

Army Regulation 600–85

Personnel—General

The Army Substance Abuse Program

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

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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).

Effective 17 February 2009

Personnel—General

The Army Substance Abuse Program

By Order of the Secretary of the Army:

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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 2-19a 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 nonattribitional 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 UPLs 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 be 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 4–11c 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 10–9a(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).
- g.* 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 thereof, 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/MS/ command, and will then forward the test results to the respective commanders in a secure fashion that complies with the provisions of the Privacy Act. 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.

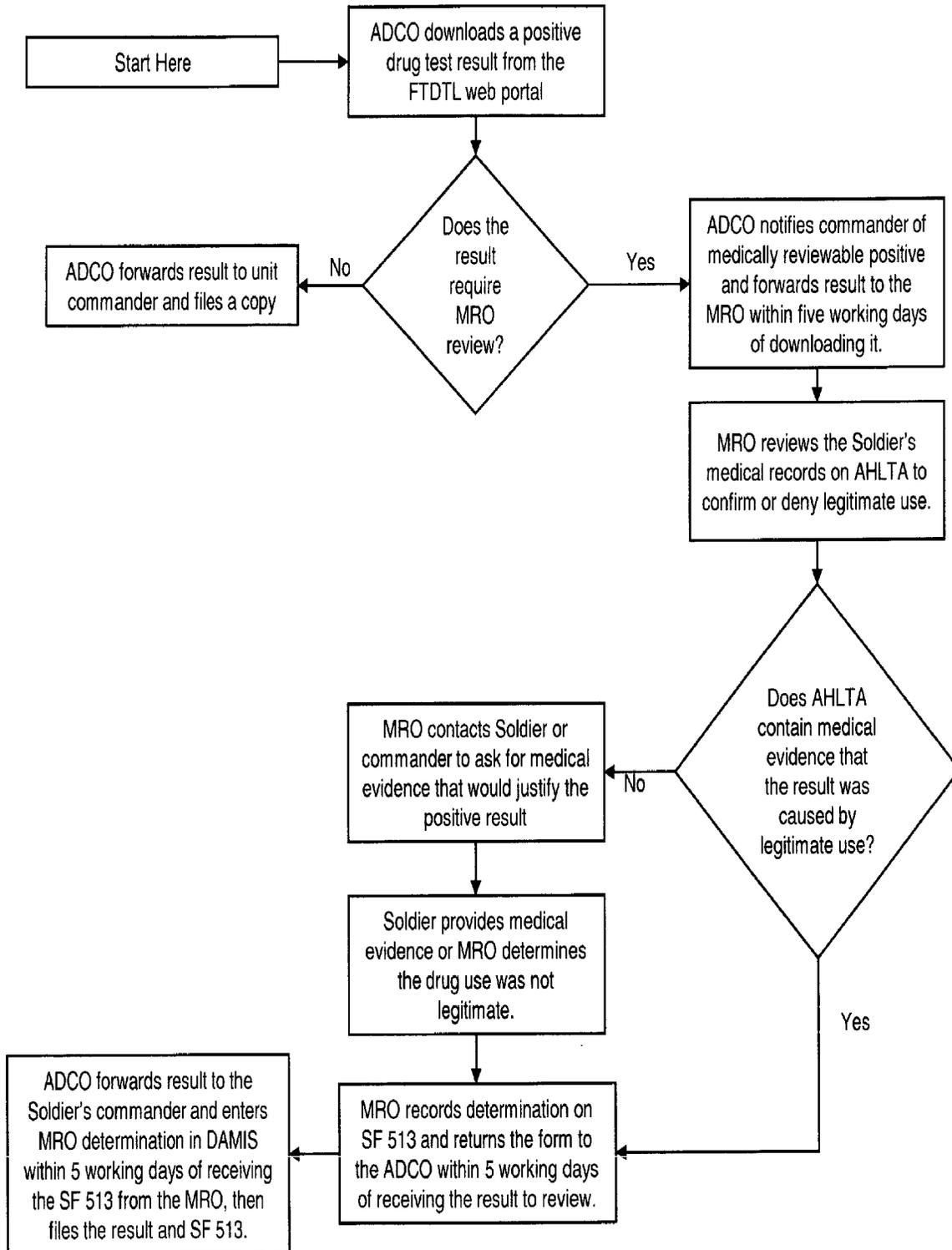


Figure 4-1. The Medical Process

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/SpecimenCollection/UrnSpecmnHndbk.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 Designated 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 from 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 9-6a (1)-(6), above, are not waivable.

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 9–8a, 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

will be documented using a sign-in sheet to record who attended, the topic, the date, the start time, and end time of the class. A copy of the sign-in sheet will be provided to the ASAP staff within 5 working days.

9–13. Civilian substance abuse awareness training

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

- (1) ASAP services to include the Employee Assistance Program.
- (2) The location and hours of operation of ASAP services.
- (3) Community laws.
- (4) Command policies.
- (5) Confidentiality.
- (6) When they are subject to drug testing including reasonable suspicion and post accident testing.
- (7) Employees in Testing Designated Positions (TDPs) and employees subject to DOT drug and alcohol testing will receive information on selection methods and testing procedures.
- (8) The supervisors of employees subject to DOT drug and alcohol testing will receive the required training outlined in 49 CFR 382, Sections 382.601 and 382.603.

b. All new supervisors' will, within 60 days assuming the supervisory position, receive information on:

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

c. The ASAP prevention, education and training for civilian corps members will be provided in conjunction with, but not be limited to, existing civilian personnel orientations and training programs. All civilians will receive a minimum of 2 hours of alcohol and other drug awareness training per year in accordance with TRADOC Regulation 350–70. Employee education will address:

- (1) ASAP policies, the Army DFW Civilian DTP, DOT Drug Use and Alcohol Misuse Rules and requirements, and the availability of EAP services to include the EAP point of contact, telephone number, address, and hours of operation.
- (2) Types, effects, signs and symptoms of substance abuse and the hazards/effects of alcohol and other drug abuse on performance and conduct.
- (3) Program confidentiality.

9–14. Family member and K–12 substance abuse awareness training

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

b. The ASAP prevention education and training of Family members will be addressed in the annual prevention plan. Attendance by Family members, retirees, and off duty contract personnel and their families will be on a voluntary basis. Training will highlight the local laws, extent of abuse, availability of counseling, rehabilitation services, and alternatives to alcohol and other drug abuse.

9–15. Alcohol and other drug abuse prevention training

a. The ADAPT is an educational/motivational intervention which focuses on the adverse effects and consequences of alcohol and other drug abuse. The ADAPT courses will consist of at least 12 hours of course material in accordance with TRADOC Reg 350–70.

b. The only currently DA-approved curricula is the ADAPT Manual published by the ACSAP; other commercial programs may be used if approved by ACSAP in advance. Requests for exceptions to the ADAPT curriculum or to conduct alternate curriculum research trials will be submitted in writing to the Director, ACSAP for approval.

c. The following personnel will and/or may attend ADAPT:

(1) All Soldiers that are referred to the ASAP for evaluation, but not enrolled will attend ADAPT. These personnel generally have been identified as first time abusers and do not require rehabilitation. Personnel who have previously attended an ADAPT class are not required to attend the class again unless directed by the counselor.

(2) Those Soldiers that are referred and enrolled in the rehabilitation program may attend ADAPT as an adjunct to the rehabilitation plan. The counselor will determine at what point in the rehabilitation process that the Soldier may attend ADAPT.

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

(4) Commanders wishing to have a Soldier attend the course for reasons related to poor performance, safety violations, high risk behaviors, and disciplinary problems, should refer the Soldier to the counseling ASAP for evaluation.

(5) The ADAPT training is permitted for civilian personnel and Family members on a space available basis.

9–16. Risk reduction training

a. Installations may request Risk Reduction Program Training for their installation prevention teams and installation activities through the IMCOM ADCO to ACSAP.

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

Section IV

Prevention strategies

9–17. Prevention planning

a. The PC, in coordination with the ADCO and EAPC, will develop an ASAP Prevention Plan each fiscal year. The ASAP Prevention Plan will be a detailed plan that addresses what and how prevention will occur. The plan will at a minimum address the following:

(1) Regulatory Requirements - such as mandatory training for Soldiers and civilians.

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

(a) The population being targeted.

(b) The activity/program/campaign goals.

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

(d) The evaluation method.

(e) Desired outcomes.

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

(4) Risk Reduction Program milestones such as data collection and submission, report printing, installation prevention team meetings and command briefings.

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

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

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

9–18. Science-based prevention

A review of science-based prevention programs suggests that effective substance abuse prevention programs must blend both individual and environmental approaches, apply multiple strategies in multiple settings and follow a logical design that includes assessment and evaluation. The Army must use the following seven strategies upon which science-based prevention programs are based to reduce the over all drug and alcohol abuse rates and increase mission readiness.

a. Policies. Commanders at all levels may establish additional policies to effectively reduce substance abuse.

b. Enforcement.

(1) Command enforcement

(a) In order for the substance abuse program to be effective, commanders at all levels must enforce established DOD, DA, and command policies. (for example, Soldiers identified as drug abusers must be processed for separation.)

(b) The deterrent or preventive effect of the DTP is only effective if Soldiers believe that they may be tested on any given day and that if they test positive that they will be subject to administrative separation and punishment.

(c) Commanders must take appropriate action against underage drinkers, suppliers of underage drinkers, and Soldiers who get DUIs or are involved in other alcohol-related incidents.

