided in accordance with ARs.

g. Develop a mutual support plan among the installation ASAP, provost marshal (PM), and CID to include—

(1) 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.

(2) The PM provides the ADCO with extracts from DA Form 3997 (Military Police Desk Blotter) from the Military Police Reporting System (MPRS) within the Centralized Operations Police Suite (COPS) on all incidents involving alcohol, drugs, or other substance abuse on a daily basis.

h. Support positive and nonattributional 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 evidentiary alcohol breath tests on Soldiers and civilian corps members and make the capability available to the ASAP staff.

l. Publish a command policy memorandum that addresses alcohol and illicit drug use. In cases where the garrison commander is not the installation commander, the installation commander will publish the memorandum with the garrison commander's input.

m. Complete a memorandum of agreement (MOA) 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 MOA 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 other drug abuse.

2–18. Installation alcohol and drug control officers

The installation alcohol and drug control officers. The installation ADCOs will—

a. Provide direct supervision and management over all garrison ASAP staff and programs.

b. Prepare garrison ASAP budget submissions and monitor execution of the funding.

c. Develop, coordinate, and recommend local garrison ASAP policies and procedures for implementation.

d. Manage and monitor the drug and alcohol testing program (see chaps 3, 4 and 5 for information on specific requirements related to the military and civilian alcohol and drug testing.)

e. Serve as the coordinator of all substance abuse and risk reduction issues for the installation prevention team/human resource council or other similar appropriate forums.

f. Monitor and evaluate the commander referral rate and the evaluation completion rate, and provide quarterly reports to the installation and battalion commanders and the Director, ASAP.

g. Ensure there is a continuous and comprehensive ASAP staff training plan for all garrison staff to enhance professional skills.

h. Establish communications, a referral network, and administrative coordination between military units and civilian activities and the ASAP to facilitate the effectiveness of ASAP rehabilitation programs.

i. Assist commanders and supervisors in the ID and referral of individuals suspected of alcohol and/or other drug abuse.

j. Maintain garrison ASAP and EAP records and authenticate all garrison 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 ASAP counseling staff, 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, ASAP, a written report of the installation prevention program activities and accomplishments.

n. For military personnel only, restrict notification of positive drug test results with personally identifiable information (name, SSN) to—

(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.

o. Provide policy guidance and assistance to the servicing Civilian Personnel Advisory Center (CPAC) to identify all Drug–Free Federal Workplace (DFW) Testing Designated Position (TDPs) and those positions subject to DOT drug 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 civilian corps members in accordance with 49 CFR.

q. Adhere to guidance for the TDPs as provided in paragraphs 5–8 and 5–9 of this regulation. Refer to Department of the Army Pamphlet (DA Pam) 600–85, chapters 3 and 4 for additional instructions.

r. Maintain ASAP statistics as directed by Director, ASAP (see paras 4–16, 5–18, 5–35, 12–5, and chap 14).

s. Collect and maintain data on the status of civilian employees' and Family members' participation in the ASAP and provide reports as required.

t. Promptly furnish extracts from the daily MP Desk Blotter to the CD 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 of this regulation. 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 C.

w. Supervise the MRO review process and ensure the review timelines in paragraph 4–14 of this regulation are met.

x. Prepare and submit all required reports in DAMIS or other electronic form as specified in chapter 14 of this regulation.

y. Ensure that DA Form 3711 (The 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 urinalysis collections in accordance with DOT guidelines.

aa. Provide reports derived from the DAMIS concerning drug positive data by UIC and drug type to military police investigators and criminal investigators on a recurring basis.

2–19. Installation prevention coordinators

The installation prevention coordinators. The installation PCs will—

a. Promote ASAP 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 (for example, a minimum of 4 hours annually for military personnel and 2 hours for civilian employees in accordance with U.S. Army Training and Doctrine Command (TRADOC) Reg 350–70). The DOT-designated positions and other high-risk civilian positions should receive more intensive 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 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 ACSAP, IMCOM, and appropriate civilian agencies for ASAP garrison 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 the DA Form 3711 and track all substance abuse training on the installation by unit.

j. Conduct pre- and post-deployment substance abuse training.

k. Teach the alcohol drug abuse prevention training (ADAPT) course at least monthly and ensure that the course is at least 12 hours long in accordance with TRADOC Reg 350–70.

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.

2–20. Installation Employee Assistance Program coordinators

The installation Employee Assistance Program coordinators. The installation EAPCs will—

a. Assess, plan, and establish local procedures for providing comprehensive EAP services for eligible civilian corps members 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, short-term counseling and referral services for employees who self-refer or whom management refers. Short term counseling is providing short-term guidance, education, and mediation to civilian employees for resolution of adult living problems. If clinical counseling is indicated, the EAPC will make a referral to an ASAP privileged provider or to a referral source in the local civilian community.

c. Provide follow-up services to assist employees in achieving effective readjustment to the job.

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

e. Consult with the installation CPAC, SAP, and supervisors of civilian corps members throughout the installation within the limits required by 42 USC 290dd-2 and 42 CFR Part 2.

f. Maintain an updated list of available community counseling and rehabilitation resources that address the full spectrum of possible adult living problems.

g. Coordinate with the PC on prevention education and training for supervisors and civilian corps members at all levels on alcohol and other drugs, and appropriate information on common adult living problems encountered by civilian employees 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 will receive a minimum of 2 hours of prevention education per year in accordance with TRADOC Reg 350–70.

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 ACSAP EAPC Guidebook and all federal laws governing the confidentiality of records.

2–21. Drug testing coordinator

The drug test coordinator. The DTCs will—

a. Operate a forensically secure installation drug and alcohol testing program control point.

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

c. Augment the installation Inspector General inspection teams.

d. Ensure that urine collections from Soldiers are performed as required in accordance with chapter 4 and appendix E of this regulation.

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 ADCO on test procedures and results.

g. Manage drug testing supplies and expenditures.

h. Ensure the substance abuse programs and urinalysis collection procedures of all units are inspected annually and written reports of the inspection findings are provided to battalion commanders within 30 days. The DTCs will inspect battalion-level units and battalion or higher-level UPLs may inspect companies.

i. Be prepared to testify as an expert witness about the urinalysis collection process during courts martial.

j. Maintain drug testing records in accordance with AR 25–400–2 in separate filing cabinets.

k. Retrieve Soldiers' drug test results from the FTDTL Web portal, and notify the commanders who ordered the tests within 5 working days of when the results were posted. For any positive results, review the Soldiers' past

urinalysis records in DAMIS to determine if they have previous positive urinalysis results. Notify the Soldiers' company commanders of all positive urinalysis results in the Soldiers' records and provide a copy of the Commander's Top 10 Guide to the ASAP with the positive result to company commanders if they have not previously received one. The Commander's Top 10 Guide to the ASAP briefly outlines a commander's responsibilities for the unit substance abuse program.

l. Initiate medical review process for drug positive results requiring such in accordance with MEDCOM Reg 40–51 and paragraph 4–14 of this regulation.

m. Maintain the Installation/Command Drug Testing SOP and ensure that the ADCO reviews it annually and the appropriate SJA reviews it when changes are made.

n. Conduct background check on UPL candidates.

o. Provide the Installation CD with the results of all rehabilitation urinalysis tests.

p. Manage installation quotas if required.

q. Manage UPL access to DA and DOD Web-based applications, as needed.

2–22. Installation Risk Reduction Program coordinators

The installation Risk Reduction Program coordinators. The installation RRPCs will—

a. Coordinate and facilitate RRP data collection and analysis.

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 Human Resource Council/IPT or similar forum.

e. Ensure the risk factor data is entered into the RRP Web-based system by the 15th of the month following the completion of a quarter.

f. Assist commanders with identifying high-risk units, conducting URI and R–URI surveys, and identifying appropriate intervention services.

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.

2–23. Installation clinical directors

The installation clinical directors. The installation CDs will—

a. Administer and manage the rehabilitation function of the ASAP.

b. Provide monthly and quarterly reports, as required, counseling data (for example, referral and evaluation completion rates, number of enrollments by alcohol and drug, and number of successes/failures) to the installation ADCO, who will include the data in the ASAP information routinely forwarded to the installation commander.

c. Inform the ADCO of clinical and non-clinical issues affecting the ASAP program.

d. Ensure ASAP evaluations and command consultations are performed as required.

e. Ensure forms are completed and submitted to the Director, ASAP and entered in DAMIS in a timely manner.

f. Conduct in-service training, supervise the ASAP counselors and ensure the counselors maintain independent privileges to perform their assigned counseling responsibilities.

g. Appoint an ASAP clinician to serve as a member of the Family Advocacy Case Review Committee and the Fatality Review Board.

h. Assess the installation ASAP on an annual basis using the guide at appendix D of this regulation. Record all assessments and inspection findings on a MFR and maintain in accordance with AR 25–400–2.

i. Ensure that all counselors diagnosed with substance abuse dependency have at least 2 years of abstinence before having client contact.

j. Ensure credentials of all prospective counselors are forwarded for review to the ASAP CC at HQ, MEDCOM prior to the final job offer by CPAC/Civilian Personnel Operations Center (CPOC).

k. Ensure that ethical infractions are documented and that appropriate privileging committees and licensing boards are notified through the Quality Management Division at HQ, MEDCOM.

l. Notify unit commanders and the ADCO when units are not conducting rehabilitation testing as outlined in the rehabilitation team meetings.

2–24. Installation provost marshals

The installation provost marshals. The installation PMs will—

a. Screen all incident reports for possible alcohol or other drug abuse involvement, and provide the ADCO with extracts from DA Form 3997 from the MPRS module within the COPS on all incidents involving alcohol, drugs, or other substance abuse on a daily basis.

b. Support the ADCO on matters pertaining to the alcohol testing of DOT-designated positions.

c. Provide quarterly Risk Reduction Program data to the installation ADCO or RRPC.

d. Coordinate alcohol and other drug abuse countermeasures with the local elements of the USACIDC and with Federal, state, and local law enforcement agencies, as well as traffic, safety, and customs agencies, and the ADCO. When appropriate, include host country agencies to minimize the incidence of alcohol and other drugs as causative factors in traffic accidents and/or criminal acts.

2–25. Installation safety officers

The installation safety officers. The installation safety officers will—

a. Coordinate with the ADCO and provide data on the incidence of alcohol and/or other drug involvement in accidents or other safety mishaps.

b. Inspect Installation Drug Testing Collection Points (DTCPs) annually for the presence of necessary safety equipment and compliance with applicable safety regulations and local requirements.

c. Provide quarterly Risk Reduction Program data to the installation ADCO or RRPC.

2–26. Installation physical security officers

The installation physical security officers. The installation physical security officers will inspect Installation Drug and Alcohol Collection Points biennially to ensure they meet the requirements for storing urinalysis specimens and records in accordance with appendix E of this regulation.

2–27. Installation/state/U.S. Army Reserve Major Subordinate Command Staff Judge Advocates

The installation/state/U.S. Army Reserve Major Subordinate Command Staff Judge Advocates. The Installation/state/USAR MSC SJAs will—

a. Assist commanders, civilian supervisors, and CPAC in interpreting regulations, directives, and policies.

b. Upon request, review installation, state, and USAR MSC SOPs for legal sufficiency.

c. Provide education support about legal aspects of the DTP during UPL training.

d. Upon request, review installation, state, and USAR MSC positive drug test result files for legal sufficiency.

2–28. Installation Prevention Team members

The Installation Prevention Team members. The IPT member's 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.

2–29. Civilian Personnel Operations Center

The Civilian Personnel Operations Center. The CPOC will—

a. Code management-identified TDP and DOT employees in the Defense Civilian Personnel Data System (DCPDS) or the successor data system.

b. Once concurrence has been obtained by the serviced organization, ensure position descriptions and vacancy announcements contain appropriate language about random alcohol (for DOT testing designated positions) and drug testing conditions of employment for positions identified by supervisors and management officials.

c. Ensure that the completed DA Form 5019 (Condition of Employment for Certain Civilian Positions Identified as 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 DOT Federal Highway Administration Rules on Drug and Alcohol Testing) are filed in the employee's SF 66 (Official Personnel Folders (OPF)).

2–30. Civilian Personnel Advisory Center

The Civilian Personnel Advisory Center. The CPAC will—

a. 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.

b. Ensure that employees assigned to Testing Designated Positions complete the following:

(1) The DA Forms 5019.

(2) The DA Forms 7412.

c. Ensure the employee, supervisor, ADCO, and servicing CPOC receive copies of the completed forms.

d. Provide a roster, which identifies all personnel who occupy TDPs and personnel who require DOT-regulated drug and alcohol testing, to the installation ADCO and USARC DCS, G–1 at least once each quarter. 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.

e. Refer to DA Pam 600–85, chapters 3 and 4 for additional instructions for the CPAC.

2–31. Battalion/squadron commanders

The battalion/squadron commanders. The battalion/squadron commanders will—

a. Implement a battalion/squadron drug and alcohol testing program (see chap 4 of this regulation for guidance).

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

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 addressed in paragraph 9–6 of this regulation.

d. Ensure all newly assigned Soldiers are briefed on ASAP policies and services within 30 days of arrival.

e. Maintain liaison with ASAP garrison and counseling staffs.

f. Maintain ASAP elements while deployed, to the maximum extent possible. (See para 4–7 of this regulation for details.) Ensure that subordinate units are prepared to conduct drug testing while deployed in accordance with paragraph 4–7 of this regulation.

g. Foster a positive command climate that discourages alcohol and drug abuse and is supportive of those who need assistance from the ASAP for problems related to alcohol and other drug abuse. 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 1–7c(7) and chapter 10 of this regulation.

i. Ensure that the Unit Risk Inventory (URI) is administered to all Soldiers at least 30 days before an operational deployment and the Reintegration Unit Risk Inventory (R–URI) is administered to all Soldiers between 90 and 180 days after returning from an operational deployment (see para 12–6 of this regulation).

j. 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, except from rehabilitation tests, that do not require a medical review as directed by USAMEDCOM. Positive tests that require MRO review as directed by USAMEDCOM will not be reported until receipt of the MRO's findings.

k. Ensure company commanders refer any Soldier to the ASAP for evaluation within 5 duty days of notification that the Soldier received a positive urinalysis for illicit drug use or alcohol-related misconduct. Commanders of geographically-remote units should contact the CD of the nearest installation for guidance.

l. Assist the BPL in the development of a battalion/Squadron Substance Abuse Program SOP and review and sign it annually.

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

n. Bring or designate a representative to bring Risk Reduction Program-related issues or requests to the attention of the installation or garrison commander and RRPC.

o. Ensure that the Unit Risk Inventory (URI) is administered to all Soldiers at least 90 days before an operational deployment and the Reintegration Unit Risk Inventory (R–URI) is administered to all Soldiers between 90 and 180 days after returning from an operational deployment (see para 12–6 of this regulation).

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

2–32. Commanders of companies, detachments, and equivalent units

The 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 of this regulation for guidance).

b. Implement ASAP prevention and education initiatives addressed in chapter 9 of this regulation. Ensure that all Soldiers receive a minimum of 4 hours of alcohol and other drug abuse training per year in accordance with TRADOC Reg 350–70.

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 paragraph 9–6 of this regulation.

d. Document that all newly assigned Soldiers are briefed on ASAP policies and services within 30 days of arrival.

e. Maintain liaison with ASAP garrison and counseling staffs.

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

g. Foster a positive command climate that discourages alcohol and drug abuse and is supportive of those who need assistance from the ASAP for problems related to alcohol and other drug abuse. 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, 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, except from rehabilitation tests, that do not require a medical review as directed by USAMEDCOM. Positive tests that require MRO review as directed by USAMEDCOM will not be reported unless the MRO findings determine illegitimate use.

j. Initiate administrative separation in accordance with AR 635–200, AR 600–8–24, and paragraph 1–7c(7), and chapter 10 of this regulation.