(2) Law enforcement and drug suppression activities. Comprehensive prevention programs include community law enforcement and drug suppression efforts that are designed to:

(a) Eliminate the supply of illegal drugs.

(b) Identify and apprehend individuals who illegally possess, use, or traffic illegal drugs.

(c) Prevent alcohol and other drug related crimes, incidents, and traffic accidents.

(d) Specific law enforcement responsibilities are identified in chapter 2 of this regulation.

c. Communications. The use of communications can increase public awareness substance abuse issues and problems, influence public opinion, and gain support for ASAP programs. Communication strategies include public education, marketing, and campaigns.

(1) The ASAP will educate the military community and market the ASAP by disseminating information on drug and alcohol abuse and ASAP services through the use of brochures, videos, public service announcements, local intranets, guest speakers and other programmed events such as health fairs and block parties.

(2) The ASAP will support national, DOD, and DA substance abuse awareness campaigns to the extent possible. At a minimum, each ASAP will support the Army's current substance abuse campaign as directed by the ACSAP and conduct, at a minimum, two events in conjunction with a DOD, DA, or national campaigns such as Red Ribbon Week, Drunk and Drugged Driving (3D) Prevention Month, or National Alcohol Screening Day.

(3) The ACSAP, based on available resources, will design, develop and distribute posters, pamphlets, and other prevention/campaign materials to the ASAPs in support of prevention efforts.

(4) The ASAP program is encouraged and authorized to purchase marketing and promotional items such as T-shirts, coffee mugs, pens, pencils, rulers, and so forth, in support of substance abuse prevention and risk reduction program campaigns. These items may be used to support and market the ASAP and/or local or Army-sponsored prevention campaigns such as Warrior Pride, National Drunk and Drugged Driving (3D) Prevention Month, National Red Ribbon Week, and National Alcohol Awareness Month. Promotional items purchased shall not indicate that the Army endorses a particular product or private organization. Purchase of promotional items must be consistent with current acquisition regulations.

d. Education and Training: The education and training of all members of the military community is a vital element of a comprehensive prevention plan. Commanders and supervisors must ensure that Soldiers and civilians receive all required education and training.

e. Collaboration.

(1) Prevention initiatives, when appropriate, will be community-based, emphasize military involvement, and be documented in a comprehensive IPP. This plan will promote and enhance healthy life choices; smart decision-making; the well-being of Soldiers, civilian employees, and Family members; and Army values.

(2) A human resources council or IPT will be established locally and will be composed of representatives of units and activities on the installation. When other uniformed Service installations are located nearby, reciprocal membership is encouraged. This council functions in an advisory capacity to the installation and garrison commanders and:

(a) Provides leadership, direction, and assistance in the design and development of the IPP, which will include a continuous assessment of installation prevention efforts to include substance abuse.

(b) Approves, monitors, and makes recommendations as necessary for the implementation of community prevention and risk reduction.

(c) Meets on a regular basis, but no less than quarterly. Minutes of each council meeting will be approved by the installation commander.

f. Alternatives.

(1) The ASAP will encourage and support community alternative alcohol free activities designed to entertain Soldiers, civilians and Family members.

(2) Commanders at all levels will support installation alternative alcohol free activities.

(3) Commanders will ensure that non-alcoholic beverages are available at all unit functions for non-drinkers.

g. Early Intervention.

(1) It is imperative that commanders and supervisors are trained to identify Soldiers and employees that are at risk for substance abuse as early as possible and refer them to the ASAP for evaluation.

(2) The Unit Risk Inventory (URI) and the Reintegration Unit Risk Inventory (R-URI) and the Risk Reduction Program are tools that commanders at all levels should utilize to identify potential problems and provide early educational/motivational interventions.

h. Evaluation.

(1) The ADCOs evaluate all ASAP garrison functions in accordance with chapter 13 and appendix D of this regulation.

(2) The ADCO, in coordination with the PC and EAPC will evaluate substance abuse prevention activities annually in accordance with chapter 13 and appendix D of this regulation.

(3) The ADCO, in coordination with the IPT, will evaluate substance abuse prevention-related risk reduction program activities identified in the IPP in accordance with chapter 13 and appendix D of this regulation.

Chapter 10

Legal and Administrative Procedures, and Media Relations

Section I

General

10-1. Overview

a. This chapter addresses legal and administrative actions and procedures involving drug and alcohol use by Soldiers and civilian corps members.

b. Participation in the ASAP rehabilitation program need not interfere with normal command administrative actions.

c. Legal requirements and guidelines for the ASAP must be consistent with the provisions of PL, civil and criminal court decisions, DOD directives, and other ARs. (See AR 340-21; 5 USC 552a (Privacy Act); part 2, chapter 1, title 42, Code of Federal Regulations; the Confidentiality Law, 42 USC 290dd-2; and AR 40-66 concerning confidentiality). It is essential that the legal issues of the ASAP be clearly understood by all levels of command and supervision and that legal procedures and protections be understood by all potential clients. The intent of applicable laws and regulations is to protect the privacy and personal confidences of the ASAP client. These laws and regulations do not conflict with the Army mission or standards of discipline when applied properly. Program effectiveness, as well as quality of client care, will depend upon the manner in which the ASAP is executed. These restrictions apply to individual client personal information and should not impair exchange of general information between staff agencies.

10-2. Policy

a. All attempts by any means to avoid providing a urinalysis specimen when selected or ordered, to dilute a urine specimen to reduce the quantitative value of that specimen when confirmed by Gas Chromatography/Mass Spectrometry (GC/MS), to substitute any substance for one's own urine, to chemically alter, adulterate, or modify one's own urine, or to assist another Soldier or civilian corps member in doing any of these actions are direct violations of the Army's official urinalysis program. Soldiers who violate this paragraph are punishable under the Uniform Code of Military Justice. Penalties for violating this paragraph include the full range of statutory and regulatory sanctions, both criminal and administrative. Civilian corps members who violate the provisions of the Federal Drug Free Workplace and DOT Testing Programs may be subject to the full range of disciplinary or adverse administrative actions or both.

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

c. Supervisors may direct any of their subordinate civilian employees to provide a urine specimen:

(1) if the supervisor of a civilian employee in a TDP has a reasonable suspicion that the employee uses illegal drugs, or for any employee if the supervisor has a reasonable suspicion of on-duty use or impairment;

(2) if the employee has been involved in a qualifying accident or unsafe practice that is under an official Army investigation,

(3) as part of, or as follow-up to a counseling or rehabilitation program to which the employee, found to have used illegal drugs, has been referred to through the EAPC.

d. Supervisors should seek legal counsel before the urinalysis collection to help them confirm they have reasonable suspicion, but the collection may proceed without legal counsel if none is available. Supervisors must subsequently seek legal counsel to confirm that reasonable suspicion existed before using the drug test result in any adverse action.

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

10-3. Use of Soldiers' confirmed positive drug test results

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

Table 10–1
Use of Soldiers' confirmed positive test result

	Usable in Disciplinary Proceedings	Usable as Basis for Separation	Usable for characterization of Service
Search or seizure			
-member's consent (VO)	Yes	Yes	Yes
-Probable cause (PO)	Yes	Yes	Yes
Inspection		Yes	Yes
-random sample (IR)	Yes	Yes	Yes
-Unit (sweep) (IU)	Yes	Yes	Yes
-Other (command policy) (IO)	Yes	Yes	Yes
Medical			
-general diagnostic purposes (MO)	Yes	Yes	Yes
Fitness for duty			
-command directed (CO)	No	Yes	No
-Competence for duty (CO)	No	Yes	No
-mishap/safety investigation (AO)	No	Yes	No
Other			
-rehabilitation testing (RO)	No	Yes	No
-entrance testing (NO)	No	Yes	*No

Section II

Administrative and Uniform Code of Military Justice Actions for Soldiers

10–4. Administrative and Uniform Code of Military Justice options

a. Commanders may take the following actions against Soldiers who test positive for illegal drugs or for illicit use of legal drugs when a MRO determines the Soldier has no legitimate medical purpose for taking the drug:

(1) Administrative actions—

- (a) Oral or written counseling/reprimand.
- (b) Suspension of access to classified information.
- (c) Suspension of favorable personnel actions.

(d) The commander must initiate administrative separation in accordance with paragraph 1–7c(7) the retention/separation authority will decide if the Soldier is retained or separated.

(2) UCMJ actions—

- (a) Nonjudicial punishment.
- (b) Court Martial.

b. Any legal or administrative actions should be based on the substance abuse-related incident that resulted in the referral to the ASAP; actions will NOT be based on the screening or enrollment determinations.

10–5. Suspension of security clearance or duty

a. All confirmed positive tests for a drug with a possible legitimate medical use as determined by USAMEDCOM must be evaluated by a MRO before any adverse action is taken against a Soldier or civilian corps member and prior to reporting the result to the CCF.

b. Commanders and Heads of an organization may suspend the access to classified material of any Soldier or civilian corps member who has a positive drug test that has been confirmed by the MRO, when such result raises a serious question as to the individual's ability or intent to protect classified information. This includes the period of time from when a Soldier or civilian corps member requests a retest of the positive result until the result of the retest has been received. If the retest does not confirm the positive result, the commander or head will reinstate access to classified material. (Refer to AR 380–67.)

c. Commanders and Heads of organizations will notify the certifying official promptly when one of their Soldiers or

civilian corps members in a PRP-designated position receives a positive urinalysis test result that is confirmed by a MRO.