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

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

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

n. Assist the UPL in the development of a Unit Substance Abuse Program SOP and sign it at least annually.

o. Ensure that the Unit Risk Inventory (URI) is administered to all Soldiers at least 30 days before an operational deployment and the Reintegration Unit Risk Inventory (R–URI) is administered to all Soldiers between 90 and 180 days after returning from an operational deployment (see para 12–6 of this regulation).

2–33. Supervisors of civilian corps members

The supervisors of civilian corps members. The supervisors will—

a. Consult with the CPAC 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 Testing Designated Positions 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 ADCO 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 that all employees receive the required 2 hours of substance abuse awareness training annually in accordance with TRADOC Reg 350–70. Ensure that employees in TDPs and those who are drug tested under DOT rules receive all additional required substance abuse training.

e. Attend substance abuse supervisor training.

f. Be familiar with the EAP program and how to refer employees.

g. Refer to DA Pam 600–85 for additional instructions and procedures for supervisors of civilian employees.

2–34. Battalion/squadron prevention leaders

The battalion/squadron prevention leaders. The BPL/SPLs will—

a. Meet the criteria in paragraph 9–6 to be a UPL.

b. Be appointed on orders by their battalion commander.

c. Be trained and certified using the ACSAP UPL Certification Training Program.

d. Supervise and provide technical guidance to UPLs.

e. Inspect and assist company UPLs in the performance of their duties in coordination with the Installation DTC or state JSAPC.

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. Maintain liaison with the servicing ASAP counseling center when in garrison and with the servicing behavioral health unit when deployed.

m. Develop command support for prevention activities by establishing an open, honest, and trusting relationship with the unit commander and subordinate leaders.

n. Advise and assist unit leaders on all matters pertaining to ASAP.

2–35. Company, detachment, and equivalent unit prevention leaders

The company, detachment, and equivalent unit prevention leaders. The UPLs will—

a. Meet the criteria in paragraph 9–6 to be a UPL.

b. Be appointed on orders by their company or equivalent commander.

c. Be trained and certified using the ACSAP UPL Certification Training Program.

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 ASAP counseling center when in garrison 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.

2–36. Officers and noncommissioned officers

The officers and noncommissioned officers. The officers and NCOs will—

a. Use the Army Values and Warrior Ethos 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.

2–37. All Soldiers

All Soldiers. All Soldiers will—

a. Be responsible for their personal decisions relating to alcohol and drug use and be fully accountable for substandard performance or illegal acts resulting from such use.

b. Encourage Soldiers suspected of having an existing or possible alcohol or drug abuse problem to seek assistance.

c. Be prepared to provide a copy of any prescription or medical treatment involving controlled substances received from any medical personnel outside the military medical system for at least 6 months after receiving such prescription or medical treatment.

Chapter 3
Alcohol

Section I
General

3–1. General

a. The consumption of alcohol is a personal decision made by individuals. Individuals who choose not to consume alcoholic beverages shall be supported in their decisions. Individuals who choose to consume alcoholic beverages must do so lawfully and responsibly. Responsible use is 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, or 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 will not be tolerated. Impairment of Soldiers is defined as having a blood alcohol content equal to or greater than .05 grams of alcohol per 100 milliliters of blood. For impairment of civilian corps members, see paragraph 3–10 of this regulation.

b. There will be no alcohol consumption during duty hours unless specifically authorized by the first GO or civilian

equivalent (member of the Senior Executive Service (SES)) in the supervisory chain or, if not reasonable available, the garrison 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, chapter 10. Any underage Soldier using alcoholic beverages will be referred to the ASAP for screening within 5 working days except when permitted by AR 215–1, paragraph 10–1f.

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 dependability 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 will promote personal responsibility and informed decision making and will ensure that subordinates are educated about alcohol abuse, signs and symptoms of abuse, intervention techniques, and alcohol's effects on the individual, Family members, and the Army's readiness. Leaders will integrate installation, unit and individual alcohol prevention strategies and publicize the fact that abuse of alcohol will not be tolerated.

f. Unit commanders that identify Soldiers who have abused alcohol must refer them within 5 working days for screening, education/training and/or rehabilitation as necessary.

g. Commanders may use unannounced unit inspections and fitness for duty testing for alcohol with non-evidentiary DOT-approved alcohol testing devices to—

(1) Promote military fitness, good order, and discipline.

(2) Promote safety.

(3) Increase awareness of the effects of alcohol consumption on duty performance, health and safety.

(4) Deter alcohol abuse.

(5) Assist in the early ID and referral to the ASAP of Soldiers at high risk.

h. Unit commanders/supervisors will confront suspected alcohol abusers, regardless of rank or grade, with the specifics of their behavior, inadequate performance or unacceptable conduct.

i. Self-referral does not absolve an individual from accountability for alcohol-related misconduct.

j. To remain in the Army, all Soldiers who are identified as alcohol abusers must successfully complete an ASAP education and/or rehabilitation program. Soldiers who fail to be rehabilitated will be processed for separation under the provisions of AR 635–200, chapter 9 and AR 600–8–24, chapter 4.

k. Rehabilitation failure requires initiation of separation proceedings.

3–3. Alcohol sanctions

a. Commanders will process Soldiers for separation who are involved in two serious incidents of alcohol-related misconduct in a 12 month period. Processed for separation is defined by AR 635–200, and means that the separation action will be initiated and processed through the chain of commands to the separation authority for appropriate actions. Additionally, any Soldier who is convicted of DWI/DUI two times during their career shall be administratively separated unless retained by the first GO in command who has a judge advocate or legal advisor available. This authority may not be delegated.

b. Military personnel will not be impaired on duty (as defined in para 3–2a of this regulation). 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 of this regulation.

c. Soldiers diagnosed as alcohol dependent will be detoxified and given appropriate medical treatment. Those Soldiers who warrant retention based on their potential for continued military Service will be offered rehabilitation and retained. Soldiers who are separated will be referred to a Veterans Administration (VA) hospital or a civilian program by the ASAP counselor to continue (or initiate) their rehabilitation.

3–4. Deglamorization

a. It is Army policy to maintain a workplace free from alcohol. Alcohol will not become the purpose for, or the focus of, any social activity. At all levels alcohol will not be glamorized nor made the center of attention at any military function (Refer AR 215–1, chap 10 for guidance concerning use, possession, sale and transportation of alcoholic beverages on military installations).

b. Personal responsibility must be emphasized at all events. Activities and events that encourage Soldiers to consume alcohol irresponsibly are strictly prohibited. All official events will have an adequate supply of non-alcoholic beverages available for those who abstain from drinking. Regardless of the event, all Soldiers and civilian corps members are responsible for their own decisions and actions.

Section II
Military Alcohol Testing

3–5. Authorized purposes for military alcohol testing

The decision to test and how to organize the testing event is made by the commander; however commanders must be cognizant that an unpredictable testing pattern will produce a more accurate indicator of alcohol impairment and abuse within a particular unit than one which is predictable. Commanders must also be aware that the Soldier must have known that they was scheduled to be on duty at the time of the test. It is recommended that commanders consider testing during/after first formation, after lunch, or for shift workers, immediately after reporting for duty. 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.

b. Search or Seizure/Probable Cause. This may include searches based on probable cause (PO) (in accordance with MRE 315) or those conducted pursuant to a recognized exception to the PO requirement.

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

d. Rehabilitation. Soldiers will submit to alcohol testing through blood or breath tests on a monthly basis as a part of the alcohol or other drug rehabilitation program. The rehabilitation team will determine if an increased frequency is required.

e. Mishap or Safety Inspection. In accordance with AR 385–40, 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. 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 MOs as are necessary for diagnostic or treatment purposes in accordance with MRE 312).

3–6. Non-evidentiary testing (screening) - military

a. Commanders may use non-evidentiary 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's DTC.

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 (ABMD) or through a legal blood alcohol test under chain of custody.

d. Soldiers that screen positive using the ABMD will be referred to the commander for a determination as to whether PO exists and further search is warranted. Under no circumstance will the Soldier that screened positive drive any personal or military vehicle until identified as not impaired or until the next day.

3–7. Evidentiary testing (confirmation) - military

a. 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 will necessarily 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 should print and maintain a copy of test data. This should include calibration, quality control, and the Soldier's specimen data.

b. Commanders should request evidentiary tests through the MP or their MTF based on established policies on the installation. Contact the alcohol and drug control officer for installation-specific information.

3–8. 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.

3–9. Alcohol incident referral - military

a. The commander will refer all potential alcohol abusers identified by self referral, alcohol testing, DUI/DWI, investigation, apprehension, underage drinking or other incident involving the use of alcohol to the ASAP using a DA Form 8003 (Army Substance Abuse Program (ASAP) Enrollment) for screening and potential enrollment within 5 working days of the incident or investigation.

b. All potential alcohol abusers identified by self referral, alcohol testing, DUI/DWI, investigation apprehension or other incident involving the use of alcohol will be required to attend the Army's educational ADAPT.

Section III
Civilian Alcohol Testing

3–10. Alcohol impaired civilian employees not subject to Department of Transportation regulations on alcohol testing

a. As far as the Army as an employer is concerned, a civilian employee's decision to consume alcohol is normally a personal matter. However, when the use or abuse of alcohol interferes with the employee's ability to perform his or her official duties, the employer does have legitimate concerns, including 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 the work and on-the-job problems, holding the employee accountable, referring the employee to the Employee Assistance Program (EAP), and taking any appropriate disciplinary action. There are many signs that may indicate a problem with alcohol that should trigger a referral to the EAP. When performance and conduct problems are coupled with any number of these signs, it is time to make a referral to the EAP for screening so that the employee can get help if it is needed.

(1) *Leave and attendance:* Unexplained or unauthorized absence from work; frequent tardiness; excessive use of sick leave; patterns of absence such as the day after payday or frequent Monday or Friday absences; frequent unplanned absences due to "emergencies." If an evidentiary alcohol test is not available, the supervisor will then privately counsel the employee and state that they believe the employee is somehow impaired and believes that the employee is incapable of performing their duties for the rest of the day.

(2) *Performance problem:* Missed deadlines; careless or sloppy work or incomplete assignments; production quotas not met; many excuses for incomplete assignments or missed deadlines; faulty analysis.

(3) *Relationships at work:* Relationships with co-workers may become strained; the employee may be belligerent, argumentative, or short-tempered, especially mornings or after weekends or holidays; the employee may become a loner.

(4) *Behavior at work:* The smell of alcohol; staggering or unsteady gait; bloodshot eyes; mood and behavior changes such as excessive laughter and inappropriate loud talk; excessive use of mouthwash or breath mints; avoidance of supervisory contact, especially after lunch; tremors; sleeping on duty. Employees who provide direct services to Soldiers, other civilian corps members, or the public should never smell of alcohol on duty.

c. The supervisor should immediately contact an employee relations specialist in servicing CPAC for advice and assistance when dealing with an employee who is apparently under the influence or intoxicated at work. He or she should also contact their servicing legal office. The following is a list of steps a supervisor should take in dealing with the employee. Not all these steps will be appropriate in all situations, but most will be applicable.

(1) If employee is performing, or required to perform, safety-sensitive duties such as driving vehicles, using heavy equipment, working around explosives or weaponry, or performing patient care activities, he or she must be restricted from performing these duties.

(2) If the employee is willing, they may be referred to the health unit for assessment. Health unit personnel may be

able to conduct a voluntary alcohol test, most likely with an evidentiary breath testing device (EBT), commonly referred to as a breathalyzer. Unless the employee is in a job with specific medical or physical requirements, a supervisor cannot order the employee to undergo any type of medical examination. Examples of the types of jobs that may have specific medical requirements include: police, firefighters, certain vehicle operators, air traffic controllers, and various direct patient-car personnel. In cases involving these categories of employees, the supervisor should immediately contact their servicing CPAC and legal office for guidance on how to proceed.

(3) The EAPC should be informed of the situation immediately and the supervisor should refer the employee to the EAP after the employee returns to duty.

(4) Due to potential safety and liability concerns, it is important to consult with the servicing CPAC and legal office. The supervisor should remove the employee from the immediate worksite. This may involve assisting the employee to their place of residence, a medical facility, or some other safe location. The employee should not be sent home alone or allowed to drive. It would be appropriate to contact a Family member or friend to take the employee home. Public transportation is also an option. An employee who is physically resisting should be dealt with by agency security or local police.

(5) Immediately and accurately document what has transpired. Record all the events that led to spending the employee home, especially if any disciplinary action is necessary. It is important to work with EAP and employee relations staff and keep them fully informed. The quality of the information they receive from the supervisor impacts the level of advice service they can provide.

3–11. Prohibited conduct (Department of Transportation rules/prohibitions) and consequences

a. The DOT rules at 49 CFR, Part 382 apply to all DA employees in transportation who drive commercial motor vehicles in commerce in any state and who are subject to the commercial driver's license requirements of 49 CFR Part 383 (commercial driver's license standards; requirements and penalties).

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

(1) 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 is considered not fit for duty and cannot return to duty until 24 hours after the confirmation test. (A return-to-duty test is not required.)

(b) If a driver's behavior or appearance suggests alcohol misuse and a breath test cannot be conducted, the driver must be removed immediately from performing safety-sensitive duties for at least 24 hours. (A return-to-duty test is not required.)

(3) Possesses alcohol, unless the alcohol is manifested and transported as part of a shipment.

(4) Used alcohol within 4 hours of performing safety-sensitive duties.

(5) Refuses to submit to an alcohol or drug test. (Pre-employment drug and alcohol tests will only be required for applicants to whom contingent offer of employment have been made.)

(6) Tested positive for a controlled substance, except when the use is prescribed by a physician who has advised the driver that their ability to safely operate a vehicle would not be adversely affected.

3–12. Categories of alcohol testing and required procedures for employees who are subject to Department of Transportation rules (49 CFR Part 382 Subpart C)

a. To deter drivers from misusing alcohol, the DOT requires employers to implement five categories of alcohol testing. (Civilian employees tested under DOT rules are not required to take a pre-employment alcohol test, but only a drug test.)

b. At the workplace/installation, effective implementation of DOT alcohol testing requires the involvement of the supervisor, the ADCO, the EAPC, the DTC, the DOT-qualified collector, the DOT-qualified screening test technician (STT), the DOT-qualified breath alcohol technician (BAT), the installation substance abuse professional (SAP) and the servicing CPAC. Installations must maintain the means to perform an evidentiary alcohol breath or saliva test.

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

(1) *Reasonable suspicion alcohol testing.* The supervisor who has been trained according to DOT rules will initiate testing when there is reasonable suspicion that a driver has violated a DOT prohibition (for example, misused alcohol); 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. A trained supervisor is one who has received at least 60 minutes of training on alcohol misuse which covers the physical, behavioral, speech, and performance indicators of probable alcohol misuse. The 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. Supervisors will document their determination and consult with the next higher level supervisor and the servicing CPAC before directing the test. The supervisor will notify the ADCO 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 to conduct the test is made, the supervisor will document the reasons for the delay. If the test is not administered within 8 hours following 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 performing 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

(b) 24 hours have elapsed following the determination that there is reasonable suspicion to believe that the driver has violated the conduct prohibitions concerning the use of alcohol. With the exception above, no supervisor shall take any action against a driver based solely on the driver's behavior and appearance with respect to alcohol use in the absence of an appropriate test.

(2) *Accident or unsafe practice post-accident testing.* Accident tests should be conducted as soon as practicable following a qualifying accident involving a commercial motor vehicle. "Qualifying accidents" are any accidents in which: loss of human life; bodily injury to any person who, as result of the injury, immediately received medical treatment away from the scene of the accident; one or more motor vehicles incurs 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; or a driver who receives a citation within 8 hours of the accident under state or local law for a moving traffic violation arising from the accident.

(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 shall cease attempts to administer an alcohol test and shall prepare and maintain the same recorded. The employee is prohibited from using alcohol within 8 hours of an accident.

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

(c) Nothing in this section shall be construed to require the delay of necessary medical attention for injured people, or for the driver from leaving the scene of an accident for the period necessary to obtain assistance or medical treatment.

(d) The supervisor shall provide drivers with necessary "post-accident" information, procedures, and instructions prior to driver operating a commercial motor vehicle, so those drivers can comply with these requirements.

(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 tests conform to applicable requirements and that the results are obtained by the employer.

(f) Used alcohol within 8 hours after an accident or until tested

(3) *Return-to-duty alcohol testing.* Before the driver can resume performing safety-sensitive duties after having engaged in conduct prohibited by the applicable law and regulation, the driver must undergo a return-to-duty alcohol test and show an alcohol concentration less than 0.02 percent. This test cannot occur until after the substance abuse professional has determined that the employee has successfully complied with prescribed education and/or treatment.

(4) *Follow-up testing.* After enrolling in a substance abuse rehabilitation program or successfully completing a substance abuse rehabilitation program and returning to duty, a driver is subject to unannounced follow-up testing for at least 12 but not more than 60 months. The SAP determines the number and frequency of the follow-up testing (a minimum of 6 in a 12 month period after the employee's return to safety-sensitive duties), and the employer/supervisor selects the dates for follow-up testing.

(a) Follow-up testing is separate from and in addition to the regular 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 shall use a scientifically valid system for randomly selecting employees to be tested. Random testing will be imposed without 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.

(a) Frequency of random testing. DOT regulated personnel will randomly tested for alcohol at a minimum rate of 10 percent of the number of DOT regulated positions in the organization. Each year, the FMCSA 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 distributed evenly throughout the year. A driver selected for testing may undergo both alcohol and illicit drug and alcohol testing; however, alcohol testing may only be conducted on civilian employees who are performing safety sensitive functions, or immediately before or after ceasing to perform such functions. Employees will report to the testing facility within 2 hours of having been notified.

(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 of this regulation.

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 first line supervisor, and date supervisor was trained regarding the DOT Testing Program.

3. Management will manage the issuance of the 30-day individual notices to incumbents of DOT safety sensitive positions and the requirement for a DA Form 7412.

(c) Notification.

1. The DMO (or other individual as 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 that 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. A driver will only be tested for alcohol while the driver is performing safety-sensitive functions, just before or just after ceasing to perform such functions.

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 the normal day shift of 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 that all employees subject to random testing believe that they may be required to provide a breath specimen any day they report to work.

3–13. Alcohol specimen collections for employees tested Under Department of Transportation rules

a. The installation/garrison 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/garrison 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 who are tested under DOT alcohol testing rules will be trained to proficiency in the operation of the breath testing devices, and will be able to provide documentation that 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 only the U.S. Department of Transportation (DOT) Alcohol Testing Form (ATF). The ATF must be three-part carbonless manifold form, and may be viewed at http://ww.dot.gov. The DOT ATF may not be modified or revised, except as permitted in 49CFR Part 40.225.

d. The BAT/STT will notify the employee's supervisor immediately of all breath 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 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 to 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 U.S. Department of Transportation (DOT) Breath Alcohol Testing Form to the driver's supervisor and the ADCO.

(1) Drivers whose confirmation test is at least 0.02 percent but less than 0.04 percent must be removed for a minimum of 24 hours.

(2) Drivers whose confirmation test are 0.04 percent or greater cannot perform safety-sensitive functions until the driver is evaluated by an installation SAP.

(3) When the test results require an SAP evaluation, the EAPC will coordinate the evaluation with the driver, the supervisor, and the installation SAP.

(4) Records will be disclosed and maintained according to 49 CFR Part 40 Subpart P Sections 40.321–40.333.

3–14. Installation substance abuse professional evaluation of employees tested under Department of Transportation rules

a. The installation SAP evaluation provides a comprehensive face-to-face assessment and evaluation to determine if the employee/driver needs assistance resolving problems associated with alcohol use or prohibited drug use. If the employee is determined to need assistance as a result of this evaluation, the installation 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 a licensed physician, or a licensed or certified psychologist, licensed or certified social worker, or licensed and certified addiction counselor with experience in the diagnosis and treatment of alcohol and controlled substance-related disorders and certified in accordance with DOT Substance Abuse Professional Guidelines.

(1) Evaluation, referral, and follow-up evaluation and testing are the basic SAP responsibilities. The specific duties and responsibilities of the SAP are in DOT SAP Procedures Guidelines for Transportation Workplace Drug and Alcohol Testing Programs.

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

(3) When a SAP evaluation is required, the installation EAPC will coordinate the evaluation with the driver, the supervisor, and the SAP. Additionally, the EAPC 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 EAPC may inform the supervisors of the ongoing status of the driver's rehabilitation or treatment.

Chapter 4
Military Personnel 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 urinalysis program requiring the honest 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 that specimen of the specimen, substitute any substance for their own urine, chemically alter, adulterate, or modify their own urine, or assist another Soldier in doing any of these actions. Penalties for violations of these prohibitions include the full range of statutory and regulatory sanctions, both criminal (UCMJ) and administrative.

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

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

(2) Facilitate early detection of drug abuse.

(3) Enable commanders to assess the security, military fitness, good order and discipline of their units, and to use information obtained to take appropriate disciplinary or other administrative actions, including referral to the ASAP counseling center for evaluation and possible rehabilitation.

(4) Monitor rehabilitation of those enrolled in alcohol and/or other drug abuse rehabilitation.

(5) Collect data on the prevalence of drug abuse within the Army.

4–2. Policy

a. Unpredictability is a determining factor deterring Soldiers from using drugs. "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 Drug Testing Program is a battalion commander's program normally executed at the company level. For purposes of this regulation, "battalion" refers to units organized in a traditional battalion structure or battalion equivalent organizations. The battalion-level commander must approve the company commander's program, ensuring that it meets the elements delineated in paragraph 4–3, below. Specifically, the battalion-level commander should

ensure that the program is conducted in a truly random manner to avoid predictability by the tested population. This approval may not delegated.

c. Company commanders will develop a completely random drug testing program with guidance from and approval by the battalion-level commander. For companies that are not assigned or attached to a battalion, the company commander will perform the duties of the battalion commander described in this chapter, if the brigade or higher commander the company is assigned to does not choose to withhold these duties from him/herself.

d. When mission and organizational structure allows, the random drug testing program should be managed at the battalion level, with the battalion level commander or their designated representative randomly selecting and testing 4–5 percent of the battalion strength weekly, detailing different companies to conduct the collection each week. Using this method, Soldiers are deterred from using drugs because they know that they have the possibility of being selected any day of any week.

e. In addition to random testing, battalion commanders should conduct periodic unit sweeps. The most effective programs use IU testing in addition to and supplementary to a good random drug testing program. IU testing will not be used as a means of testing a Soldier the commander suspects of abusing drugs but does not have sufficient probable cause to conduct a PO collection. The battalion commander should ensure that the number of specimens collected under the IU test basis is no more than 75 percent of the number of IR specimens submitted for testing annually.

f. 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.)

g. The most important elements of the Army's drug testing program are that it is conducted completely randomly and that it is executed consistently. The test bases 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 status in the program or previous drug testing history, the program must be applied to all Soldiers consistently.

h. Even though a Soldier has tested positive on previous drug tests or is pending separation for drug test failures, these are not valid reasons to exempt any Soldier from continued testing.

i. Commanders should not stop random testing or probable cause testing on any Soldier. Soldiers should only be exempted from drug testing when they are truly not available to provide a specimen (leave, TDY, and so forth.); however, the tenets of paragraph 4–11*c* must be implemented in these cases. Installation ASAP staffs do not have the authority to direct or recommend that commanders discontinue testing Soldiers who continue to test positive on drug tests, regardless of the test basis. Neither Commanders nor ASAP staffs will discontinue unit sweeps, random tests, command-directed tests, or rehabilitation tests just because Soldiers continue to test positive under these test bases.

j. All military urine specimen collections will be conducted in accordance with procedures set forth in appendix E of this regulation.

k. Field testing of urine specimens is unauthorized; all urine specimens will be forwarded to the supporting forensic toxicological drug testing laboratory (FTDTL) for testing.

l. Soldiers who test positive for illicit drugs for the first time will be evaluated for dependency, disciplined as appropriate, and processed for separation within 30 calendar days of the company commander receiving notification of the positive result from the ASAP (the procedures in 10–9*a*(1) of this regulation may also apply.) If the positive drug report is for a MRO-reviewable drug, all adverse administrative and legal actions will be suspended pending MRO determination that the use was not for legitimate medical purposes. All separation actions will be forwarded to the separation authority, who will make the final determination on separating the Soldier in accordance with AR 635–200. Retention should be reserved for Soldiers that show clear potential for both excellent future service to the Army and for remaining free from substance abuse. Soldiers diagnosed as drug dependent will be offered rehabilitation prior to separation.

m. If a Soldier tests positive for illicit drugs, is subsequently retained by the separation authority, then tests positive again, the Soldier chain of command will initiate administrative separation and forward the case to the first general officer in the of command for decision as to the disposition of the action. This disposition decision authority may not be delegated.

n. Article 112a, Uniform Code of Military Justice; specifically prohibits the unlawful use of the following substances: opium, heroin, cocaine, amphetamine, lysergic acid diethylamide (LSD), methamphetamine, phencyclidine, barbituric acid, marijuana, and any compound or derivative of any such substance.

o. Article 112a, UCMJ, 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).

p. In addition, this regulation prohibits Soldiers from using Hemp or products containing Hemp oil. It also prohibits using the following substances for the purpose of inducing excitement, intoxication, or stupefaction of the central nervous system. This provision is not intended to prohibit the otherwise lawful use of alcoholic beverages.

(1) Controlled substance analogues (designer drugs).

(2) Chemicals, propellants, or inhalants (huffing).

(3) Dietary supplements that are banned by the United States Food and Drug Administration.

(4) Prescription or over-the-counter drugs and medications (when used in a manner contrary to their intended medical purpose or in excess of the prescribed dosage).

(5) Naturally occurring substances (to include but not limited to Salvia Divinorum, Jimson Weed, and so forth).

q. Violations of paragraph 4–2*p* may subject offenders to punishment under the UCMJ and/or administrative action. Paragraph 4–2*p* is not intended to prohibit the otherwise lawful use of alcoholic beverages or tobacco products. If a commander has any question regarding whether a substance or its use is prohibited by this provision, they should contact the servicing judge advocate before initiating any adverse action.

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

s. Neither a UPL nor an observer shall be involved with processing their own urinalysis specimen.

t. Commanders jeopardize the integrity and effectiveness of their urinalysis programs when they do not employ effective direct observation of urine collection. In all cases, observers will be briefed on and provided a demonstration of their duties before they perform them. Observers will also sign a Urinalysis 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

u. The use of Peyote Cactus as a religious sacrament in connection with the bona fide practice of a traditional religion by Soldiers who are members of Native American tribes recognized by the Federal Government shall be accommodated (see AR 600–20, para 5–6 for procedures). Reasonable limitations on use, possession, transportation, and distribution of peyote shall be imposed in accordance with the American Indian Religious Freedom Act Amendments of 1994 to promote readiness, safety, to comply with international law, and the ensure unit morale and discipline.

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

w. When a Soldier is selected for a random urinalysis, but is not present for duty, their commander will collect a urinalysis specimen from the Soldier upon their return or during the next random urinalysis test after the Soldier's return. Commanders should promulgate their own unit policy to prescribe procedures to implement this requirement and that in paragraph 4–2*u*, below, and should ensure that this policy is reviewed by their legal advisor.

x. If a Soldier's urinalysis specimen is not tested and is destroyed because the specimen of accompanying forms 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 drug testing program, varying frequency (how many times per month/week) and periodicity (day(s) of the week, time of day, week(s) of the month) of random testing.

b. Submit at least 95 percent of its urinalysis specimens to the FTDTL using the DOD DTP.

c. Smart Testing Techniques—

(1) Soldiers who abuse drugs will do almost anything to avoid being caught. A Soldier who knows when the urinalysis will be conducted may attempt to substitute another fluid for his specimen or contaminate his 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 urinalysis specimen are to—

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

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

(c) Ensure the observers perform their duties correctly.

(2) Soldiers will have no more than two 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 the Soldier to leave before providing his specimen. If the commander allows the Soldier to leave the holding area, he/she should provide an NCO or officer escort for the tested Soldier while he/she is away from the holding area.

(3) Some examples of Smart Testing techniques include—

(a) Maintain a completely random testing program.

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

(c) Weekend/Holiday testing.

(d) During field exercises.

(e) At the end of the duty day.

(f) During afternoon PT.

(4) Some examples of poor urinalysis collection techniques include—

(a) Conduct routine monthly testing.

(b) Always testing on Mondays.

(c) Asking for volunteers.

(d) Listing the test on the training schedule.

(e) Announcing the next day's test at the end of the duty day or by e-mail.

(f) Calling Soldiers in for an alert but telling them it's for a urinalysis.

(g) Calling attention to future drug testing by conspicuously handling urinalysis supplies or preparing required forms.

(h) Stopping collections before every Soldier selected has provided a specimen.

(i) Printing out testing documents and labels on shared printers.

d. Have at least 2 UPLs on appointment orders signed by the commander and certified in accordance with the ACSAP UPL Certification Training Program.

e. Have passed a unit-level inspection, using the ACSAP checklist or similar standard, by a higher unit or the ASAP staff each fiscal year.

f. Have a unit-level substance abuse program standing operating procedures (SOP) signed by the commander.

g. Collect random urinalysis specimens from 4 percent of the unit each week when not deployed.

h. Have command team presence during most urinalysis collections.

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

j. Conduct testing in a manner that is unpredictable to the Soldiers in the unit.

k. Emphasize to observers the crucial importance of performing their duties exactly as specified in paragraph 4–9.

l. Test every Soldier selected. Do not excuse a Soldier before they provide a complete and acceptable urine specimen.

m. Take every step to prevent Soldiers from learning that a urinalysis 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 urinalysis specimens for the drugs listed in DODI 1010.16 or the most recent DOD Policy Memorandum, whichever is more current. If a commander wishes to test for a drug not specified by the DOD, they will coordinate with the ASAP staff, and request this test in a memorandum to the commander of the supporting FTDTL. If the lab is unable to test for this drug, the specimen and request will be sent to the Armed Forces Institute of Pathology for testing after coordinating with ACSAP and Army Forces Institute of Pathology (AFIP).

4–5. Purposes for conducting drug testing

In accordance with DODD 1010.1, there are nine purposes for ordering urinalysis testing of Soldiers. Commanders should consult with their legal advisor, ADCO, or DTC when unsure of which test basis code to use for testing. The test bases (with DTP test codes in parentheses) are—

a. Inspection. An inspection is an examination of a unit, or part there of, conducted as a function of command, the primary purpose of which is to ensure the security, military fitness, 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 (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 this type of inspection is conducted.

(2) *Inspection Other (IO).* This is a valid inspection under circumstances specified by a commander's policy memorandum. Some examples include testing Soldiers who were selected but unavailable for testing during a recent random inspection 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 of this regulation because the Soldier has not been previously selected under random IR testing, the commander will use the IO test code.

(3) *Inspection Unit (Unit Sweep) (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 shall 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 PO.

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

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

d. Rehabilitation (RO). Production of a specimen is required as a part of the alcohol or other drug rehabilitation program. The rehabilitation team will determine the frequency, which will then be included in the rehabilitation plan.

e. Mishap or Safety Inspection (AO). In accordance with AR 385–40, 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. Consent (VO). A command representative, who suspects a Soldier of having unlawfully used drugs, may request that the Soldier consent to urinalysis after advising the Soldier that he or she may decline to provide the specimen. Where practical, the command representative should obtain the consent in writing, but this is not required. Article 31(b) UCMJ 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 (MO). A specimen may be required during any examination for a valid medical purpose (for example, emergency treatment, periodic physical examinations, and other MOs as are necessary for diagnostic or treatment purposes in accordance with MRE 312).

h. New Entrant (NO). Testing of personnel as part of an application for entry to the Army in accordance with DODD 1010.1.