10-6. Separation actions

Illicit drug use is grounds for disciplinary action under the UCMJ and/or the initiation of administrative separation proceedings. In addition to the rules for administrative separation actions and boards (refer to AR 600-8-24 and AR 635-200), the following rules apply to administrative separation actions and boards for illicit drug abuse:

a. Drug test results from an Army FTDTL normally can be substantiated by a “Laboratory Documentation Package” alone (see para 11-7 of this regulation). Counsel for the respondent will be allowed adequate opportunity to interview laboratory officials before the board date.

b. A respondent’s request for production of an expert witness should not be approved automatically. As with any other witness request, the burden is on the requesting party to demonstrate the relevance of the witness’ testimony. Even when relevance has been established, alternative forms of testimony, to include telephonic testimony, may be an adequate substitute to a personal appearance.

c. When a unit commander, in consultation with the ASAP counseling staff, determines that rehabilitative measures are not practical and that separation action will be initiated, the following procedures are required:

(1) All Soldiers, to include USAR Soldiers, identified as illegally abusing drugs will be processed for administrative separation in accordance with appropriate enlisted or officer separation regulations.

(2) Soldiers diagnosed as being drug dependent by a physician will be detoxified and then processed for administrative separation in accordance with appropriate enlisted or officer separation regulations, and be considered for disciplinary action under the UCMJ. These individuals should be referred to VA medical facilities under the conditions listed in paragraph 8-13 of this regulation.

(3) Soldiers who are rehabilitation failures will be processed for administrative separation when:

(a) The member is enrolled in the ASAP.

(b) The unit commander determines that further rehabilitation efforts are not practical (for example, a rehabilitation failure).

(4) When not precluded by the Limited Use Policy (see para 10-13 of this regulation), offenses of alcohol or other drug abuse may properly be the basis for discharge proceedings under appropriate enlisted or officer separation regulations. The evidentiary aspect of the Limited Use Policy is applicable to discharges under appropriate enlisted or officer separation regulations. Soldiers processed for separation under other provisions of that regulation, who also are or become subject to separation under this chapter and whose proceedings on other grounds ultimately result in their retention in the Service, will be considered for separation under this chapter.

(5) When the unit commander determines that a Soldier who has never been enrolled in the ASAP lacks the potential for further useful service, the Soldier will be evaluated by the ASAP counseling staff in accordance with this regulation. If found nondependent, the Soldier will be considered for separation under the appropriate provisions of appropriate enlisted or officer separation regulations.

(6) Soldiers identified for separation in accordance with guidance contained in this paragraph will be reported to the CCF in accordance with AR 380-67.

10-7. Granting leave

Commanders may grant leave to Soldiers who have tested positive for illicit drugs. (Refer to AR 600-8-10).

10-8. Transfer to the Department of Veterans Affairs

a. Alcohol or other drug dependent Soldiers may be transferred to VA Medical Treatment Facilities only under the following conditions:

(1) When within 30 days of separation.

(2) On the Soldier’s written request for transfer and additional rehabilitation.

b. The request will specify the length of rehabilitation to which the Soldier agrees. No Active Army Soldiers will be transferred to the VA through medical channels without completing the separation process. (Refer to AR 635-200.)

10-9. Actions before, during and after deployments and reassignments

a. Deployments.

(1) Legal and administrative actions against a Soldier on deployment orders with a confirmed positive drug test may be suspended at the discretion of the separation authority until the Soldier’s unit redeploys from the theater of combat operations.

(2) The unit commander in consultation with the ASAP counseling staff will determine the deployment availability of Soldiers enrolled in the ASAP. The same standards used for other medical treatment will be applied. Ordinarily, Soldiers:

(a) Enrolled in the ASAP who are receiving Level I services are deployable.

(b) Undergoing inpatient detoxification have a temporary physical profile and are not deployable.

(c) Participating in, or awaiting admittance to, an ASAP partial inpatient care program are deployable.

b. Reassignments.

(1) Continuity of client counseling is critical to successful rehabilitation. The losing CD will monitor the departure of enrolled Soldiers, notify the gaining ASAP, and ensure that ASAP client records are forwarded through the local MTF's Patient Administration Division to the gaining ASAP counseling center. If the losing ASAP counseling center is unable to determine the location of the gaining ASAP counseling center within 60 days, the losing CD will provide ACSAP with the Social Security Account Number. The ACSAP will then query the Total Army Personnel Database for assignment information and contact the gaining ASAP counseling center to verify the Soldier's assignment. The gaining ASAP counseling center will notify the losing ASAP counseling center and Patient Administration Division of the Soldier's assignment in the most expeditious manner and request the Soldier's ASAP outpatient medical record.

(2) To complete the mandatory follow-up outpatient program, patients who have received ASAP inpatient care should be stabilized in their current assignment for 12 months from the date of the inpatient enrollment. The servicing ASAP CD will provide the effective date of stabilization (date of enrollment) to the Military Personnel Office for enlisted personnel or the appropriate DA Assignment Authority for officers. Soldiers serving in CONUS should be stabilized in their present unit assignment for 12 months from the date of inpatient enrollment, and their records should be annotated to ensure stabilization. Soldiers serving OCONUS will not be involuntarily extended beyond their established Date Eligible for Rotation Overseas to complete the mandatory follow-up Level I program. Follow-up rehabilitation can be obtained at the next CONUS duty station. However, unit commanders should encourage Soldiers to extend their overseas tour voluntarily, under the provisions of AR 614-30, paragraph 6-2g, to receive the maximum benefit of this program. Stabilization may be terminated, requests for early termination of the 12 month stabilization will be forwarded through USAMEDCOM (MCHO-CL-H), 2050 Worth Road, Fort Sam Houston, TX 78234-6000 to HQDA (DAPE-HRS) Army Center for Substance Abuse Programs, 4501 Ford Avenue, Suite 320, Alexandria VA, 22302.

Section III

Legal actions for Soldiers

10-10. Law enforcement relationship to the Army Substance Abuse Program

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

b. Title 42, Code of Federal Regulations, prohibits undercover agents from enrolling or otherwise infiltrating an alcohol or other drug treatment or rehabilitation program for the purpose of law enforcement activities. This restriction does not preclude the enrollment in the ASAP, for rehabilitation purposes, of MP, USACIDC, or other investigative personnel who have an actual alcohol or other drug abuse problem. Their law enforcement status must be made known to the ADCO and Clinical Director at the time of their enrollment. These measures are for the protection of the law enforcement client as well as the ASAP.

c. The PM and the ADCO will exchange information for the purpose of identifying drug abuse trends, drug "trouble spots," and high-risk areas to include specific prevention efforts. This may include information on drug prevalence by type of drug, cost, strength and purity, and current drugs of choice. This exchange of information will be specific and will not mention names or social security numbers of any client nor violate program confidentiality.

d. If requested by USACIDC, the ADCO will provide a report that contains the number and type of drug positives by unit, excluding positive results for drugs that must be medically reviewed until the medical review has been completed. The report will not contain Soldier-specific information, such as names or social security numbers.

10-11. Limited Use Policy

The objectives of the Limited Use Policy are to facilitate the ID of Soldiers, who abuse alcohol and other drugs by encouraging ID through self-referral to facilitate the rehabilitation of those abusers who demonstrate the potential for rehabilitation and retention. When applied properly, the Limited Use Policy does not conflict with the Army's mission or standards of discipline. It is not intended to protect a member who is attempting to avoid disciplinary or adverse administrative action.

10-12. Definition of the Limited Use Policy

a. Unless waived under the circumstances listed in paragraph 10-13d of this regulation, Limited Use Policy prohibits the use by the government of protected evidence against a Soldier in actions under the UCMJ or on the issue of characterization of service in administrative proceedings. Additionally, the policy limits the characterization of discharge to "Honorable" if protected evidence is used. Protected evidence under this policy is limited to:

(1) Results of command-directed drug or alcohol testing that are inadmissible under the MRE. Commanders are encouraged to use drug or alcohol testing when there is a reasonable suspicion that a Soldier is using a controlled

substance or has a blood alcohol level of .05 percent or above while on duty. This information will assist a commander in his determination of the need for counseling, rehabilitation, or medical treatment. Competence for duty tests may be directed if, for example a Soldier exhibits aberrant, bizarre, or uncharacteristic behavior, but PO to believe the Soldier has violated the UCMJ through the abuse of alcohol or drugs is absent. Competence for duty test results may be used as a basis for administrative action to include separation, but shall not be used as a basis for an action under the UCMJ or be used to characterize a Soldier's service.

(2) Results of a drug or alcohol test collected solely as part of a safety mishap investigation undertaken for accident analysis and the development of countermeasures is further described in paragraph 4–5.

(3) Information concerning drug or alcohol abuse or possession of drugs incidental to personal use, including the results of a drug or alcohol test, collected as a result of a Soldier's emergency medical care solely for an actual or possible alcohol or other drug overdose. To qualify for Limited Use protection, Soldiers must inform their unit commander of the facts and circumstances concerning the actual or possible overdose. The commander must receive this information as soon after receipt of the emergency treatment as is reasonably possible. If treatment takes place at a civilian facility, the Soldier must give written consent to the treating civilian physician or facility for release of information to the Soldier's unit commander concerning the emergency treatment rendered. If the medical treatment resulted from an apprehension by military or civilian law enforcement authorities, or if the admission for treatment resulted from other than abuse of alcohol or drugs, such as for injuries resulting from a traffic accident, the limited use protection will not be available to the Soldier.

(4) A Soldier's self-referral to the ASAP.