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

4–6. Drug testing in the Reserve Components

a. Army National Guardsmen and Army Reservists on AD for 30 days or longer are subject to every provision of this regulation. Army National Guardsmen and Army Reservists 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 to inactive duty shall not preclude reservists on extended AD from receiving appropriate rehabilitation while on AD. The date of release to inactive duty may be extended to complete appropriate rehabilitation, if necessary. Any aftercare would then be completed while the Soldier was on inactive duty and would be monitored by the USAR or Army National Guard chain of command.

c. Army Reservists and Army National Guardsmen on inactive duty for training (IADT) may be referred for ADAPT, but the training should be in a non-pay, additional IADT status. If an Army Reservist or Army National Guardsman on IADT is diagnosed as an alcohol abuser and rehabilitation at a military facility is not available, the command should counsel the Soldier to seek appropriate rehabilitation through available civilian resources.

d. An Army Reservist or Army National Guardsman, who is alleged to have committed a drug-related offense while on AD or IADT may be subject to nonjudicial punishment or courts-martial jurisdiction following the offense if their duty status changes. However, the existence of such jurisdiction will depend on the facts of each individual case.

e. An Army Reservist or Army National Guardsman 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. Inactive duty Soldiers may be processed for an Other Than Honorable discharge for drug abuse established through urinalysis conducted during IADT.

4–7. Deployed drug testing

a. Commanders will maintain their substance abuse programs to the maximum extent practical while deployed. Soldiers under the influence of drugs are a danger to themselves, their fellow Soldiers, mission accomplishment, and the civilian populace. A leader's responsibility to deter drug use and identify drug abusers does not stop during deployments. On the contrary, given the nature of operations and the 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. When necessary in these areas, battalion commanders may delegate management and execution of the DTP to company commanders.

d. All company and larger units will mobilize and deploy with at least two trained UPLs and enough drug testing supplies to test 100 percent of their assigned strength. Units smaller than company strength will receive drug testing support from the next higher unit in the chain of command.

e. The BACs are assigned for selected deployment areas. The senior commander for each deployed unit that is assigned a BAC will appoint a BACM to manage the ASAP for the command and maintain liaison with higher commands and ACSAP. The BACM will—

(1) Retrieve urinalysis 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.

(3) Ensure that subordinate units have sufficient drug testing supplies to conduct testing.

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

(5) Provide reports, as requested.

(6) Monitor UPL certification.

(7) Maintain ASAP files in accordance with AR 25–400–2, Army Records Information Management System.

f. The MTF commanders in deployed areas that have been assigned a BAC will—

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

(2) Coordinate with USAMEDCOM 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.

g. All mobilized Army National Guard and USAR units company size and larger will arrive at their mobilization stations with at least two trained UPLs and enough drug testing supplies to test 100 percent of their assigned strength. From the day of mobilization to the day of deployment, mobilized units will use the BAC of their mobilization station. After deploying, these units will use the BAC of the command to which they are attached. Mobilization stations will train UPLs as necessary before deployment.

h. Installation ASAPs will provide drug testing supplies as necessary, so units deploy with enough to test 100 percent of their assigned strength. Deployed units will order supplies through the normal supply system.

i. The BACMs of deployed units will forward test results for redeployed units to the respective home or mobilization station ADCOs. Mobilization station ADCOs will forward the test results for demobilized units to the respective state Joint Substance Abuse Program Coordinator (JSAPC) or MSC ADCOs.

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 have been developed which allow—

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

(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 U.S. Army CCF.

(5) Increased frequency of random drug testing. Commanders will test Soldiers identified in this paragraph a minimum of once in each fiscal year. If a Soldier is not selected for testing within the first 10 months of the period, the commander will direct the Soldier to provide a specimen and will use the IO test code at any point during the last 2 months of the fiscal year.

b. Alcohol and drug abuse by Soldiers with access to Top Secret or Sensitive Compartmented Information (SCI) 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 SCI access are required to submit a urinalysis specimen a minimum of once in each fiscal year. Participation in the ASAP rehabilitation 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 U.S. Army CCF.)

c. The Chemical Surety Program and Nuclear Surety Program 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 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 Chemical Surety Personnel Reliability Program and the Nuclear Surety Program. (Refer to AR 50–5 and AR 50–6 for details.)

d. The ASAP CD must ensure that potentially disqualifying information related to the Soldier's participation in ASAP counseling center evaluation and the Soldier's subsequent enrollment in rehabilitation will be made available

promptly to the PRP certifying official for consideration. ASAP counseling personnel should be familiar with their PRP responsibilities identified in AR 50–5 and AR 50–6.

e. Before PRP certification, all Soldiers must submit to a urinalysis 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 urinalysis 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. 40–501 provides medical fitness standards. 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 dependence or alcohol abuse, in accordance with DSM–IV–TR (303.90 and 305.00) are "medically disqualified" from aviation duties in accordance with AR 40–501. Further, a medical waiver must be obtained for all Active 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, HRC (AHRC–PLP–A) 200 Stovall Street, Alexandria, Virginia 22332–0406. The process to follow 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) Enrolled and successfully progressing in the Army Substance Abuse Program (according to ASAP Counselor, Commander and Flight Surgeon) with an active sobriety program (weekly group therapy, and so forth).

(3) Written assessment and recommendation from the ASAP Counselor/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, United States Army Aero-Medical Activity (USAAMA) (MCXY–AER), Fort Rucker, Alabama 36362–5000, for medical review and recommendation.

(4) Recommendation for waiver of disqualification(s) from the Director, USAAMA accompanied by all relevant documentation to Commander, HRC (AHRC–PLP–A), 200 Stovall Street, Alexandria, Virginia 22332–0456.

(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. NOTE: ALL WAIVERS MUST BE REVIEWED FOR RENEWAL EACH YEAR.

i. Aviation personnel that are involved in alcohol related incidents or are otherwise identified and determined by ASAP counselors to be "Non-dependent abusers of alcohol" may be "temporarily suspended from aviation duties" for a period of evaluation and review to ensure that the aviation person poses no unusual threat to aviation safety. When the ASAP Counselor, local commander and Flight Surgeon agree that the aviation person is ready to return to flying, the temporary suspension may be lifted, and the aviator may return to flying.

j. Aviation personnel who use illicit drugs, whether or not determined by aviation medical authorities to be medically fit, are subject to disqualification from flying duties in addition 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. Alcohol and other drug abuse by Soldiers performing some duties can have a direct, immediate, and life-threatening impact on the health, safety and security of other Soldiers and civilians. Therefore, Soldiers performing the duties in the MOSs listed below are required to submit a urinalysis specimen a minimum of once in each fiscal year unless they are detailed to duties outside their MOS or are assigned as instructors or to battalion or higher staffs for the entire fiscal year.

(1) 21M Firefighter.

(2) 31B MP.

(3) 31D CID Special Agent.

(4) 31E Corrections Specialist.

(5) 68D Operating Room Specialist.

(6) 68E Dental Specialist.

(7) 68K Medical Laboratory Specialist.

(8) 68P Radiology Specialist.

(9) 68Q Pharmacy Specialist.

(10) 68W Healthcare Specialist.

(11) 68X Mental Health Specialist.

(12) 92R Parachute Rigger.

(13) All officers in the medical corps, dental corps, medical specialist corps, nurse corps, or medical Service corps officers with a primary Area of Concentration of 67E, 67F, 67G, 71E, 62C, 73A, or 73B.

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

4–9. Drug testing coordinator, battalion prevention leader/unit prevention leader, and observer qualifications, training and certification

a. Since DTCs, BPL/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, BPL/UPLs, and observers must meet the same standards as Active Army personnel.

b. Specific requirements for DTC and BPL/UPL qualifications, training, and certification are explained in chapter 9 of this regulation.

c. Observers must—

(1) Be an officer, warrant officer, or NCO (E–5 or above), or civilian corps member (general schedule (GS–5) or National Security Personnel System (NSPS) Pay Band equivalent). (Commanders are recommended to select unit leaders in the rank of Sergeant First Class or above.)

(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 be currently enrolled within the ASAP Rehabilitation Program.

(5) Not be under investigation for legal, administrative, or substance abuse related 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 Urinalysis Observation Briefing Memorandum that outlines their duties and the penalties for not properly performing them. (See app E, fig E–4 of this regulation 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 leave the Soldier's body and enter the specimen bottle.

(3) Ensure that 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. Soldiers who abuse drugs will do almost anything to avoid being caught. A Soldier who knows when the urinalysis will be conducted may attempt to substitute another fluid for his specimen or contaminate his 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 urinalysis 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 no more than 2 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 the Soldier to leave before providing his specimen. If the commander allows the Soldier to leave the holding area, they 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 (PT).

c. Some examples of poor urinalysis 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 e-mail.

(5) Calling Soldiers in for an alert but telling them it's for a urinalysis.

(6) Calling attention to future drug testing by conspicuously handling urinalysis 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 urinalysis:

a. The battalion commander orders the test and selects the testing date and time. After the battalion commander has determined the date, time and unit(s) or subunit(s) to be tested in a unit sweep, they should implement positive measures to ensure that the selected Soldiers remain unaware of the urinalysis until no more than 2 hours before they are to report to the testing site. The preferred method for maintaining the security of this information is to ensure all UPLs are prepared to conduct a unit sweep with no notice and to tell only the battalion CSM and BPL about the test until it is time to notify the selected Soldiers.

b. The battalion commander directs whether the collection will be executed at battalion or company level. If the battalion commander has decided to use the company-level collection method, the company commanders will be notified.

c. The battalion commander selects the personnel to be tested. For random tests, the battalion commander may delegate this responsibility to the CSM or BPL. If a company-level collection will be employed, the Company 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 BPL or UPL performs the random selection for the commander, the commander must approve the selection before any Soldier provides a urinalysis specimen. Soldiers selected, but not available for a random test, must be tested upon their return or during the next random urinalysis after the Soldier's return. For unit sweeps, the battalion commander must designate which unit(s) or sub-unit(s) will be tested.

d. The Commander orders the Soldiers selected for the test to report to the urinalysis 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.

e. 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.

f. 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.

g. The UPL may notify the DTC about the test after the Soldiers to be tested have been notified, but not before. This notification of the DTC is not required, but 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.

h. 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 app E, fig E–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.

i. 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 that each observer reads and signs an observer's memorandum that clearly explains the observer's duties and the penalties for not complying completely. (See app E, fig E–4 of this regulation for an example memorandum.)

j. The UPL will brief the Soldiers to be tested on the procedures for the test and who the observers will be. (See app E, fig E–3 of this regulation for an example briefing.)

k. 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 E of this regulation.

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 urinalysis collection site, the commander may refer the Soldier for medical evaluation. If this occurs the commander should ensure the Soldier is escorted to the medical treatment facility by a more senior Soldier. If the Soldier is determined to not have a medical condition precluding him 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 PO 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.

b. When the DTC receives urinalysis specimens, they will review the DD Forms 2624 (Specimen Custody Document-Drug Testing), 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 app E, fig E–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 by UPLs that were certified at the time of collection. 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 Social Security Number (SSN) (for example, SSN on bottle does not match SSN on DD Form 2624 and cannot be verified).

(2) When the specimen bottle has 2 labels on it or does not have the Soldier's initials on the label.

(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 one of the following: the Garrison, Region, or IMCOM ADCO, ACSAP, or the FTDTL.

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

e. 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.

(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 UPS).

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

f. If the UPL is deployed or is a reserve component UPL, who is not using a DTC, they will perform the steps above.

4–14. Managing drug test results and medical reviews

a. The FTDTLs will post drug test results on the Web portal located at https://iftdtl.amedd.army.mil. ADCOs, DTCs, and BACMs will register with the Web portal to download the test results for their installation/state/MSC/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. The commander may designate another responsible individual in writing to receive the results for him/her.

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 non-fatal 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 year after the test date, and positive results for 3 years after the test date.

d. If the DTC receives a positive drug test result from the FTDTL Web portal that requires a medical review per MEDCOM Regulation 40–51, the DTC will forward it to the MRO within 5 working days of when the result was posted to the FTDTL Web portal. Within 5 working days of receiving the result from the DTC, the MRO will determine if the Soldier legitimately used the drug(s) in accordance with MEDCOM Regulation 40–51, and forward the determination back to the DTC. The DTC then will have 5 working days to forward the result to the commander and post the MRO determination in DAMIS. A hard copy of the MRO determination will be maintained by the DTC with the positive result for 3 years from the date of the test. The process to conduct MRO reviews is outlined in figure 4–2, below.

e. All Soldiers who test positive for illicit drug use must be evaluated for drug dependence.

f. Commanders will report all confirmed positive results, regardless of location, to the appropriate military law enforcement authority (MP, Security Police, Criminal Investigation Division (CID), and so forth) within 72 hours of receiving notification. The company commander will contact CID within 72 hours of receiving notification that one of their Soldiers tested positive consistent with CID investigatory procedures.

g. Before reporting a Soldier's positive urinalysis result to their commander, the DTC will review the Soldier's past urinalysis results in DAMIS to determine if the Soldier has a previous positive urinalysis result. The DTC will notify the Soldier's commander of all positive urinalysis results in the Soldier's career and any previous enrollments in the ASAP for rehabilitation that are in the Soldier's records.

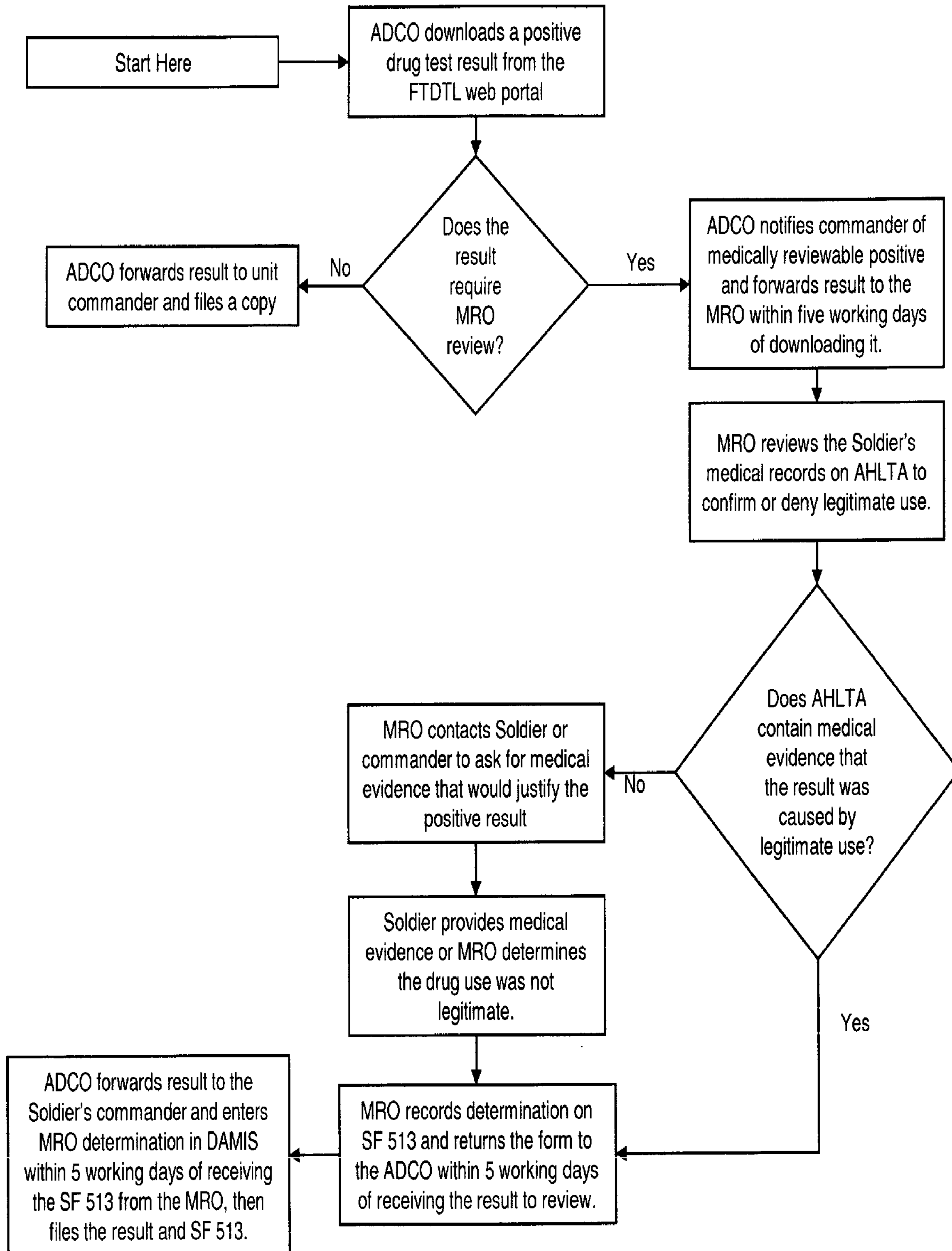

Figure 4–1. The Medical Process

4–15. 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 ADCO will inspect the DTCP operations quarterly using at least 25 percent of the ACSAP 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 with appendix E of this regulation and any applicable local regulations.