(5) Admissions and other information concerning alcohol or other drug abuse or possession of drugs incidental to personal use occurring prior to the date of initial referral to the ASAP and provided by Soldiers as part of their initial entry into the ASAP. This includes an enrolled Soldier's admission to a physician or ASAP counselor concerning alcohol or other drug abuse incidental to personal use occurring prior to the initial date of referral to the ASAP.

(6) Drug or alcohol test results, if the Soldier voluntarily submits to a DOD or Army rehabilitation program before the Soldier has received an order to submit for a lawful drug or alcohol test. Voluntary submission includes Soldiers communicating to a member of their chain of command that they desire to be entered into a rehabilitation program. This limited use protection will not apply to test results, which indicate alcohol or other drug abuse occurring after the voluntary submission to the rehabilitation program. Examples: The unit commander has ordered a urinalysis on Monday for all members of the unit (an inspection under MRE 313). Before receiving an order (or having knowledge of a pending test) to appear for the urinalysis, a Soldier approaches the platoon sergeant, admits having used illegal drugs over the weekend, and indicates a desire to receive help. Later that day, the Soldier is ordered to and provides a specimen for the urinalysis, which results in a positive report for cocaine use. Those results are protected by the limited use policy unless there is some evidence that demonstrates the use reflected by the test occurred after the admission was made to the platoon sergeant. Later that week, the commander orders another unit inspection for the following Monday. The inspection is conducted properly under MRE 313, and the Soldier once again has a positive result for cocaine. These test results, as interpreted by an Army Forensic Toxicology Drug Testing Laboratory (FTDTL) expert, indicate the Soldier had used cocaine after admitting use to the platoon sergeant. This test result is not protected by the Limited Use Policy.

(7) The results of a drug or alcohol test administered solely as a required part of a DOD or Army rehabilitation or treatment program.

b. The Limited Use Policy does not prevent a counselor from revealing, to the commander or appropriate authority or others having a need to know, knowledge of certain illegal acts which may compromise or have an adverse impact on mission, national security, or the health and welfare of others. The unit commander will report the information to the appropriate authority. Likewise, information that the client presently possesses illegal drugs or that the client committed an offense while under the influence of alcohol or illegal drugs, other than prior illegal possession incident to the prior use, is not covered under this policy. Limited use is automatic. It is not granted, and it cannot be vacated or withdrawn. It may be waived in the situations described in paragraph 10–13d of this regulation.

c. An order from competent authority to submit to urinalysis or breath or blood alcohol test is presumed a lawful order. Soldiers who fail to obey such orders may be the subject of appropriate disciplinary action under the UCMJ.

d. The Limited Use Policy does not preclude the following:

(1) The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse (or lack thereof) has first been introduced by the Soldier. This rebuttal or impeachment may include evidence that test data indicate the presence of a controlled substance or alcohol, although not in sufficient quantity to meet the cutoff level for a positive result that has been established by DOD.

(2) The initiation of disciplinary or other action based on independently derived evidence, including evidence of continued drug abuse after initial entry into the ASAP.

e. If the command is made aware of a Soldier's illegal drug use through the Soldier's self-referral and admissions, the requirement to initiate separation proceedings pursuant to the appropriate enlisted or officer separation regulation

will not apply. The unit commander may initiate a separation action; however, the information is protected by the Limited Use Policy.

10–13. Implementation of the Limited Use Policy

a. Unit commanders will explain the Limited Use Policy to Soldiers during the commander’s interview as set forth in paragraphs 7–9, 15–14, and 16–11 of this regulation. Commanders will not make any agreement, or compromise, or expand the Limited Use Policy in any way.

b. One or more military associates of an actual or possible alcohol or drug overdose victim might be reluctant to assist the victim in obtaining emergency treatment from an MTF because they themselves are abusers of alcohol or other drugs. An assisting person may fear that adverse personal consequences could result from becoming involved. Although Limited Use protection is not extended automatically to such a person, the availability of the following options to those Soldiers and their commanders should reduce reluctance to assist the victim:

(1) Soldiers may seek help for their own alcohol or other drug problem from:

(*a*) Their unit commander.

(*b*) The physician at the MTF.

(*c*) Any other agency or individual described in chapter 7 of this regulation.

(2) If the unit commander suspects a Soldier of alcohol or other drug abuse, or possession of drugs incidental to personal use, solely because of a Soldier’s assistance to an actual or possible alcohol or drug overdose victim, and there is no reason to believe the Soldier provided illegal drugs to the victim, the commander should consult with the supporting legal office and thereafter may:

(*a*) Inform the Soldier of these suspicions.

(*b*) Ensure the Soldier is aware of the rehabilitation services available and the Limited Use Policy.

(3) If the Soldier admits to alcohol or other drug abuse and volunteers for help, the Limited Use Policy becomes effective as of the time the Soldier asks for help.

c. Soldiers will receive an honorable discharge regardless of their overall performance of duty, if discharge is based on a proceeding where the Government initially introduces limited use evidence except as authorized in paragraph 10–13d(1) of this regulation. The “Government” includes the following:

(1) The unit commander or intermediate commanders (in a recommendation for discharge or in documents forwarded with such a recommendation).

(2) Any member of the board of officers or an administrative separation board adjudicating the case.

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

(4) The separation authority.

d. Alternatively, if Limited Use evidence is improperly introduced by the Government before the board convenes, the elimination proceeding may be reinitiated, excluding all reference to the evidence protected by the Limited Use Policy. If the Limited Use evidence is improperly introduced by the Government after the board convenes, only a general court-martial convening authority may set aside the board proceeding and refer the case to a new board for rehearing. The normal rules governing rehearings and permissible actions thereafter will apply in accordance with the appropriate enlisted or officer separation regulations.

e. All situations that could arise in applying the Limited Use Policy in the field cannot be foreseen. As in other instances in which regulatory guidance is applied to an actual case, the commander should seek advice from the supporting legal office.

Section IV

Confidentiality regarding military personnel

10–14. Scope

a. This section prescribes policy and provides guidance on the release of information about abusers of alcohol or other drugs who are or have been enrolled in the ASAP. The primary intent of the references in paragraph 10–18 and of the policies in this section is to remove any fear of public disclosure of past or present abuse. It is also intended to encourage participation in a rehabilitation program.

b. The restrictions on disclosure prescribed in this section are allowed by the Freedom of Information Act (5 USC 552), 42 USC Sec 290dd-2 and 42 CFR Part 2, and the Privacy Act (5 USC 552a).

c. No person subject to the jurisdiction or control of the Secretary of the Army shall divulge any information or record of identity, diagnosis, prognosis, or treatment of any client. This includes any information which is maintained in connection with alcohol or other drug abuse education, training, rehabilitation, or research, except as authorized in 10–16 through 10–17, below.

10–15. Confidentiality of military client Army Substance Abuse Program information

a. The release and/or discussion of information within the Armed Forces concerning a Soldier’s abuse of alcohol and other drugs is governed by the restrictions contained in the 5 USC 552a, 42 USC 290dd-2), AR 40–66, and AR

340–21 and HIPAA. Such information will be made known to those individuals within the Armed Forces who have an official need to know. The restrictions on release of information outside the Armed Forces concerning Soldiers is prescribed by the laws regarding confidentiality of drug and alcohol abuse counseling records and information cited above.

b. Limited Use Policy does not prevent a counselor from revealing, to the appropriate authority, knowledge of illegal acts, which may have an adverse impact on mission, national security, or the health and welfare of others.

(1) ASAP counseling records are protected by the restrictions contained in The Privacy Act (5 USC 552a), 42 USC 290dd-2, AR 40–66 and AR 340–21, and the HIPAA of 1996 (Public Law 104–191 Section 264) and DOD 6025.18–R DOD Health Information Privacy Regulation. These records will be maintained by the ASAP counseling staff and stored for 5 years in accordance with Army Records Information System (ARIMS).

(2) The ASAP Clinical Director will periodically review ASAP client files. He or she will ensure that counselors maintain high ethical standards in recording only relevant ASAP counseling information.

(3) Commanders seeking information from an individual’s ASAP record must specify their need to know specific information. Their request must be made to the responsible Clinical Director for proper release of information. Commanders do not have unlimited access to review a client’s ASAP counseling notes or records.

(4) For clients in certain sensitive positions or with the PRP, counselors or medical personnel will immediately advise the commander if any information is provided by the client, which would serve to disqualify the person for continuation in any sensitive duty position. If the need to release the information is in doubt, it should be released to the commander based on that requirement to protect the interest of the U.S. Government.

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

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

10–16. Overview

a. Responding to an inquiry that concerns an abuser or former abuser of alcohol or other drugs is a complicated and sensitive matter. Requests for information may originate from a variety of sources and take a variety of forms. They may be direct (for example, from a parent) or through an intermediary (for example, a member of Congress inquiring for a parent). They may be received by written correspondence, by telephone, or during face-to-face conversation. Further, alcohol or other drug involvement may not surface until after an investigation has been initiated to provide information upon which to base a reply. The guidance contained in this section is intended to assist commanders or other officials receiving requests for information in preparing replies and complying with the policy contained in paragraphs 10–15 and 10–16, above; however it should not take the place of consulting with their servicing legal office.

b. In all cases where disclosure is prohibited or is authorized only with the client’s written consent, every effort should be made to avoid inadvertent disclosure. Even citing a referenced statute or this regulation as the authority for withholding information would identify the client as an abuser. Accordingly, replies to such inquiries should state that disclosure of the information needed to fully respond to the inquiry is prohibited by regulations and statutes. As appropriate, the reply may suggest that the inquirer contact the client directly. Where disclosure is permitted with the client’s written consent, an interim reply may state that an attempt will be made to obtain the client’s written consent.

c. The disclosure that an individual is not or has not been a client in the ASAP is fully as much subject to the prohibitions and conditions of the statutes and this regulation as a disclosure that such a person is or has been a client. Any improper or unauthorized request for disclosure of records or information subject to the provisions of this section should be addressed as specified in paragraph (2), above. Army policy is to neither confirm nor deny whether an individual has been a client in the ASAP.

d. Limitations on information. Any disclosure made under this section, with or without the client’s consent, shall be limited to information necessary in light of the need or purpose for the disclosure.

e. Written statements. All disclosure shall be accompanied by written statement substantially as follows: “This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any farther disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.” An oral disclosure, as well, should be accompanied or followed by such a notice.

f. Regulations governing release of information.