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

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

(6) The ACSAP will inspect installation drug testing collection programs at least every 3 years using the ACSAP DTC Inspection Checklist.

(7) Army FTDTLs will be inspected three times a year and will be certified annually in accordance with DODI 1010.1 and DOI 1010.16. An ACSAP representative will periodically accompany the inspection team.

4–16. Statistical management

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

(1) Brief leader's 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 non-fatal 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.

4–17. Physical security

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. Proper physical security and storage of urine specimens at all levels are essential to ensure the integrity of the DTP. Urinalysis specimens will be secured using the minimum security standards for evidence storage as outlined in appendix E of this regulation.

4–18. 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 at the Soldier's expense, 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.

4–19. Requesting urinalysis documents

a. Personnel identified below may request FTDTL documents pertaining to positive urinalysis 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 urinalysis. Documents will be furnished at no expense upon—

(1) Request of the installation or unit commander, a Staff Judge Advocate (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.

(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 intralaboratory 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.

4–20. 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 random testing and preparing the required testing forms and labels. Units should submit at least 95 percent of their urinalysis specimens using the DOD DTP.

4–21. Maintaining drug testing program records

The ASAP records will be maintained in accordance with AR 25–400–2.

4–22. Pre-service use of Drugs

a. Drug dependent persons, current drug abusers, and persons whose pre-service drug abuse indicates a tendency to continue abuse shall not be permitted to enter the Army. Recruiting procedures will include positive measures to identify and screen out drug abusers at the point of application for enlistment, appointment, or commission. Any applicant for the Army who has a positive urinalysis during the application process for any branch of Service at a Military Entrance Processing Station shall be permanently disqualified for enlistment eligibility unless granted a waiver by the Commander, Army Accessions Command (USAAC). The Commander, USAAC may delegate approval of these waivers to the Commander, US Army Recruiting Command.

b. Individuals convicted of a drug-related offense are processed within the same guidelines developed by Army Accessions Command for processing applicants with other types of criminal convictions.

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

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.

4–23. 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 flexibility and mitigate disruptions in the supply chain. DTCs should resupply units based on the number of specimens they turn in to prevent a UPL from tipping off a test by 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 F.

Chapter 5
Civilian Corps Member 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 civilian corps members and DA contractors. Additional instructions and procedural guidance are provided in DA Pam 600–85.

5–2. Background
On 15 September 1986, EO 12564 established the foundation for a DFW. This Executive Order (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 enacted the Civilian DTP for civilian corps members.

5–3. Policy
a. Drug testing of civilian corps members for the purpose of gathering evidence for use in criminal proceedings will not be conducted under this regulation.

b. Any attempt by civilian corps members to defeat the Army's DTP (for example, 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 shall be subject to the full range of disciplinary or administrative actions as appropriate.

c. Employees in and applicants for testing designated positions under DHHS rules will only be drug tested using the single specimen collection procedure. Employees in and applicants for positions that are drug tested under DOT rules will only be tested using the split specimen collection procedure.

d. Frequency of random testing will conform to DOD guidance. Random testing will take place at a rate of one random test per assigned TDP (100 percent random testing) unless directed otherwise by published memorandum from the director, ACSAP.

Section II
Drug-Free Workplace Program

5–4. Objectives
The goal of the Army's DFW DTP is to ensure that workplaces are safe, healthful, productive, and drug-free. To achieve this goal, the Army has implemented drug abuse testing programs for civilian corps members. 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 drug abusers.

d. Assist employees who are seeking rehabilitation for illegal drug abuse.

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

5–5. Applicability
Executive Order 12564, which established the goal of a DFW, applies to all civilian corps members and applicants tentatively selected for TDPs. (See para 5–8 of this regulation defining TDPs.)

5–6. Purposes for conducting drug-free workplace drug testing
To achieve the objectives in paragraph 5–4 of this regulation, six categories of drug testing have been established which fully conform to Executive Order 12564. These categories are (Refer to DA Pam 600–85 for detailed definitions of DFW drug testing categories.)—

a. Reasonable suspicion testing. When there is reasonable suspicion that any TDP employee may have used illegal drugs. Reasonable suspicion testing may be required of any employee in a position, which is designated for random testing, when there is a reasonable suspicion that the employee may have used illegal drugs whether on or off duty. Reasonable suspicion testing may also be required of any employee in any position when there is a reasonable suspicion of on-duty use or impairment.

b. Injury, accident, or unsafe practice testing. in accordance with AR 385–40, 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 counseling and rehabilitation.

e. Applicant testing. Before appointment to or selection for a TDP.

f. Random testing. On a random basis after appointment to or selection for 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 urinalysis specimens of civilian corps member TDPs for the drugs specified in the most recent DHHS directive.

5–8. Drug-free workplace testing designated positions

a. Positions defined 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, which have been identified as TDPs. These positions have duties and responsibilities, which are consistent with the parameters established by the DHHS and the ONDCP.

b. Frequency of random testing will conform to DOD guidance. Random testing will take place at a rate of one random test per assigned TDP (100 percent random testing) unless directed otherwise by published memorandum from the Director, ASAP.

c. Employees in the following TDPs are subject to random testing which occurs without suspicion that a particular individual is using illicit 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 at least a weekly 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.

(b) Who drive motor vehicles designed to transport more than 16 passengers.

(c) Who drive motor vehicles that transport hazardous materials.

(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) The ASAP positions in which the incumbent provides direct rehabilitation and treatment services to identified alcohol or illegal drug abusers.

(8) The PRP positions, (nuclear duty positions or chemical duty positions) under the provisions of 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) Medical positions—

(a) That are directly involved in patient care in which the incumbent has direct patient contact or performs diagnostic testing or therapeutic functions.

(b) That 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.

(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 (LPNs)/Licensed Veterinary Nurses (LVNs).

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. 0660 Pharmacists.

15. 0661 Pharmacy Technicians.

16. 0668 Podiatrists.

17. 0680 Dentists.

18. 0681 Dental Technicians.

19. 0682 Dental Hygienists.

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 positions 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. Even if no TDPS are identified, activities must be prepared to test for reasonable suspicion, to conduct follow up testing, and test volunteers. The certification must also include—

(1) Designation of the activity CSP, by name, title series, grade/rank, and telephone number.

(2) A verified TPD list, by activity, containing the name, social security, gender, position title, series, and pay plan (for example, GS) of each position in the TDP testing pool.

f. Ensure to all employees the availability of strong CEAP emphasizing employee education, counseling and referral to rehabilitation services.

g. Provide a safe harbor for any employee who voluntarily admits his or her drug use, per chapter II of reference.

5–11. Drug testing for 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. Army Central Clearance Facility (CCF) for drug or alcohol related issues.

b. For details concerning the Chemical Surety Personnel Reliability Program and the Nuclear Surety Personnel Reliability Program refer to AR 50–5 and AR 50–6. The ASAP counseling personnel should be familiar with their PRP responsibilities identified in AR 50–5 and AR 50–6.

c. The ASAP CD must ensure that potentially disqualifying information related to the civilian corps member's

participation in ASAP counseling center evaluation and the civilian corps member's subsequent enrollment in rehabilitation will be made available promptly to the PRP certifying official for consideration. Any such disclosure can only be made with the employee's written consent or in accordance with PL 100–71, Section 503 (e).

d. Before PRP certification, all civilian corps members must submit to a urinalysis for illicit drug use.

e. Organizations that contract with companies to provide employees that work in positions which would be classified as being within the scope of the PRP if performed by Soldiers or civilian corps members should specify in such contracts that the contractor will test those employees for illegal drugs using the same guidelines set forth by DHHS and ARs. See paragraph 5–13 of this regulation and the Defense Federal Acquisition Regulation Supplement (DFARS) 252.223–7004 drug-free work force for details.

5–12. Collection site personnel qualifications, training and certification

Since collection site person (CSP), who conduct civilian corps member 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, CSPs are normally the DTC or an alternate DTC; however, other personnel who are not DTC-certified may also serve as CSPs as long as they meet the requirements specified in chapter 9 of this regulation.

5–13. Contractor requirements

a. Employees who use illegal drugs tend to be less productive, less reliable, and prone to greater absenteeism. The use of illegal drugs by contractor employees results in the potential for increased cost, delay, and risk in the performance of a Government contract. If a contractor's employees use illegal drugs at any time, it can—

(1) Impair their ability to perform tasks that are critical to proper contract performance.

(2) Increase the potential for accidents and for failures that can pose a serious threat to the national security, health, and safety.

(3) Cause less than the complete reliability, stability, and good judgment required of an individual who has access to sensitive information.

(4) Create the possibility for coercion, influence, and irresponsible action under pressure that may post a serious risk to national security, health, and safety.

b. The Federal Acquisition Regulation (FAR) and DFARS address requirements for a drug-free to Government contractors, specifically in FAR Subpart 23.5 and in DFARS 223.570. Requiring activities should remind contracting officers of their need for contract terms to include the appropriate clauses prescribed by the FAR and DFARS, and, if necessary, to request deviations from those standard clauses. In addition, requiring activities should request the cognizant contracting officer to review existing contracts to ensure inclusion of appropriate clauses. Specifically, the contract should address employee assistance programs supervisor training, self-and supervisory-referrals to counseling, testing for the use of illegal drugs by employees in sensitive positions, and appropriate personnel procedures to deal with employees who are found to be using drugs illegally.

5–14. 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 CSP, 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 CSP. 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 written in the installation or command substance abuse program SOP. Personnel in TDPs who are selected, but not available for a random test, must be tested within 5 working days of their return or during the next random urinalysis 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 urinalysis 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 CSP 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 CSP inspects the latrine(s) before the collection to remove any possible adulterants and to eliminate access to any sources of water. The CSP will ensure that testing personnel have soap and paper towels to wash their hands in full view of the CSP before and after providing a specimen.

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

5–15. Collection procedures

The CSP 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 Division of Workplace Programs, DHHS, which is available at http://www.workplace.samhsa.gov/DrugTesting/ Specimen Collection/UrnSpcmnHndbk.html.

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 CSP may collect the specimens of employees of both sexes. If the CSP is not the same sex as the individual providing the specimen, the CSP 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 CSP will notify the supervisor that a situation exists that requires a direct observed collection document/describe the situation and provide a copy to the ADCO. If the employee refuses to undergo an observed test, the CSP will notify the supervisor prepare a MFR concerning the refusal, and follow the guidelines in the DHHS handbook.

c. If a civilian corps member does not provide a specimen within 3 hours of reporting to the urinalysis collection site, the CSP should follow the procedures in the DHHS Urine Specimen Collection handbook.

5–16. Post-collection procedures

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

b. The CSP may pack several different donors' specimens into the same package for shipment to the FTDTL. The CSP will ensure that the outermost package that contains civilian urinalysis 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 urinalysis 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) US flag commercial airfreight, air express, and airfreight forwarder (for example, FedEx or UPS).

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

5–17. Medical review and reporting of drug-free workplace test results

a. The medical review serves as a critical safeguard in the urinalysis 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.

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 FTDTL or at any other National Laboratory Certification Program (NLCP)-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 tests will be reviewed by the centralized MRO unless the Commander, USAMEDCOM approves an exception in coordination with the Director, ASAP.

5–18. Statistical management

a. To assess and manage the program, the ADCO must collect, maintain and analyze ASAP statistics, but must also prevent the disclosure of personal information to unauthorized personnel. The ADCO 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 Testing Designed Positions (TDPs) by category.
(2) Number of TDP specimens collected per reason for test.
(3) Number of other civilians (non-TDP) tested per reason for test.
(4) The TDP positive rates by drug.
(5) The TDP discrepancy rate.
(6) The TDP testing rate.

5–19. Refusal to test
When a civilian corps member refuses to provide a lawfully-directed urinalysis or breathe specimen, the employee is subject to the adverse administrative or disciplinary actions listed in paragraph 10–31 of this regulation.

5–20. Disciplinary and adverse actions
In accordance with DODD 1010.9, any civilian corps member found to be using illegal drugs or to be impaired by alcohol while on duty may be subject to disciplinary action. For a complete review of such actions, see paragraph 10–31 of this regulation.

5–21. Suspension from testing designated positions and personnel reliability program positions
When a civilian employee receives a confirmed positive test for illicit drugs, the employee's supervisor will consult with the CPAC and his or her service legal office and suspend the employee from the TDP and access to classified information pending a determination of administrative action in accordance with AR 380–67. If the employee is in a PRP position, the supervisor will promptly notify the certifying official and suspend the employee from their position in accordance with AR 50–5 or AR 50–6 pending a final determination of administrative action.

5–22. 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 corps members' safety and security in hostile fire areas solely to conduct drug testing.
c. The BACM of any deployed unit that includes civilian corps members in Testing Designated Positions will coordinate the following with the ACSAP:
(1) Training and certification for CSP to collect urinalysis specimens from TDP personnel randomly selected for testing.
(2) Civilian Collection Kits, Custody and Control Forms, 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

5–23. Objectives
The DOT alcohol and other 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.

5–24. Applicability
The DOT rules at 49 CFR, Part 382 apply to all civilian corps members who drive commercial motor vehicles in commerce in any state and are subject to the commercial driver's license requirements of 49 CFR Part 383. (Definitions of DOT words and phrases used in this regulation are provided in the Glossary, Section II).

5–25. Safety-sensitive functions
The DOT rules apply to all on duty time that a driver performs any safety-sensitive function as defined in 49 CFR, Section 382.107. (Refer to DA Pam 600–85 for a list of safety-sensitive functions).

5–26. Department of Transportation prohibited conduct and consequences
a. The DOT-prohibited conduct is listed in DA Pam 600–85 and is further described in 49 CFR Part 382, Subpart B.
b. Consequences of prohibited conduct are listed 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 they have met the requirements of 49 CFR Section 382.605. Additionally, supervisor/managers having actual knowledge that a

violation has occurred are prohibited from permitting the driver to perform safety-sensitive functions. (See DA Pam 600–85 for additional guidance regarding the consequences of engaging in prohibited conduct.)

5–27. Department of Transportation categories of testing

a. Civilian corps member drivers to whom DOT testing rules apply are subject to testing under circumstances described in 49 CFR, Part 382, Subpart C. These include the following six bases for alcohol and other drug testing: pre-employment testing; 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 of this regulation, DOT categories have different requirements (see DA Pam 600–85 for more information).

b. Eligibility for testing under the DOT requirements does not exempt the employee form the requirements for testing under the auspices of the DHHS DFW regulations.

5–28. Department of Transportation testing procedures and required education and training

a. Civilian corps member drivers to whom DOT rules apply are subject to the testing procedures identified in 49 CFR, Part 40.

b. The DOT rules require supervisor training and driver education. Requirements are in 49 CFR 382, Sections 382. 601 and 382.603.

5–29. 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.

5–30. Specimen collection for Department of Transportation drug testing

Personnel who collect urinalysis specimens from civilian corps members 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 urinalysis specimens as long as they meet the requirements specified in chapter 9 of this regulation. The collector must successfully complete required training and have met all the collection requirements prescribed by DOT alcohol and other drug testing procedures and rules in 49 CFR, Part 40, Subpart B.

5–31. Medical review and the reporting of Department of Transportation drug test results

a. The medical review serves as a critical safeguard in the urinalysis 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.

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).

5–32. Alcohol testing

The IBAT will have been trained to proficiency in the operation of the evidentiary breath testing device(s) and/or the non-evidentiary breath testing devices used at the installation and the alcohol testing procedure in 49 CFR Part 40.

5–33. Substance abuse professional evaluation, referral, and follow-up

The installation SAP will evaluate any employee/driver who has engaged in prohibited conduct associated with alcohol misuse and/or controlled substance (drug) abuse. If the SAP determines that the employee/driver needs assistance, the SAP will recommend a course of rehabilitation and refer the individual to an appropriate rehabilitation resource. DOT rules also require that such an employee shall be subject to unannounced follow-up alcohol and drug testing. Evaluation, referral, and follow-up requirements are provided in 49 CFR, Section 382.605. Additional guidance is provided in the DOT Substance Abuse Professional Procedures for Transportation Workplace Drug and Alcohol Testing Programs, dated June 1995. (See DA Pam 600–85 for instructions for the installation EAPC.)

5–34. Department of Transportation reporting requirements

a. Each Army installation, state and MSC shall prepare and maintain an annual calendar year summary of the results of its DOT alcohol and other DTPs. The information required is found in 49 CFR Section 382.403.

b. Each ADCO will ensure that a U.S. Department of Transportation Drug and Alcohol Testing MIS Data Collection Form are completed not later than 15 February of each year. Test data are to be maintained for at least 5 years. ADCOs will promptly forward complete data forms to the Director, ASAP not later than 1 March of that year. The Director, ACSAP will summarize and analyze the IMCOM data and forward a completed report to the Department of Human Services and to Office of the Secretary of Transportation, Drug Enforcement and Program Compliance.

5–35. Statistical management

a. To assess and manage the program, the ADCO must collect, maintain and analyze ASAP statistics, but must also prevent the disclosure of personal information to unauthorized personnel. The ADCO 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 urinalysis 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
Civilian Corps Member, Family Member, and Retiree Services

This chapter specifies policies of the ASAP pertaining to civilian corps members and their families, military Family members, and military retirees and their Families. (Additional instructions and procedural guidance are provided in DA Pam 600–85).

6–1. Policy

a. Civilian corps members should refrain from alcohol abuse 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.

b. Reducing or eliminating alcohol and/or other drug misuse or abuse creates safe, healthful, productive and secure workplaces. Civilian personnel will receive a minimum of 2 hours of prevention education per year in accordance with TRADOC Reg 350–70.

c. Supervisors will be encouraged to consult with the EAP, who helps employees with problems that may affect their job performance, attendance, and/or conduct. (The EAP procedures and instructions are provided in DA Pam 600–85).

d. Civilian corps members in appropriated and non-appropriated fund positions, military and civilian Family members, and military retirees and their Family members will be offered screening and/or referral services for rehabilitation for alcohol and other drug misuse/abuse and related problems. They will also be offered screening, short-term counseling, and referral services for other non-substance abuse related problems that may affect their job performance and/or well-being. Also eligible are nonuniformed OCONUS personnel who are eligible to receive military medical services, as well as some foreign nationals where Status of Forces Agreements or other treaty arrangements provide for medical services.

e. The ASAP counseling services will be offered when resources are available.

f. Civilian employees and Family members' enrollment in ASAP rehabilitation is voluntary.

g. Civilian employees have the option of participating in either the installation ASAP counseling program, when available, or being referred to an approved program in the civilian community.

h. Whenever possible, an employee's Family will be involved in rehabilitation as appropriate if the employee agrees to and signs releases of information for such involvement.

i. Civilian corps members will be granted an approved absence to obtain counseling according to existing civilian personnel regulations and local union agreements.

j. Civilian corps member performance appraisals will not mention current or past enrollment in the ASAP.

k. Adolescent Family members of Soldiers and civilian employees in OCONUS locations will be provided substance abuse prevention and counseling services through a school-based centrally-funded contract.

6–2. Eligibility

ASAP civilian services are authorized within resource constraints for all civilian corps members in appropriated and non-appropriated fund positions, military and civilian Family members, and military retirees and their Family members. Also eligible are nonuniformed OCONUS personnel who are eligible to receive military medical services, as well as some foreign nationals where Status of Forces Agreements or other treaty arrangements provide for medical services.

6–3. Purpose of the Employee Assistance Program

The Army's Employee Assistance Program includes a wide variety of services for various adult living problems. These

services are provided to enhance productivity and reduce absenteeism, promote safety on the worksite, and ensure that the Army's mission is accomplished in the most efficient manner. The EAP services include but are not limited to screening, short-term counseling, and referral for all adult living problems. Guidance, advice, mediation and prevention education on a variety of topics promote the well-being of the employee while supporting Army mission accomplishment. Supervisory services of consultation and mediation are provided to guide employees and managers in resolving issues that may impact on the productivity of the civilian workforce. Assistance to Family members of civilian employees is provided to assist Family members in resolving adult living issues, and enhancing the employee's ability to perform the duties of the worksite.

6–4. Evaluation and referral

Supervisors and management will refer civilian employees whose job performance, conduct, or attendance records may be indicative of adult living problems requiring professional assistance to the installation EAPC. Supervisors will inform all civilian corps members who display performance and/or conduct issues that the EAP may help them address adult living problems that have the potential to affect performance and conduct. Supervisors will market the EAP as a benefit of employment for all eligible employees, and that services are not dependent on worksite related problems. (See DA Pam 600–85 for evaluation and referral procedures by the EAPC.)

6–5. Client costs

a. The Army Federal Civilian Employee Health Services Program will perform no direct charge medical evaluations for civilian employees.

b. In overseas areas, medical treatment facilities will provide partial inpatient care to civilians when they are eligible for Army medical services.

c. The ASAP counseling centers may require all civilian clients, regardless of location, to provide information on their medical insurance as part of the enrollment process. This includes those eligible for Tri-Service Medical Care or Third Party Coverage. Their insurance carriers may be billed for services rendered. Clients will not be denied services solely because they do not have medical insurance coverage.

d. Civilian employees are responsible for all other costs.

6–6. Participation of Family members

Family members, including minor children, may participate in all aspects of the ASAP except drug testing within the capabilities of existing resources. (Refer to DA Pam 600–85 concerning Family members' participation in ASAP civilian services).

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 granted after application showing good cause therefore, including the need to avert a substantial rush of death or serious bodily harm. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

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 42CFR Part 2, as long as the employee is considered a "patient". A "patient" is defined in 42CFR 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 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 EAPC the current use of illegal drugs or significant alcohol use, and the employee has not given written permission to disclose the information, the EAPC must consult with the installation ADCO and the servicing legal office without releasing identifying information of the TDP employee for guidance regarding disclosure to supervisory chain for purposes of determining temporary abeyance of TDP duties.

d. During the initial encounter, 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, is encouraged.

f. Civilian ASAP and EAP records will be maintained in accordance with 42 CFR 2.16; 49 CFR, part 382; AR 25–400–2; and the EAPC Guidebook.

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. Counseling records of any civilian being seen at the ASAP counseling center for substance abuse rehabilitation will meet the requirements of AR 40–66, Medical Records Administration and Healthcare Documentation, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

i. ASAP and EAP records will be maintained and secured (for example, in a secure room, locked file cabinet, or safe), separate from other records.

6–8. Confidentiality of alcohol and other drug test result

a. Release of alcohol and/or other 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 employee assistance program 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 use 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.

6–9. Conflict of interest - Employee Assistance Program coordinator and civilian drug testing issues

At installations where the EAPC is a separate position from other drug testing roles (ADCO, DTC and so forth), EAPCs will not take part in the selection or collection process of civilian employee testing in support of the DFW to include DOT testing. It is a conflict of interest for the EAPC to conduct these activities or to have the ability to determine testing dates for affected civilian employees. At installations where the EAPC is combined with other drug testing roles (ADCO, DTC and so forth), the ASAP will develop a mechanism whereby a neutral witness observes the selection method for random civilian drug testing. The witness must not be part of the testing pool and will be approved by the installation Staff Judge Advocate to ensure neutrality.

Chapter 7
Identification, Referral, and Evaluation

Generally, this chapter applies to Soldiers. It applies to civilian corps members and Family members where noted.

Section I
Methods of identification

7–1. Overview

The Army recognizes that substance abuse and dependency are preventable and treatable. While self-ID is the preferred

method of ID, commanders are also responsible for identifying Soldiers at risk and for referring them to the ASAP for evaluation by the counseling staff and ordering them into the recommended intervention and rehabilitation.

a. Alcohol. Soldiers who abuse alcohol shall receive the education, counseling, and rehabilitation services indicated by the severity of the abuse. Alcohol problems are effectively addressed in most cases through engaged leadership, immediate intervention, and discipline as appropriate, education, counseling and rehabilitation. The primary function of the ASAP rehabilitation program is to return the abuser to full duty status with a positive, productive, and healthy lifestyle. Soldiers diagnosed with alcohol abuse or dependencies are permitted one period of rehabilitation for an alcohol incident per career. A company commander may recommend a second period of rehabilitation for a Soldier if the commander evaluates that Soldier as possessing exceptional potential for further useful Army service and is evaluated by the ASAP counseling staff as appropriate for another period of rehabilitation. Any alcohol incident after two periods of rehabilitation during a career is viewed as a failure to successfully complete rehabilitation and requires mandatory processing for administrative separation.

(1) Prevention training, such as ADAPT, is not considered rehabilitation for administrative separation purposes.

(2) Soldiers referred for reasons that do not include an alcohol-related incident may receive a second period of rehabilitation at any time during their career.

b. Other Drugs. All Soldiers, to include ARNG and USAR Soldiers ordered to AD, under Title 10 U.S. Code, who are identified as drug abusers, without exception, will be referred to the ASAP counseling center for evaluation.

(1) Nondependent drug users will be enrolled in the ASAP if such enrollment is clinically recommended.

(2) Soldiers diagnosed as drug dependent should be detoxified and given appropriate medical treatment. These Soldiers generally do not have potential for continued military Service and should not be retained. These Soldiers will be referred to a VA hospital or a civilian program by the ASAP counselor to continue (or to initiate) their rehabilitation.

7–2. Methods of identification

a. Early ID is a critical aspect of the ASAP intervention process. Identification 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.

b. Commands will identify Soldiers as drug abusers based upon evidence provided by these methods.

7–3. Voluntary (self) identification

a. Voluntary (self) ID is the most desirable method of discovering alcohol or other drug abuse. The individual whose performance, social conduct, interpersonal relations, or health becomes impaired because of the abuse of alcohol or other drugs has the personal obligation to seek rehabilitation. The Soldier's unit commander must become involved in the evaluation process. Command policies will encourage Soldiers and civilian corps members to volunteer for assistance and will avoid actions that would discourage these individuals from seeking help. Normally Soldiers with an alcohol or other drug problem should seek help from their unit commander; however, they may initially request help from their installation ASAP, a MTF, a chaplain, or any officer or non commissioned officer in their chain of command. If a Soldier initially seeks help from an activity or individual other than his or her unit commander, the individual contacted should immediately notify the Soldier's unit commander and installation ADCO. The Limited Use policy will apply when Soldiers seek help from any of the listed personnel or organizations.

b. In situations where a Soldier reveals to a chaplain that he or she is abusing or has abused alcohol or a drug, privileged 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. This is required for a Commander to enroll the Soldier in ASAP. If the Soldier does not waive his or her privilege, the chaplain would inform the Soldier that:

(1) Professional alcohol and drug rehabilitation counseling is available through the ASAP counseling services.

(2) The Chaplain cannot assist the Soldier's entry into the ASAP without going through the member's unit commander.

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 volunteering. For reporting purposes, such cases will be classified as self referral.

d. The Limited Use Policy restricts the consequences of the Soldier's involvement in the ASAP (see paras 10–12 through 10–14). These provisions are unchanged by the mandatory initiation of separation processing of drug abusers, and such separation processing must comply with the provisions of limited use and AR 600–8–24 and AR 635–200.

e. A Soldier may seek assistance from other agencies for problems associated with Family members in which the

Soldier's abuse of alcohol or other drugs is a factor. Every effort will be made to ensure that those agencies (for example, military or civilian services) are aware of the ASAP services and procedures (for example, mandatory command involvement) for referral to the ASAP counseling center for an initial evaluation.

f. Civilian employees and Family members voluntarily seeking assistance for alcohol and other drug abuse problems will be offered Employee Assistance Program evaluation and/or referral services to the ASAP counseling program, if resources permit, or to rehabilitation programs off the installation (see para 6–5 of this regulation).

7–4. Commander/supervisor identification

a. 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 abuse of alcohol or other drugs.

b. Soldiers who are identified as abusers or suspected abusers will be processed by their unit commander or designated representative in accordance with paragraph 7–9 of this regulation and referred to the ASAP counseling center for an evaluation.

c. Civilian employees identified through their supervisors as having problems that impact the work site will be referred to the Employee Assistance Program for an evaluation. Supervisors will follow procedures indicated in DA Pam 600–85.

7–5. Drug testing identification

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

b. Any Soldier identified as an illegal drug abuser through drug testing requires a mandatory referral to the ASAP counseling center for evaluation within 5 duty days of receipt of the validated positive drug test results.

c. Any civilian employee identified as an illegal drug abuser through drug testing requires a mandatory referral to the Employee Assistance Program for an evaluation in accordance with DA Pam 600–85.

7–6. Alcohol testing identification

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

b. Any Soldier on duty whose alcohol breath or blood test result indicates alcohol impairment as discussed in paragraph 3–2 of this regulation requires a mandatory referral to the ASAP counseling center for evaluation within 5 duty days of receipt of the test result.

c. 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 Substance Abuse Professional (SAP) for evaluation 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.

7–7. Investigation/apprehension Identification

A Soldier‘s alcohol or other drug abuse may be identified through military or civilian law enforcement investigation and/or apprehension. The unit commander will refer the Soldier to the ASAP counseling center for an initial evaluation within 5 duty days of notification of apprehension of the Soldier for apparent alcohol or other drug abuse. Referral for evaluation or enrollment does not interfere with or preclude pending legal or administrative actions in any way.

7–8. Medical identification

a. During routine or emergency medical treatment, a physician or health care provider may note apparent alcohol or other drug abuse. In such instances, the physician or health care provider will refer the individual to the ASAP counseling center, using a SF 513 (Medical Record – Consultation Sheet). If the patient is a Soldier, the physician will immediately notify the Soldier's unit commander of the referral.

(1) If a Soldier reveals, as part of a routine medical screening with a physician or other health care provider, his personal abuse of alcohol or other drugs, the health care provider will evaluate further, with possible ASAP referral for in-depth evaluation and rehabilitation. The revelation of personal abuse, by itself, will not subject the individual to adverse administrative action. Urinalysis which may follow such disclosure will be covered under the Limited Use Policy. The health care provider will provide information about the Soldier's alleged alcohol or other drug use immediately to the commander should it appear that any of the following conditions exist:

(a) The abuse by the Soldier is current.

(b) Impaired judgment is evident.

(c) Potential danger to others exists as a result of alcohol or other drug use (for example, Chemical or Nuclear Surety Programs, aviator).

(d) Drug use subjects the individual to potential risk of coercion by others as a result of drug use or related activities. (For example, abuser holds a Top Secret security clearance.)

(2) If a physician or other health care provider notes possible alcohol or other drug abuse during routine or emergency medical screening of a civilian employee or Family member, the physician or health care provider will strongly recommend to the individual that they see the EAPC or Adolescent Substance Abuse Counseling Service (ASACS) counseling center for evaluation and referral to available community resources.

b. The evaluation, ID and referral of Healthcare Providers with substance abuse related problems are very sensitive issues. Health care providers are responsible for helping to identify and refer to the Impaired Health Care Provider Program (IHCPP) any colleague whose performance is impaired by alcohol or other drugs. All Health Care Providers will be responsible for reporting any suspicious alcohol or other drug related problems to the Impaired Health Care Provider Committee (IHCPC) or Deputy Commander for Clinical Services. The medical commander will manage the potentially impaired provider through the IHCPC established per AR 40–68, chapter 11.