(1) To the extent that the contents of this section are in conflict with any other regulatory directives, the contents of this section will prevail.

(2) Disclosures authorized by this section are subject to further restrictions imposed by other regulatory directives pertaining to the release of information that are not in conflict with this section.

(3) This section does not prohibit release of information concerning the abuse of alcohol or other drugs from records other than those specified in paragraph 10–16. For example, a record of trial is not a record maintained in connection with alcohol or other drug abuse education, training, treatment rehabilitation, or research. If, in the judgment of the commander, disclosure of information not otherwise prohibited by this section would assist in providing an appropriate reply to an inquiry, the information may be released.

10–17. Disclosure to medical personnel or to rehabilitation programs

a. Disclosure to medical personnel, either private or governmental, to the extent necessary to meet a bona fide medical emergency, is authorized without the consent of the client. This includes emergency situations such as Family violence where there is spouse/child abuse of a potentially life threatening nature. If an oral disclosure is made under the authority of this paragraph, the CD will make a written memorandum for the record. This memorandum will be filed in the same manner as a written consent (see para 10–28, below). It will show the following:

- (1) The client's name.
- (2) The reason for the disclosure.
- (3) The date and time the disclosure was made.
- (4) The information disclosed.
- (5) The name of the individual to whom it was disclosed.

b. In other than emergency situations, the written consent of the client is required (see 10–28 below). Such disclosure may be made to medical personnel or to nonmedical counseling and other rehabilitative services to enable such individuals or activities to furnish services to the client.

10–18. Disclosure to a Family member or to any person with whom the client has a personal relationship

a. Written consent of the client is required (see para 10–28, below).

b. Written approval of a program physician or the Clinical Director that disclosure will not be harmful to the client is required (see para 10–28 and e, below).

c. The only information that is releasable is an evaluation of the client's current or past status in the ASAP.

10–19. Disclosure to the client's attorney

a. Written consent of the client is required (see para 10–28, below).

b. A bona fide attorney-client relationship must exist between an attorney and the ASAP client.

c. The attorney must endorse the DA Form 5018 (ADAPCF Client's Consent Statement for Release of Treatment Information).

d. Subject to the limitations stated by the client in their written DA Form 5018, any information from the client's ASAP records may be disclosed.

e. Information so disclosed may not be further disclosed by the attorney, unless the client explicitly consents in writing to the disclosure. General waivers of attorney-client privilege or authorization to share medical information are not sufficient for this purpose. The attorney's attention will be directed to section 2.32 chapter 1, 42 CFR.

10–20. Disclosure to client's designee for the benefit of the client

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

b. Disclosures under the provisions of this paragraph require written consent of the client (see para 10–28, below).

c. For the purpose of this section, the circumstances under which disclosure may be deemed for the benefit of a client include, but are not limited to, those in which the disclosure may assist the client in connection with any public or private—

- (1) Claim.
- (2) Right.
- (3) Privilege.
- (4) Gratuity.
- (5) Grant.
- (6) Or, other interest accruing to, or for the benefit of, the client or the client's immediate Family.

d. Examples of the foregoing include—

- (1) Welfare,

- (2) Medicare.
- (3) Unemployment.
- (4) Workmen's compensation,
- (5) Accident or medical insurance.
- (6) Public or private pension or other retirement benefits.
- (7) Any claim or defense asserted or which is an issue in any civil, criminal, administrative, or other proceeding in which the client is party or is affected.

e. The criteria for approval of disclosure are the following:

(1) The statutes and implementing regulation, chapter 1, title 42, CFR, provide specific criteria for disclosure in 2 of the circumstances under which such disclosure may be deemed for the benefit of the client.

(2) In any other benefit situation (such as those listed in para 10–17e(3), above), disclosure is authorized with the written consent of the client only if the CD determines that all of the following criteria are met:

(a) There is no suggestion in the written consent or the circumstances surrounding it, as known to the CD, that the consent was not given freely, voluntarily, and without coercion.

(b) Granting the request for disclosure will not cause substantial harm to the relationship between the client and the ASAP. Nor will it cause harm to the ASAP's capacity to provide services in general. This determination is to be made with the advice of the Clinical Director.

(c) Granting the request for disclosure will not be harmful to the client. This determination is to be made with the advice of the program Clinical Director.

10–21. Disclosure to employers, employment services, or agencies

a. Written consent of the client is required (see para 10–28, below).

b. Ordinarily, disclosures pursuant to this paragraph should be limited to a verification of the client's status in treatment or a general evaluation of progress in treatment. More specific information may be furnished where there is a bona fide need to evaluate hazards which employment may pose to the client or others or where such information is otherwise directly relevant to the employment situation.

c. Subject to the provisions of a and b, above, disclosure is authorized if the ADCO determines that the following criteria are met:

(1) There is reason to believe, on the basis of past experience or other credible information (which may in appropriate cases consist of a written statement by the employer), that such information will be used for the purpose of assisting in the rehabilitation of the client. Such information must not be disclosed for the purpose of identifying the individual as a client in order to deny him or her employment or advancement because of his or her history of alcohol or drug abuse.

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

10–22. Disclosures in conjunction with Civilian Criminal Justice System referrals

a. Written consent of the client is required (see para 10–28, below).

b. Disclosure may be made—

(1) To a court granting probation, or other post-trial or pretrial conditional release.

(2) To a parole board or other authority granting parole.

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

c. The client may consent to unrestricted communication between the ASAP and the individuals or agencies listed in (b), above.

d. Such consent shall expire 60 days after it is given or when there is a substantial change in the client's criminal justice system status, whichever is later. For the purposes of this paragraph, a substantial change occurs in the criminal justice system status of a client who, at the time such consent is given, has been sentenced, or when the sentence has been fully executed. Examples of substantial changes are the following:

(1) Arrested, when such client is formally charged or unconditionally released from arrest.

(2) Formally charged, when the charges have been dismissed with prejudice, or the trial of such client has been commenced.

(3) Brought to a trial which has commenced, when such client has been acquitted or sentenced.

e. A client's release from confinement, probation, or parole may be conditioned upon his or her participation in the ASAP. Such a client may not revoke his or her consent until there has been a formal and effective termination or revocation of such release from confinement, probation, or parole.

f. Any information directly or indirectly received by an individual or agency may be used only in connection with their official duties concerning the particular client. Such recipients may not make such information available for general investigative purposes. Nor may such information be used in unrelated proceedings or made available for unrelated purposes. The recipient's attention will be directed to Section 2.35, Chapter I, title 42, CFR.

10–23. Disclosures to the President of the United States or to Members of the United States Congress acting in response to an inquiry or complaint from the client

- a.* Written consent of the client is required (see para 10–28c, below).
- b.* Any information not otherwise prohibited from release by other regulations or directives may be disclosed. This is subject to the limitations stated by the client in their DA Form 5018.
- c.* This authority for disclosure from a client’s record does not extend to situations where the President or a Member of Congress is acting as an intermediary for a third party (such as the client’s parents or spouse). However, most correspondence concerning Army personnel that is addressed to the President is forwarded to the Army for direct reply to the inquirer. Such correspondence addressed to the President may be treated as inquiries directed initially to the Army.
- d.* The limitation in (c), above, should not be interpreted as a restriction on complete and accurate responses to inquiries on behalf of third parties concerning—
 - (1) The nature and extent of the drug and alcohol problem in a unit, installation, or command.
 - (2) A description of the ASAP, program facilities, techniques, or the like.

10–24. Disclosure for research, audits, and evaluations

Subject to AR 340–1 and this paragraph and paragraph 8–8 of this regulation, AR 340–21, a disclosure to qualified personnel for the purpose of scientific research, management or financial audit, or program evaluation is authorized whether or not the client gives consent.

- a.* The term qualified personnel means persons whose training and experience are appropriate to the nature and level of work in which they are engaged. These are persons who, when working as part of an organization, are performing such work with adequate administrative safeguards against unauthorized disclosures.
- b.* The personnel to whom disclosure is made may not identify, directly or indirectly, any individual client in any report of such research, audit, or evaluation. They may not otherwise disclose client identities in any manner. Personnel to whom disclosure is made will be reminded that Sections 2.52 through 2.53, Chapter I, Title 42, CFR apply.
- c.* In cases of scientific research, the restrictions contained in AR 340–1 apply.

10–25. Disclosure in connection with an investigation

Release of information to conduct an investigation against a civilian client or to conduct an investigation outside the Armed Forces against a military client is prohibited; the only exception is by order of a court of competent jurisdiction (see para 10–27, below). An investigation conducted by governmental personnel in connection with a benefit to which the client may be entitled (for example, a security investigation by an FBI agent in conjunction with the client’s application for Government employment) is not considered to be an investigation against the client. Hence, with the written consent of the client, the required information may be disclosed under the provisions of paragraph 10–21, above.

10–26. Disclosure upon court orders

- a.* Under the provisions of 42 USC 290-dd2(b)(2)(c) and subpart E, chapter 1, title 42, CFR, a court may grant relief from duty of nondisclosure of records covered by 21 USC 1175 and 42 USC 4582 and direct appropriate disclosure.
- b.* Such relief is applicable only to records as defined in the glossary. Such relief is not applicable to secondary records generated by disclosure of primary records to researchers, auditors, or evaluators in accord with/above.
- c.* Such relief is limited to only that objective data such as facts or dates or enrollment, discharge, attendance, and medication that are necessary to fulfill the purpose of the court order. And, in no event, may such relief extend to communications by a client to ASAP personnel.
- d.* Such relief may be granted only after strict compliance with the procedures, and in accord with the limitation, of subpart E, chapter 1, title 42, CFR. This is whether the court order deals with an investigation of a client, an investigation of the ASAP, under-cover agents, informants, or other masters.

10–27. Written consent requirement

- a.* Where disclosure of otherwise prohibited information is authorized with the consent of the client, such consent must be in writing and signed by the client, except as provided in I and K, below.
- b.* The client will be fully informed of the nature and source of the inquiry. And, he or she will be informed that his or her voluntary written consent is required to release information upon which to base a reply.
- c.* If the client consents to the release of all or part of the requested information, he or she will confirm that fact by signing the DA Form 5018.
- d.* As indicated in paragraph 10–19 above, the only information releasable to the client’s Family or to a person with whom the client has a personal relationship is information evaluating the client’s present or past status in a treatment or rehabilitation program. Release of such an evaluation requires not only the consent of the client, but also the approval of the Clinical Director. The Clinical Director must signify that in his or her judgment the disclosure of such information would not be harmful to the client.

e. In the judgment of the Clinical Director, release of information may be considered to be harmful to the client although the client has already signed the DA Form 5018. In this event, the inquirer will be informed that statutes and regulations prohibit the release of certain personal information.

f. The consent will be prepared in an original only-reproduction is not authorized. For a client actively participating in the program, it will be filed in the client's ASAP rehabilitation record. For a Soldier or Army civilian no longer in the ASAP at the time written consent is given, the form will be filed in the individual's health records.

g. The DA Form 5018 is not a continuing document. Its retention is to justify the specific disclosure described thereon and to maintain a record of that justification. Any future disclosure of information must be supported by a new DA Form 5018. Exception: Duration of consent for disclosures in conjunction with criminal justice referrals is prescribed in paragraph 10-23, above.

h. Where the client's unit commander provides information for a higher HQ reply to an inquiry, the forwarding correspondence will specifically verify that the consent—

- (1) Has been signed by the client and, where applicable, signed by the Clinical Director.
- (2) Has been, or will be, filed in the client's ASAP records.

i. If the client does not consent to the release of the requested information or if the client limits the scope of releasable information to the extent that an adequate reply is impossible—

- (1) He or she will be encouraged to correspond directly with the originator of the inquiry.
- (2) He or she will be informed that the reply to the inquiry will state that if no consent is given, statutes and regulations prohibit the release of personal information and will state that he or she has been requested to correspond directly with the inquirer. Or, if the client authorizes only the release of limited information, he or she will be informed that the reply will state this, and will state that he or she has been requested to correspond directly with the inquirer.

(3) Where the client's unit commander provides information for a higher HQ reply to an inquiry, forwarding correspondence will include a statement that—

- (a) The client refused to sign a form of consent or authorized the release of only limited information.
- (b) The client has been encouraged to correspond directly with the inquirer.

j. When disclosure is authorized with the consent of the client, such consent may be given by a guardian or other person authorized under state law to act in the client's behalf; this would only be in the case of a client who has been adjudged as lacking the capacity to manage his or her own affairs. Such consent may also be given by an executor, administrator, or other personal representative, in the case of a deceased client

k. When any individual suffering from a serious medical condition resulting from alcohol or other drug abuse is receiving treatment at a military medical facility, the treating physician may, at his discretion, give notification of such condition to a member of the individual's Family. Or, notification may be given to any other person with whom the individual is known to have a responsible personal relationship. Such notification may not be made without such individual's consent at any time he or she is capable of rational communication.

10-28. Verbal inquiries

a. Telephonic inquiries.

(1) Without violating the requirements of this section or other policies on the release of personal information, every effort should be made to provide the requested information.

(2) If the caller specifically requests information on a client's abuse of alcohol or other drugs, the following actions will be taken: (Such actions will also be taken if the answer to a more general question, such as health and welfare, would require the divulgence of information prohibited under the provisions of this section.)

- (a) Inform the caller that statutes and regulations prohibit the disclosure of such information.
- (b) Request that the caller submit a written request stating the specific type of information desired. Included must be the purpose and need for such information.

b. Inquiries made in face-to-face conversation. The policy and implementing guidance of this section make no exceptions for face-to-face inquiries. Commanders, supervisors, and staff officers should anticipate and be prepared to respond to such inquiries without compromising the client's personal privacy. The guidance on telephone inquiries (see para 10-28a, above) should be utilized for the disclosure.

10-29. Authority

- a. Confidentiality of Records (42 USC, 290dd-2).
- b. 42 CFR Part 2.
- c. The HIPAA of 1996 (Public Law 104-91 Section 2647).
- d. Privacy Act of 1974 (5 USC 552a).

10-30. Penalties

The provisions of this section apply to individuals responsible for any client record and to individuals who have knowledge of the information contained in client records. Such records include those maintained in connection with

alcohol or other drug abuse education, training, treatment, rehabilitation, or research. The criminal penalties for unauthorized disclosure of information protected by the Federal statute and regulations may include a fine of up to \$5,000 for each offense under the Privacy Act and up to a \$250,000 fine and 10 years of imprisonment under the HIPAA.

Section V

Administrative actions for civilian corps members

10–31. Disciplinary and adverse actions

a. Supervisors must consult with their servicing CPAC before initiating any formal disciplinary or adverse action and before offering an employee a referral to the ASAP. The servicing CPAC will advise the supervisor about options and responsibilities. For civilian corps members found to have used illegal drugs or to be impaired by alcohol while on duty, a range of disciplinary actions is available from a written reprimand to removal, except for employees who—

(1) voluntarily identify themselves as users of illegal drugs before being notified to provide a urinalysis or breath specimen or before being identified by other means, and

(2) obtain applicable counseling and rehabilitation, and, thereafter,

(3) refrain from illegal drug use for the duration of the employee's Federal employment,

b. Supervisors are required to begin administrative action, and have discretion in deciding what disciplinary measures to initiate, consistent with the requirements of the Civil Service Reform Act and other applicable factors. The following discretionary disciplinary measures may be available:

(1) Reprimanding the employee in writing.

(2) Suspending the employee for 14 days or less consistent with the procedural requirements in 5 CFR 752.203.

(3) Suspending the employee for 15 days or more consistent with the procedural requirements in 5 CFR 752.404.

(4) Suspending the employee, consistent with the procedural requirements in 5 CFR 752.404, until such time as he or she successfully completes counseling or rehabilitation or until management, in coordination with the CPAC, determines that action other than suspension is more applicable to the individual situation.

(5) Removing the employee from Federal Service, consistent with the procedural requirements of 5 CFR 752.404c. The following mandatory actions are required:

(6) Initiation of removal from Federal Service is required after a second finding that the employee has used illegal drugs.

(7) Initiation of removal from Federal Service of any employee who is found to use illegal drugs.

(a) Refuses to obtain counseling or rehabilitation through an Employee Assistance Program.

(b) Does not thereafter refrain from using illegal drugs.

c. Verified positive test results and information developed in the course of the drug testing of the employee, subject to the limitations of 5 U.S.C. 552a, PL 100–71, 42 USC 290dd-2, and 42CFR Part 2, may be considered in processing any adverse action against the employee or for other administrative purposes. Preliminary test results may not be used in an administrative proceeding.

d. The servicing CPAC will ensure that appropriate coordination with the labor counselor is accomplished.

e. Civilian corps members in TDPs who are found to use illicit drugs shall not remain in the TDP.

f. Upon successful completion of rehabilitation, or as a part of a rehabilitation program if progress is evident and the employee poses no danger to health, safety or security, the employee may be returned to the TDP. (Refer to Executive Order 12564, section 5 para (c), and DODD 1010.9 para F2d.)

10–32. Release Army Substance Abuse Program information to the media

a. This section provides guidance for the release to the news media of program information that does not identify any individual, directly or indirectly, as either an abuser or non-abuser of alcohol or other drugs.

b. This includes information concerning a former abuser of alcohol or other drugs. Release of information pertaining to DOD activities is the function of the Office of the Assistant Secretary of Defense (Public Affairs). The Office of the Chief of Public Affairs, HQDA, coordinates, plans, and monitors the execution of appropriate Army information activities.

10–33. Guidelines for releasing information

a. Unclassified factual information on the following may be provided to the news media in response to queries about:

(1) The Army's alcohol and other drug abuse program issues.