Section II
Referrals for military personnel

7–9. Command responsibilities for referring Soldiers

a. When Soldiers are identified as probable alcohol or other drug abusers the unit commander or designated representative must—

(1) Coordinate with law enforcement about whether the commander or designated representative should conduct the initial interview of the alcohol or drug abuser.

(2) When the unit commander believes the Limited Use Policy applies, the unit commander should consult with the ADCO and supporting legal advisor. The unit commander may then explain the Limited Use Policy, if applicable to the particular circumstances.

(3) If law enforcement does not initiate an investigation, the commander may wish to investigate suspected misconduct through a commander's inquiry, AR 15–6 investigation, or other appropriate method after consulting with the legal advisor.

b. The unit commander will refer individuals suspected or identified as alcohol and/or other drugs abusers, including those identified through drug testing (except those determined to be legitimate medical use by the MRO) and /or blood alcohol tests, to the ASAP counseling center for screening. Soldiers impaired by alcohol as described in paragraph 3–2 of this regulation while on duty will be referred to the ASAP counseling center for the initial evaluation. Soldiers who are referred by the unit commander for evaluation, regardless of the means of ID, will be referred using a DA Form 8003, which the commander must sign.

c. Positive drug test results for illicit use and law enforcement citations for alcohol and other drug abuse are ID sources that require mandatory referral to the ASAP counseling staff. Commanders must refer Soldiers who receive such drug test results or legal citations within 5 duty days of receipt of the notification.

7–10. Self referrals

The ASAP counseling staff will conduct an initial interview with all eligible personnel who self-refer to the ASAP counseling center for assistance. During the initial interview, the counselor will advise the Soldier of the unit commander's role in the referral, evaluation and rehabilitation process, or other disposition, explain Limited Use Policy , and provide information about ASAP services. If, after the initial interview, further services are warranted, the ASAP counselor will contact the unit commander and coordinate the Soldier's formal referral using DA Form 8003, which will be signed by the unit commander and be annotated as a self referral. The commander will be a part of the rehabilitation program and, as a member of the Rehabilitation Team, will be directly involved in the decision of whether rehabilitation is required.

7–11. All other referrals

In addition to referrals from medical or law enforcement agencies, other sources (for example, military Chaplains) may identify or refer Soldiers suspected of alcohol or other drug abuse. Referrals from sources other than command, medical, investigation and/or apprehension sources will be handled in the same manner as self referrals.

Section III
Evaluation process for military personnel

7–12. Screening/evaluation

a. An in-depth individual biopsychosocial evaluation interview will be conducted with all individuals who are either referred for evaluation or who voluntarily seek assistance. The ASAP counselor will explain the Limited Use Policy. The evaluation will be conducted by a member of the ASAP counseling staff and will be completed within 12 duty days of the referral. Command input into the evaluation is essential.

b. Individuals with an emergency referral, as determined by the counseling staff, will receive priority when

scheduling biopsychosocial evaluation interviews. Clinical Directors must have a written SOP that allows for determination of emergency cases at the time of the client presentation for evaluation services.

c. The counselor, in consultation with the commander, will be responsible for evaluation decisions. Evaluation decision disagreements between the counseling staff and the commander will be resolved jointly by the first Colonel in the Soldier's chain of command and the MTF commander, who has the final authority.

d. If a unit commander believes a Soldier does not have potential for future service, the Soldier will be processed for administrative separation in accordance with AR 600–8–24 or AR 635–200, as appropriate. If rehabilitation services are indicated, the Soldier will be provided services until separation.

7–13. Medical evaluation

a. Medical evaluation is required in cases of suspected alcohol or other drug dependence and all cases prior to entry into residential or inpatient treatment.

b. The unit commander, supervisor, CD, counselor or Soldier may request a medical evaluation by a physician at any time to determine the extent of alcohol or other drug abuse.

7–14. Rehabilitation team

The rehabilitation team will convene a face to face meeting, unless prevented by operational necessity, as soon as possible after the ASAP counseling staff has completed the individual biopsychosocial assessment and finalized the evaluation summary. The purpose of the team is to review the results of the evaluation summary and to develop rehabilitation options. The team will be composed of the Soldier, the unit commander and/or First Sergeant, the ASAP counseling staff, and others as appropriate. The ASAP counselor will recommend to the commander the appropriate disposition of the referral with input of the rehabilitation team. Any of the following actions will be recommended:

a. Counseling by the unit commander or the commander's designated representative.

b. Referral to other agencies (for example, military chaplains, marriage counselors, behavioral health activity, Alcoholics Anonymous (AA) and so forth)

c. No ASAP services required at the present time.

d. Referral to ADAPT. (See para 9–13 of this regulation for a description of ADAPT.)

e. Enrollment in ASAP rehabilitation, Level I or Level II.

Chapter 8
Rehabilitation

Section I
Introduction

8–1. General

a. The unit commander's attitude and direct involvement are critical in the Soldier's successful rehabilitation process. Command support must be positive and clearly visible. The commander must be aware of the Soldier's immediate problem identified during the biopsychosocial evaluation and be familiar with the counseling strategies and goals addressed in the rehabilitation plan. In support of the rehabilitation process, the commander must:

(1) Have a full understanding of the various program elements within the ASAP.

(2) Help Soldiers cope with the environment in which they are expected to function and support Soldiers' efforts to avoid relapse.

b. Rehabilitation begins with good leadership, management, and command counseling. Initial efforts should begin with counseling by the commander or, in the case of civilian employees, with counseling by the supervisor for job-related issues that are impacted by the Soldier's or employee's alcohol or drug abuse.

c. In some instances, special expertise is required to bring about desired changes in a Soldier's performance or conduct. The commander must provide the ASAP counseling staff with as much information as possible regarding the Soldier's behavior, involvement with alcohol and/or other drugs, and other signs and symptoms that suggests an alcohol or other drug abuse problem.

8–2. Rehabilitation objectives

a. The objectives of the rehabilitation program for military personnel are to:

(1) Return Soldiers to full duty as soon as possible.

(2) Identify Soldiers who cannot be rehabilitated within the scope of this regulation and to advise their unit commanders of that.

(3) Assist and refer Soldiers who cannot be rehabilitated in the ASAP to a rehabilitation facility in the vicinity where they reside after discharge from the Army.

(4) Help resolve alcohol and other drug abuse problems in the Family, with the ultimate goal of enabling the Soldier to perform more effectively.

b. For civilian employees, the primary objective is to restore civilian employees with job performance problems to effective duty performance.

8–3. Rehabilitation team concept

a. Soldiers. In the interest of developing the best rehabilitation program for the Soldier, the ASAP counselor will employ the rehabilitation team concept. The rehabilitation team membership will include the Soldier, the unit commander and/or First Sergeant, the ASAP counseling staff, and others as appropriate. A record of the team's face to face meetings, discussions, and decisions will be maintained in the ASAP client record. The rehabilitation team will ensure the compatibility of the rehabilitation plan with the mission requirements of the Soldier's unit or organization.

b. Civilian Employees. The rehabilitation team concept will only be used for civilian employees if the employee has given consent to involve the supervisor by signing the appropriate release forms (see DA Pam 600–85).

c. Family Members. The rehabilitation team concept does not apply.

8–4. Rehabilitation program elements

The ASAP rehabilitation program is comprised of four fundamental operating elements. It is essential that careful coordination and open communication between these elements be maintained to ensure the smooth transition of the individual through the rehabilitation process. The four elements are—

a. Identification and referral.

b. Individual, comprehensive biopsychosocial assessments, and command consultation.

c. Rehabilitation and follow-up.

d. Mandatory monthly rehabilitation alcohol and drug testing for all Soldiers enrolled for rehabilitation. (Increased frequency, if needed, will be determined by the rehabilitation team.) Drug testing frequency will be included in the Soldier's rehabilitation plan.

Section II
Rehabilitation Procedures

8–5. Referral methods, biopsychosocial evaluation, and rehabilitation determination

a. Soldiers may seek program information anonymously. However, should an evaluation be necessary, the unit commander will be notified immediately (see para 7–9 of this regulation).

b. Referred individuals will undergo an individual, comprehensive biopsychosocial evaluation. It will be completed within 12 working days from the date of the referral (date of receipt of DA Form 8003).

c. After the biopsychosocial evaluation has been completed, the rehabilitation team will meet to determine what rehabilitation approach will best meet the needs of the Soldier or the civilian employee, when applicable (see para 8–3, above).

d. If enrollment in the ASAP is required, the frequency, length of counseling sessions, and level of rehabilitation will be discussed and determined by the rehabilitation team. In the event of disagreement between the commander and the rehabilitation team regarding rehabilitation approaches, the MTF commander has final authority (see para 7–12c of this regulation).

8–6. Rehabilitation Program

The rehabilitation program is based upon the severity of the individual's involvement with substance abuse and may provide individual, group, and/or Family counseling on a non-residential (Level I) or partial inpatient/residential (Level II) basis. Program design allows for flexibility and offers a wide variety of rehabilitation modalities structured to meet both individual needs and Army requirements for effective duty performance. Modalities are structured within the scope of individualized, short-term rehabilitation. Placement in Level I or Level II is based upon American Society of Addictive Medicine criteria regarding the severity of impairment. Additionally, the ADAPT is an option, though not a part of the rehabilitation program itself. (Refer to para 9–15 of this regulation for ADAPT information.)

8–7. Rehabilitation levels

a. Level I. Non-Residential/Outpatient Rehabilitation. This program provides individual, group, or Family counseling on a non residential or outpatient basis. In addition, the education sessions of ADAPT are available, as necessary. Enrollment in this level will be for a minimum of 30 days and will not exceed 360 days. Enrollment requires an appropriate medical assessment/evaluation by a physician when the Clinical Director suspects substance abuse dependency. A medical evaluation can be requested at any time during the evaluation or rehabilitation process for any client who is eligible for DOD medical services. When a Clinical Director documents signs or symptoms of suspected dependency, the MTF must provide access to a physician for the evaluation. The client may be transferred to Level II or referred to another agency at any time during Level I rehabilitation.

b. Level II. Partial Inpatient/Residential Treatment This level provides an intensive partial residential treatment program of varying lengths. Following completion, Soldiers are involved in a mandatory, nonresidential follow up period for a total rehabilitation period of 1 year. In the case of deployed Soldiers, the total rehabilitation time will be 1 year, insofar as deployment allows. Initial treatment is provided under medical supervision in a partial residential treatment facility setting. This level is designed for individuals who cannot respond favorably to outpatient treatment or who have a long-standing history of alcohol or other drug dependency. The decision to enter a client into Level II is made by a physician in consultation with other rehabilitation team members. The partial residential phase of treatment is the direct responsibility of the MEDDAC/MEDCEN commander; however, Level II remains an integral part of the ASAP and operates in accordance with the provisions of this regulation and applicable medical regulations. All client accountability and reporting is done by the referring ASAP counseling staff of the client. Referring ASAP counselors are required to remain in contact with and monitor progress of clients who have been referred from their ASAP to the partial residential program. When a client is referred directly to a partial residential program or a full residential inpatient program (without responsible ASAP staff knowledge), it is the responsibility of the unit commander to ensure that the client's servicing ASAP has been notified and that all administrative information is provided for the client's enrollment in the ASAP. Normally, all referrals to the residential treatment facility will be coordinated through the installation ASAP Clinical Director. A medical evaluation is required prior to placement in Level II and again before release from the residential phase of Level II.

8–8. Standards for transfer to Level II, partial inpatient/residential treatment programs

Partial residential programs are located at Eisenhower Army Medical Center, Tripler Army Medical Center, and Landstuhl Army Medical Center. All referrals for evaluation and residential treatment for substance abuse will have a medical evaluation coordinated by the Clinical Director and CC or other physician, dependent upon apparent urgency and local resources, but no later than 24 hours after the referring ASAP's initial presentation to the residential/inpatient program. The CC will develop a standing operating procedures document, per the most current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, describing circumstances under which a medical evaluation will be conducted. A physician will conduct a medical evaluation for initial and interval screening for evidence of toxicity and withdrawal. Medical management of drug toxicity and withdrawal is a critical element of substance abuse treatment. The attending physician will determine the time necessary for detoxification. No individual will be medically evacuated who has not been completely detoxified. Where necessary, consultation and/or transfer to specialized levels of care must be readily available. The counseling practice guidelines will include written multi-disciplinary agreements as the preferred method for such consultations or transfers.

8–9. Goals of rehabilitation

The rehabilitation goals are to be based on the biopsychosocial evaluation with the production of an individualized rehabilitation plan which is formulated, written and periodically re-assessed. These goals may range from short-term goals to long-term goals. Some examples include:

a. Brief abstinence to enable safe medical treatment or to enable the feasibility of more extensive sobriety or to enable better assessment of the level of rehabilitation needed;

b. Abstinence of sufficient length to achieve clarity of thinking and concentration and to determine the client's need for more extensive rehabilitation, and

c. Life-long abstinence as a long-term goal.

8–10. Informed consent

Informed consent refers to the process of making the client aware of the proposed rehabilitation services, the risks and benefits of rehabilitation, rehabilitation alternatives, and the risks of rehabilitation versus no rehabilitation.

8–11. Biopsychosocial evaluation

A comprehensive biopsychosocial assessment will be used to determine the extent of alcohol and other drug abuse and the level of rehabilitation required. Critical to this assessment is the provision by the client of written permission for the release of information, so that other viewpoints of the client's general behavior and substance abuse patterns may be made available to the ASAP counseling staff, thereby minimizing the risk of distortion of information critical to the evaluation.

8–12. Initial medical screening

This process begins with the ASAP counseling staff. The counselor refers a client for medical screening if there is reason to believe that the individual may need medical care for dependency, detoxification, active suicidal ideation or other medical needs. The CC will determine the criteria for initial medical screening by the ASAP counseling staff and what medical provider is most appropriate for performing the next level of medical screening. A case review with the CC (or their designated medical personnel) will be included for any client that the Clinical Director has determined to

have medical needs. If no physician is available on the installation, the CD will refer the Soldier to the nearest MEDCOM-approved physician. Geographically remote units should contact the nearest installation CD for guidance.

8–13. Rehabilitation progress

a. The unit commander, in consultation with the other members of the rehabilitation team, determines rehabilitation progress using the following factors:

(1) Conduct, duty performance, and relationships with co-workers.

(2) Further incidents of alcohol or other drug abuse.

(3) Motivation to overcome alcohol or other drug abuse problems.

b. If the unit commander determines that conduct, duty performance, and progress are unsatisfactory, and that further rehabilitation efforts cannot be justified, they will initiate a discharge from military Service. ASAP counseling services will be provided until the Soldier is separated. Referral to VA services will be offered.

c. This paragraph does not apply to Family members. For civilian employees who have authorized their supervisor's participation in a rehabilitation team, only duty performance will be used by the rehabilitation team to assess progress.

8–14. Frequency of counseling

The type and frequency of counseling sessions varies depending upon the individual's need. For Soldiers, it will be determined by the rehabilitation team. For civilian employees and Family members, it will be determined by the counseling staff in consultation with the client.

8–15. Relapse

If a relapse occurs during rehabilitation, the counselor will promptly notify the unit commander. The rehabilitation team will then determine an appropriate course of action. Relapse occurrences of civilian employees and Family members will be assessed by the counseling staff in consultation with the client.

8–16. Re-enrollment

a. Only under extraordinary conditions will the Soldier be reenrolled (see para 7–1 of this regulation). Reenrollment in the ASAP requires completion of a termination DA Form 4466 (Patient Progress Report (PPR)) and a new DA Form 4465 (Patient Intake/Screening Record (PIR) for enrollment.

b. The counseling staff, in consultation with the client, will evaluate on a case-by-case basis, re-enrollment as a credible option for civilian employees and Family members.