(2) The Army's alcohol and other drug abuse prevention and rehabilitation program as described in this regulation.

b. Tours of facilities and discussions with ASAP staff personnel must have the prior approval of the installation commander and, if appropriate, the MEDCEN/MEDDAC commander. Such tours or discussions will not be conducted at a time or location that could result in the ID of a client as an alcohol or other drug abuser.

c. Information on quantitative results for the urinalysis program and overall ASAP statistics will not be given until released by the Director, ASAP.

d. IMCOM will ensure that command information materials receive wide distribution and will respond to queries as provided in this section.

10-34. Administration

a. Public Affairs officers may communicate directly with the Office of the Chief of Public Affairs, HQDA.

b. Requests for authority to release additional information will be directed to HQDA (SAPA-PCD), 1500 Pentagon, Washington, DC 20310-1500.

Chapter 11 Drug Testing Laboratory Operations

11-1. General

The mission of the U.S. Army Forensic Toxicology Drug Testing Laboratories (FTDTL) is to deter drug abuse by forensically identifying drugs of abuse in DOD personnel, to assist commanders, MREs, and military lawyers in interpreting laboratory results, and to provide litigation and expert witness support for all adverse actions. The FTDTLs will detect drug use by measuring the parent drug or drug metabolite concentration in Soldiers' and civilian corps members' urine. Each specimen will be tracked under a strict chain of custody procedure. The FTDTLs will only report as positive those specimens that meet or exceed the levels established by DOD or DHHS. The cutoff concentration is well above the detection sensitivity of the instruments and procedures used in testing. FTDTLs will adhere to the operating guidance in DODI 1010.16 and this regulation.

11-2. Specimen receiving operations

a. Beginning with the receipt of specimens, the laboratory will maintain a record of each specimen bottle location and of each individual who has custody of the bottle in the laboratory.

b. The processing technician will assign a fatal (not tested) or nonfatal (tested) discrepancy code to specimens that are not submitted in compliance with appendix E. The laboratory will assign a discrepancy code to a specimen if the integrity of the specimen bottle or its packaging is compromised. The laboratory will not test such affected specimens.

11-3. Screening and confirmation process

a. For military specimens, the FTDTL will test every specimen a minimum of three times before reporting it as positive. If a specimen screens negative during its first test, it will be disposed of and reported as negative. The FTDTL will use an approved technique, such as gas chromatography/mass spectrometry (GC/MS), to confirm the presence of drugs in urine. The quantitative results of the GC/MS procedure will be compared to the published DOD cutoff levels. If the quantity of all the drug(s) or drug metabolite(s) is below the DOD cutoff levels, the specimen will be disposed of and reported as negative. If the quantity of the drug(s) or drug metabolite(s) in a specimen meets or exceeds the cutoff level, the quantity will be recorded and the specimen will be reported as positive for that (those) drug(s). Confirmed positive specimens will be frozen and retained for 1 year, which can be extended at the request of the commander of the Soldier with the positive specimen. Negative adulterated, substituted, and invalid specimens may be discarded after validity testing and transmission of the negative report.

b. For civilian specimens, the FTDTL will test specimens under guidelines established by the DHHS and PL. After screening, all specimens will receive a validity test to determine if they are human urine or have been diluted, adulterated, or substituted with some other substance. If a specimen is negative during the initial screening, it will be disposed of and reported as negative unless the validity test indicates that the specimen has been diluted, adulterated, or substituted with some other substance. If this is the case, then the lab will report the specimen as negative, but will retain the specimen and report the validity finding to the MRO. If a specimen screens positive for drug(s) or drug metabolite(s), a new aliquot of urine will be poured and forwarded for confirmation testing for the drugs that were found in the screening test. The FTDTL will use an approved technique, such as gas chromatography/mass spectrometry (GC/MS), to confirm the presence of drugs in urine. The quantitative results of the confirmation procedure will be compared to the published DHHS cutoff levels. If the quantity of all the drug(s) or drug metabolite(s) is below the DHHS cutoff levels, the specimen will be disposed of and reported as negative unless there is an issue with the validity of the specimen as discussed above. If the quantity of the drug(s) or drug metabolite(s) in a specimen meets or exceeds the cutoff level, the quantity will be recorded and the specimen will be reported as positive for that (those) drug(s). Confirmed positive specimens will be frozen and retained for 1 year. Negative specimens may be discarded after transmission of the negative report.

11-4. Quality control procedures

a. The FTDTL quality assurance program must monitor quality control, internal methods development, instrument

and drug certification, personnel certification, overall data review, instrument and equipment calibrations, open and blind proficiency performance, and external audits.

b. The FTDTLs will use quality control specimens during each phase of testing to ensure that the testing equipment is functioning according to specifications.

c. Each FTDTL will insert both open (known to the equipment technician) and blind (not known to the technician) quality control specimens among normal Soldiers' and civilian corps members' specimens to be tested. Open and blind controls will account for at least 5 percent of the total number of specimens analyzed. In order for a Soldier's or civilian corps member's test result to be accepted, all of the quality controls associated with that result must be acceptable.

d. As part of the DOD program to ensure the accuracy and integrity of FTDTL operations, the AFIP routinely sends both blind negative and positive to FTDTLs. These specimens are disguised as real specimens, with social security numbers and chain of custody forms. In addition, the AFIP sends monthly open proficiency specimens directly to the laboratory. The FTDTLs will not know what the specimens are positive for or what their concentrations are, but must correctly identify and quantitatively the drugs present in the specimens to maintain their certification and authority to conduct forensic drug testing.

e. The FTDTLs will be inspected three times per year by a team of inspectors from the Office of the Judge Advocate General (OTJAG), U.S. Army Medical Command, Armed Forces Institute of Pathology, and contract civilian toxicology consultants. The inspection team will examine operating procedures, review new or modified procedures, and examine data associated with positive and negative specimens to ensure that the results are forensically supportable in a court of law. The ACSAP will periodically accompany the inspection team.

11-5. Certification of drug test results

Guidelines for the acceptability of urinalysis results are outlined in DOD directives and instructions and will be addressed in FTDTL standard operating procedures. Data generated by screening and confirmation testing will be reviewed in a multi-step process by different personnel at different levels including the technician performing the test, quality control personnel who review the results of quality control specimens used to validate the testing process, and Laboratory Certifying Officials.

11-6. Reporting results

a. The concentration of a drug or drug metabolite in a Soldier's urine should not be used to determine how much drug the individual consumed nor the degree to which the individual was affected.

b. A military urinalysis specimen will only be reported as positive when all of the below criteria are met:

- (1) Positive initial screening test result that is equal to or greater than the established cutoff level.
- (2) Positive verification screening test result that is equal to or greater than the established cutoff level.
- (3) Positive confirmation test result that is equal to or greater than the established cutoff level.
- (4) An intact Chain of Custody

c. A civilian urinalysis specimen will only be reported as positive to the MRO when all of the below criteria are met:

- (1) Positive initial screening test result that is equal to or greater than the established cutoff level.
- (2) Positive confirmation test result that is equal to or greater than the established cutoff level.
- (3) An intact Chain of Custody

d. The FTDTLs will release results to the MRO electronically through a secure, password-protected Web site (currently FTDTL) or by mail upon special request. Results will not be released over the phone. Electronic reports will contain both positive and negative results.

e. For military results, the FTDTL will report the identity and concentration level of the drug(s) detected. These results will be provided to the Commander by the ASAP. No test results will identify personnel by name. The lab will prevent the ID of individuals whose specimens screened as positive but subsequently did not confirm as positive.

f. For civilian results, the FTDTL will report the identity of the drug detected, however they will only provide the concentration drug to the MRO if—

- (1) The MRO requests this information;
- (2) If opiates for morphine and/or codeine are greater than or equal to 15,000 nanograms per milliliter (ng/ml), even if the MRO has not requested the concentration levels.

g. Electronic reports for civilian positive test results will inform the submitting unit's DMO of the identity of the drug(s) detected; concentration levels will not be provided to anyone other than the MRO. No test results will identify personnel by name. The lab will prevent the ID of individuals whose specimens screened as positive but subsequently did not confirm as positive.

h. On average, results should be reported within the timeline listed below:

- (1) Negative military results: 1 working day.
- (2) Positive military results: 6 working days.

- (3) Negative civilian results: 1 working day.
- (4) Positive civilian results: 3 working days.

11-7. Litigation support

A commander or member of a legal office that requires litigation support for legal or administrative proceedings will request such support from the commander of the FTDTL that tested the specimen. Upon request of the commander or legal counsel, the FTDTL commander will provide in-person or telephonic expert witness testimony for courts martial or administrative board proceedings. If in-person testimony is required, the requesting command shall provide accounting information or invitational travel orders to the FTDTL at least 10 days before the date for the testimony.

11-8. Suspected adulterated military specimens

If a military specimen appears to be adulterated, a commander may request that the FTDTL perform validity testing to determine if the specimen is human urine. The FTDTLs are not required to determine the exact type or quantity of adulteration.

11-9. Special tests

a. If a commander desires to test a Soldier's urine for a drug that is not on the current test panel, the commander will coordinate through the FTDTL and/or the local ASAP with the ACSAP to request the test. If the test is approved, the request must be in writing to the respective FTDTL or AFIP, must list the requested drug(s) to test for, and must accompany the specimen to AFIP. The specimen should be on its own chain of custody document using an AFIP Form 1323 (AFIP/Division of Forensics Toxicology – Toxicological Request Form). If the specimen is sent to or through the FTDTL, the DD Form 2624 will be used.

b. If the commander desires to ensure that a Soldier is tested for one of the rotational drugs that the FTDTLs test a percentage of all specimens for, the commander will submit the request in writing to the respective FTDTL, listing the requested drug(s) to test for, with the specimen on its own chain of custody document.

c. All requests for steroid testing must be coordinated with ACSAP and the Ft. Meade FTDTL. Once approved, the commander must send a memorandum requesting the test with one DD Form 2624 for one to 12 specimens submitted. All specimens must contain at least 60 ml of urine. If a specimen is submitted for steroid testing, no other testing will be performed on the specimen.