8–17. Appointments

a. Rehabilitation success is enhanced by the Soldier's uninterrupted participation in counseling. Consistent with mission requirements, unit commanders will ensure that the Soldier's rehabilitation plan is followed. The counseling appointment at the ASAP will be considered the Soldier's appointed place of duty. Appointments will be scheduled so as not to interfere with the Soldier's duty requirements, in so far as possible. Counselors may schedule appointments during duty and non-duty hours, as resources permit. When Soldiers are engaged in field exercises that conflict with the counseling appointments, the unit commander or First Sergeant will notify the counselor of the impending field exercises. The counselor will reschedule to accommodate the field training. Only the commander or First Sergeant can cancel an appointment.

b. Counseling appointments for civilian employees and Family members will be scheduled to meet client and counseling staff schedules.

8–18. Return to duty

To facilitate a return to duty following rehabilitation, the Soldier's unit commander must:

a. Assign duties commensurate with abilities, experience, and Military Occupational Specialties.

b. Require compliance with the same standards of performance and behavior expected of other Soldiers.

c. Provide positive support.

d. Encourage the Soldier to participate in the recommended rehabilitation follow-up plan.

8–19. Self-help groups

a. As part of the rehabilitation plan, the Soldier will be encouraged to attend and participate in AA and/or other self-help groups. The rehabilitation plan will specify an appropriate number of meetings per week the client will be encouraged to attend. Under no circumstances will self-help groups be required to provide the names of members. Participation in a self-help organization cannot be used as the sole criterion for rehabilitation success or failure.

b. Unit commanders and ASAP staff should become familiar with self-help organizations.

c. Installations may facilitate the formation of self-help organizations on military installations and provide assistance as appropriate

8–20. Unacceptable rehabilitation modalities

a. Methadone maintenance will not be used.

b. Use of Disulfiram (Antabuse) will not be mandatory.

8–21. Counseling staff standards/competency

a. The ASAP clinical providers will have a master's degree in social work or psychology from a regionally accredited university and a state issued independent license, as well as have passed an examination administered by an Army approved certifying body that provides certification in substance abuse rehabilitation. They perform screening/ assessment, provisional diagnostics, treatment planning/delivery, and after-care of individuals impaired by substance abuse. These efforts in rehabilitating Soldiers assist the Army through manpower conservation, mission readiness, and environmental safety.

b. The ASAP clinical providers will have a minimum of a master's degree in social work or psychology from a regionally accredited university, and will have passed an examination administered by an Army-approved certifying body that provides certification in substance abuse rehabilitation, as well as a state independent licensing examination in the discipline in which they matriculated at the independent provider level. NOTE: Licensed Marriage Family Therapists may be accepted if the applicant has at least 60 graduate hours in psychology. They must also have special training, a minimum of 1 year full-time experience in substance abuse rehabilitation, and must adhere to the ASAP Clinical Code of Ethics. Both counselors and Clinical Directors must have current competence, as defined by the JCAHO in substance abuse rehabilitation. Clinical Director candidates must also have a minimum of 1 year's program management experience. NOTE: ASAP counseling positions require a minimum of 2 years' sobriety or post-rehabilitation period. Appointments or placements are subject to prior approval by an addiction medicine specialist at the Regional Medical Command or the Army Medical Command. Review of the packet and other records will determine whether the applicant had substance abuse, ethical infractions, or other disqualifying actions in the past 2 years. Forwarded recommendations will be accompanied by the completed pre-employment verification package (see AR 690–300). In addition to new hires, pre-employment verification procedures also apply to transfers from other agencies, assignments within the Army, Priority Placement Program placements, and any other situation where personnel are assigned clinical ASAP duties.

c. See specific requirements for Categories I–IV on the current substance abuse credentialing DA Form 5440–58 (Delineation of Clinical Privileges – Substance Abuse Rehabilitation).

d. In accordance with applicable medical regulations, USAMEDCOM will periodically review credentials and all ASAP counseling staff.

e. Clinical directors will assess the skills and training needs of each counseling staff member and prepare individual development plans. These plans will identify the skill needs of each member and will outline the steps planned to enhance the identified skills.

Section III
Detoxification

8–22. General

Detoxification involves the medical management of the withdrawal from alcohol or other drugs. The decision to hospitalize the Soldier is a medical decision. The unit commander will maintain contact with the Soldier undergoing detoxification and will participate in the detoxification effort when appropriate.

8–23. Line of duty determination

During detoxification, a line of duty determination is not required. One exception would be if a physician determined a patient to be incapacitated for more than 24 hours. In such cases, the determination will be "Not in Line of Duty Due to Own Misconduct" only for the period of actual incapacitation. (Refer to AR 600–8–4.)

Chapter 9
Prevention, Education, and Training

Section I
General

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

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

(1) Prevent, deter, and reduce alcohol and other drug abuse.

(2) Provide Soldiers with substance abuse prevention and awareness training to include at a minimum the following:

(a) The ASAP policies and services.

(b) Consequences of alcohol and other drug abuse.

(c) Incompatibility of alcohol and other drug abuse with physical and mental fitness, combat readiness, Army Values, and the Warrior Ethos.

b. Train, sustain and improve the skills, proficiency, and professionalism of garrison and counseling ASAP staffs, MROs, and UPLs 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 EAPCs.

9–2. Definitions

a. Prevention. Alcohol and other drug abuse prevention include all measures taken to deter and reduce the abuse or misuse of alcohol and other drugs to the lowest possible level. Prevention for 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.

b. 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 system.

9–3. Policy

a. Prevention efforts will be tailored to diverse groups and integrated with other mission-related efforts.

b. Prevention initiatives will emphasize cooperation and partnerships with the installation and local communities and encourage military involvement in local civilian community alcohol and other drug prevention efforts.

c. Education and training programs must include information on the effects and consequences of alcohol and other drug use. These programs must also include information describing which counseling and other substance abuse services are available at the installation.

d. Alcohol deglamorization 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.

e. Commanders and supervisors must be provided with the information and skills they need to enable early ID of substance abusers.

f. Alcohol and other drug abuse education will be conducted throughout the Army Training System.

g. Alcohol and other drug abuse instruction will be compatible with the indoctrination of recruits in the standards of discipline, performance, and behavior.

h. Leaders at all levels will support readiness through installation-wide prevention efforts.

i. The ACSAP will develop and distribute training support materials and prevention products to the garrison ASAPs. Training products will be updated periodically, be consistent with Army policy and be automated and capable of being electronically delivered whenever possible.

j. The USAMEDCOM, through the Army Medical Department Center and School (AMEDDC&S), will develop and offer training modules for ASAP counseling personnel. Training products will be updated periodically, be consistent with Army policy, and be automated and capable of being electronically delivered whenever possible.

Section II
Army Substance Abuse Program staff and unit prevention leader training, professional development and certification

9–4. Department of the Army sponsored Army Substance Abuse Program staff training

a. The Director, ASAP is responsible for developing the professional development training of the ASAP garrison staff and will manage lifecycle training through the Army Civilian Education System.

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

c. The garrison commander is responsible for resourcing the professional development training of all ASAP garrison positions. USAMEDCOM through the AMEDDC&S is responsible for the professional development training of all ASAP counseling positions.

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

9–5. 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) Give professional recognition to assigned positions.

(3) Assure continued professional development for PCs and EAPCs.

b. Alcohol and Drug Control Officer. The ADCOs will attend the ASAP Program Manager course within the first year of assuming the ADCO duties, and must complete the refresher course every 3 years thereafter.

c. Newly hired EAPCs must attain Certified Employee Assistance Professional (CEAP) status through the Employee Assistance Certification Commission (EACC) established by the Employee Assistance Professionals Association (EAPA) within 3 years of assuming their duties. The EAPCs who occupied their current positions on the date this regulation was published must gain CEAP status within 4 years of when they assumed 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 EAPCs.

(3) The EAPCs who fail to obtain their certification within 3 years of starting in that position or who fail to maintain their EAP certification will be subject to administrative actions and removal from their positions.

(4) The ADCOs are encouraged to gain CEAP.

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

d. Prevention coordinators must gain certified prevention professional status through ACSAP 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.

(3) The PCs who fail to obtain their certification within 3 years or fail to maintain their PC Certification may be subject to administrative actions and removal from their positions.

(4) The ADCOs are encouraged to gain certified PC status.

(5) It is highly recommended that PCs attend an instructor-certification course.

e. The DTCs must be of unimpeachable moral character, must be free of suspicion due to legal or 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. Utilizing non-certified 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 ADCO may request an exception to policy from the Director, ASAP.

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

(2) Primary and alternate DTCs will 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) The DTCs who fail to obtain their certification or fail to maintain their certification may be subject to administrative actions and removal from the position.

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

(6) The ADCOs 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) In coordination with CPAC, an ADCO may temporarily suspend a DTC from handling urinalysis specimens because of an alcohol or drug-related incident or pending legal or administrative proceedings until a final determination has been made on the DTC's suitability for remaining in the position.

(9) The DTCs are encouraged to volunteer to be added to the random drug testing pool.

9–6. Battalion/unit prevention leader qualifications, training and certification

Unit prevention leader (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 non-commissioned officer (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 ACSAP standardized certification training program prior to collecting any drug testing specimens.

(4) Possess unimpeachable moral character.

(5) Not be currently enrolled in the ASAP Rehabilitation Program.

(6) Not be under investigation for legal, administrative, or substance abuse related offenses or have had a drug or alcohol-related incident within the last 3 years. Soldiers that have previously been enrolled in the ASAP for counseling or completion of ADAPT should not be considered as potential UPLs for at least 36 months after release from counseling or completion of ADAPT.

(7) Commanders should request a local review of the UPL candidate's medical, personnel, and criminal records and a background check by the ASAP for past drug or alcohol treatment or positive urinalysis tests. The commander will make the final decision to appoint the candidate based on all the information received except that the requirements in paragraph 9–6*a* (1)-(6), above, are not waiverable.

b. Qualifications - Civilian personnel.

(1) If military personnel are not reasonably and consistently available to perform Unit Prevention Leader duties, those UPL duties may be performed by an Army corps civilian providing all of the following criteria are met:

(2) The employee must be GS–5/NSPS equivalent or above.

(3) The employee must be trained and certified as a UPL in accordance with AR 600–85 requirements and must be, thereafter, recertified annually.

(4) The UPL duties must be annotated in the employee job description as an additional duty to their primary duties.

(5) Trained and certified DTCs can serve as UPL in accordance with the criteria set forth in paragraph b(1), above.

c. The UPLs must be certified to perform their duties by successfully completing the DA UPL Certification Training Program (CTP), a standardized course of instruction and evaluation. No other UPL certification course is authorized without the written approval of the Director, ASAP. If a UPL candidate is deployed, they may be certified using the distance learning and certification procedures explained at www.acsap.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) The UPLs must recertify every 18 months by successfully completing the UPL CTP exam. If a UPL's certification expires while they are deployed, the UPL may recertify using the distance learning and certification procedures at www.acsap.army.mil. If a UPL fails the re-certification exam, they must retake the entire UPL CTP before retaking the exam.

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

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

9–7. Collection site personnel qualifications, training and certification

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

a. Qualifications:

(1) Be a civilian corps member (certified DTC or GS–05 or above or NSPS Pay Ban equivalent), officer, warrant officer or non-commissioned officer (E–5 or above).

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

(3) Successfully complete the ACSAP standardized certification training program prior to collecting any drug testing specimens.

(4) Possess unimpeachable moral character.

(5) Not be currently enrolled in the ASAP Rehabilitation Program.

(6) Not be under investigation for legal, administrative, or substance abuse related offenses or have had a drug or alcohol-related incident within the last 3 years. Individuals that have previously been enrolled in the ASAP for rehabilitation should not be considered as CSP candidates for at least 36 months after release from rehabilitation.

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

c. Recertification:

(1) The CSPs must recertify every 12 months by successfully completing the CSP CTP exam. If a CSP's certification expires while they are deployed, the CSP may recertify using the distance learning and certification procedures at www.acsap.army.mil. If a CSP fails the re-certification exam, they must retake the entire CSP CTP before retaking the exam.

(2) If a CSP's certification expires, the CSP 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 CSP is not authorized to collect drug testing specimens. If a CSP's certification has been expired for more than 90 days, then the CSP must retake the entire CSP certification course.

(3) The ADCOs may revoke the certification of any CSP for an excessive number of discrepancies in drug testing collection procedures, urinalysis specimens, or on associated forms. However, if the CSP is military, the ADCO must immediately notify the CSP's commander in writing of such revocation and the purpose for it.

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

9–8. 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 civilian corps member (GS–05 or above), officer, warrant officer or non-commissioned officer (E–5 or above).

(b) Be designated on appointment orders by the ADCO.

(c) Successfully complete the ACSAP standardized certification training program prior to collecting any drug testing specimens.

(d) Possess unimpeachable moral character.

(e) Not be currently enrolled in the ASAP Rehabilitation Program.

(f) Not be under investigation for legal, administrative, or substance abuse related offenses or have had a drug or alcohol-related incident within the last 3 years. Individuals that have previously been enrolled in the ASAP for rehabilitation should not be considered as candidates for at least 36 months after release from rehabilitation.

(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 shall 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 ADCOs may revoke the certification of any DOT Drug Test Collector for an excessive number of

discrepancies in drug testing collection procedures, urinalysis specimens, or on associated forms. However, if the DOT Drug Test Collector is military, the ADCO must immediately notify their commander in writing of such revocation and the purpose 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 listed in this section.

d. The DOT Drug Test Collectors, STTs, and IBATs are encouraged to volunteer to be added to the random drug testing pool.

9–9. United States Army Medical Command sponsored Army Substance Abuse Program training

a. The USAMEDCOM is the proponent for all counseling and medically-related training. Under MEDCOM direction and oversight, formal courses will be offered by AMEDDC&S which will be publish a training schedule with complete course descriptions and eligibility criteria. Course nominations will be forwarded annually to AMEDDC&S Alcohol and Drug Training Section. Newly assigned CCs and CDs will attend an orientation training session at AMEDDC&S within 120 days of assignment. All other counseling personnel will attend required training within 6 months of assignment. All counseling staff will attend AMEDDC&S-sponsored continuing education training in order to maintain counseling skills and remain current with DA policies. The AMEDDC&S will sponsor Additional Skill Identifier training (M8 and Z qualifier) for eligible active and reserve component Soldiers.

b. Clinical consultants will receive the orientation described in paragraph 9–8*a*, above, and will be offered continuing medical education training at AMEDDC&S every 2 years.

c. The CDs will receive orientation described in paragraph 9–8a, above, and will participate in continuing education training at AMEDDC&S.

d. Civilian counselors will attend required AMEDDC&S courses within 6 months of assignment and will complete continuing education training at AMEDDC&S.

e. The MROs will attend MEDCOM-sponsored MRO training (and retraining every 3 years) and become certified to review urinalysis drug testing results within the first 6 of duty assignment.

Section III
Education and training requirements

9–10. Deployment training

a. The ACSAP and installation ASAPs will provide substance abuse awareness training during predeployment and redeployment training.

b. The AMEDDC&S will design and furnish deployment-specific training packages for behavioral health and combat stress control medical units.

c. Commanders of all components will ensure that they deploy with at least 2 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.

9–11. Leadership training and schools

a. The TRADOC will ensure that current and appropriate substance abuse awareness training and information on the ASAP occurs at initial entry and pre-commissioning and is 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, ASAP.

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

9–12. Soldier substance abuse 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. In addition, corporals and above will receive information on the signs and symptoms of drug and alcohol abuse and how to refer a suspected or verified abuser to the ASAP.

b. All Active Army Soldiers, to include Active National Guard and USAR Soldiers, will receive a minimum of 4 hours of alcohol and other drug abuse awareness training per year in accordance with TRADOC Reg 350–70. When in an inactive status, Army National Guard and USAR Soldiers will receive a minimum of 2 hours of alcohol and other drug abuse awareness training per year in accordance with TRADOC Reg 350–70. The ASAP staff should provide at least one of the 4 hours of training to each unit on the installation per year.

c. All unit substance abuse training whether conducted by the commander, UPL, the ASAP staff, or a guest speaker