11-10. Laboratory security

a. Specimens and aliquots must always be in the possession of an authorized member of the FTDTL staff, in a secure storage area, or assigned to an instrument on which aliquots are tested.

b. Laboratory commanders will designate and document access to limited access areas to include the specimen processing section, all temporary and long-term specimen storage areas and record testing document storage areas.

c. At no time, regardless of access authority, will a single person be alone in the specimen processing area.

d. The physical security of every FTDTL will be inspected annually to insure the integrity and security of every specimen. The FTDTL will make a copy of the inspection results available to the inspectors during the triennial DOD lab inspection.

Chapter 12 Risk Reduction Program

12-1. Overview

The Risk Reduction Program (RRP) is a commander's tool designed to identify and reduce Soldiers' high-risk behaviors in the areas of substance abuse, spouse and child abuse, sexually-transmitted diseases, suicide, crimes against property, crimes against people, AWOL, traffic violations, accidents and injuries, and financial problems. The RRP focuses on effective use of installation resources and a coordinated effort between commanders and installation agencies to implement intervention and prevention programs. The RRP supports the Army's well-being program initiatives by integrating prevention and intervention programs into a framework contributing to performance, readiness, and retention. The RRP also allows commanders to compare their units against others to determine if their units require command and/or other interventions.

12-2. Objectives

The objectives of the RRP are to—

- a.* Compile, analyze, and assess behavioral risk and other data to identify trends and units with high-risk profiles.
- b.* Provide systematic prevention and intervention methods and materials to commanders to eliminate or mitigate individual high-risk behaviors.

12-3. Policy

a. All installations with 500 or more Active Army Soldiers will offer RRP services to the tenant units of the installation. RRP services are defined as data collection, data analysis, Unit Risk Inventory surveys and intervention services.

b. Installations will provide risk incident data for risk factors to the ACSAP by the 15th of the month following the end of each calendar quarter. Data will be submitted for every battalion and major separate company by UIC and unit name.

12-4. Headquarters Risk Reduction Program working group

a. To effectively coordinate the RRP, the organizations listed below will form a HQDA RRP Working Group.

(1) The DCS, G-1 (Human Resources Policy Directorate to include representatives from ACSAP and the Suicide Prevention, Sexual Assault Prevention and Response, and Well-Being programs).

(2) The DCS, G-3/5/7 (Security, Force Protection and Law Enforcement Division).

(3) Surgeon General.

(4) Director of Army Safety.

(5) The IMCOM (U.S. Army Family and MWR Command and IMCOM ADCO).

(6) The ACOMs, ASCCs, and DRUs.

b. The working group will establish definitions, standards and goals for risk factor incident rates for use in RRP and in the Army Well-Being Action Plan.

c. Functional proponents will interact with other HQDA level panels and GO Steering Committees. (for example, safety coordinating panel, Army Family action plan and other HQDA agencies.)

d. Functional proponents will participate in the design, development and delivery of IPT training.

e. Through IMCOM, functional proponents will ensure installation program providers in their functional areas participate in and assist the RRP in meeting its objectives.

f. Functional proponents will provide information for the RRP knowledge base repository in their functional areas.

12-5. Installation/command reporting requirements

a. Installation commanders will ensure installation risk factor proponents provide incident data to the RRPC in the correct format and in a timely manner. The data provided will include, but not be limited to the high-risk factors listed in table 12-1, below.

b. Risk Data Proponents will provide/input data to the RRPC by the 10th of the month following completion of the reporting quarter. The RRPC (or their installation/command proponents) will input the data on the RRP Web-based system provided by ACSAP (<http://risk.acsap.army.mil>) by the 15th of the month following the completion of the reporting quarter (15 January, 15 April, 15 July, and 15 October).

c. Data collection population will both include and differentiate permanent party, professional military education students attending school, and initial entry training Soldiers.

Table 12-1
High-Risk Factors

No.	Factor	Definition	Data proponent
1.	Deaths	The number of all deaths among members of the reporting unit.	Casualty Assistance Office, Safety Office, Provost Marshal Office (PMO), Hospital
2.	Accidents	The number of accidents involving \$2,000 or more damage to government property assigned to the reporting unit. (Class A, B, C & D accidents)	Safety office
3.	Injuries	The number of injuries among members of the reporting unit that require medical attention, and result in 1 or more duty days lost.	Safety Office
4.	STDs	The number of new cases of all STDs among members of the reporting unit (whether they remain deployable or become non-deployable).	Prevention Medicine. DCS, G-1
5.	Suicide Attempts & Self Harm	The number of suicide gestures and suicide attempts. Not ideations, by members of the reporting unit.	Behavioral Health, PMO, Chaplain, DCS, G-1
6.	AWOLS	The number of AWOL charges brought against members of the reporting unit.	PMO

**Table 12-1
High-Risk Factors—Continued**

7.	Drug Offenses	The number of drug-related offenses charged to members of the reporting unit. These include, but are not limited to, possess and sale (but not USE) of a controlled substance.	PMO
8.	Alcohol Offenses	The number of alcohol-related offenses charged to members of the reporting unit. These include, but are not limited to, Driving While Intoxicated (DWI)/DUI, public intoxication, drunk and disorderly conduct, alcohol-related reckless driving possession by a minor m, and consumption by a minor.	PMO
9.	Traffic Violations	The number of moving traffic violations charged to members of the reporting unit. These include, but are not limited to, speeding, failure to obey a traffic device, accidents, and non-alcohol-related reckless driving.	PMO
10.	Crimes Against Persons	The numbers of crimes against persons charged to member of the reporting unit. These include, but are not limited to simple assault, aggravated assault, murder, robbery, concealed weapons, kidnapping, harassment and threats, sodomy, rape indecent assault, adultery, and forgery. Note: Do not include any of the Drug Offenses or Alcohol Offenses in the factor.	PMO
11.	Crimes Against Property	The number of crimes against property charged to members of the reporting unit. These include, but are not limited to, house breaking/burglary, automobile theft of private property, damage to property, and vandalism.	PMO
12.	Spouse Abuse	The number of substantiated cases of spouse abuse where the perpetrator and/or victim are member of the reporting unit.	Social Work Services, Army Community Service (ACS)/ Family Advocacy Program (FAP)
13.	Child Abuse	The number of substantiated cases of child abuse where the perpetrator is a member of the reporting unit	Social Work Services, ACS/FAP
14.	Financial Problems	The number of Soldiers who seek financial assistance for Army Emergency Relief or assistance with debt liquidation or money mismanagement (for example, problems with creditors due to bounced checks; problems paying the Army or mortgage; or borrowing from "payday" lending institutions) among members of the reporting unit	ACS/Army Emergency Relief (AER)
15.	Urinalysis (UA) Specimens Shipped	The number of Urinalysis specimens that were shipped for testing from this reporting unit.	DTC, DAMIS, G-1
16.	Positive UA	The number of confirmed positive urinalysis test results among members of the reporting unit.	DTC, DAMIS, G-1
17.	Warning Letters	The number of letters to members of the reporting unit that, if inappropriate behavior continues, the consequence is a loss of on-post housing.	Garrison Commander (CDR), Housing Office
18.	Eviction Notices	The number of notices issued to members of the reporting unit evicting them from on-post housing.	Garrison CDR, Housing Office
19.	Chapter Elimination	The number of chapter eliminations in the reporting unit that are based on AR 635-200 (chapter 5, 9, 10, 13, or 14), and AR 600-8-24 (chapter 4).	Staff Judge Advocate (SJA), Adjutant General (AG)
20.	Court Martial	The number of courts-martial in the reporting unit.	SJA, AG
21.	Disciplinary Actions	The number of administrative disciplinary actions (non-judicial) in the reporting unit (Article 15, GO memorandums of reprimand, and so forth)	SJA, AG

12–6. Unit Risk Inventory and Reintegration Unit Risk Inventory

Two prominent features of the Risk Reduction Program are the Unit Risk Inventory (URI) and the Reintegration Unit Risk Inventory (R–URI). These command climate surveys help commanders determine the actual occurrences of high-risk behaviors, not just reported incidences, because Soldiers complete the surveys anonymously. Combined with data on actual occurrences of high-risk behaviors and the expertise of the IPT, these surveys help installation care providers target appropriate intervention strategies where they are needed most. Commanders will coordinate with the installation ASAP to administer the Unit Risk Inventory (URI) to all deploying Soldiers at least 30 days before an operational deployment and the R–URI to redeploying Soldiers between 90 and 180 days of their return from deployment. Commanders may coordinate with the installation ASAP to administer the URI to their units at any time; however, incoming commanders should consider this a necessary action during their change of command.

12–7. Installation Prevention Team

a. The IPT is composed of representatives from the installation human services agencies (for example, Army Substance Abuse Program, safety, PM, army community services/Family advocacy, preventive medicine, chaplain's office, community behavioral health center, staff judge advocate, and so forth). Installation commanders may modify team composition to meet their RRP mission requirements.

b. The IPT will meet quarterly to discuss prevention issues that affect the entire garrison community. The IPT will review and analyze the installation's risk reduction unit data and URI/R–URI data. In collaboration with commanders, the IPT will develop prevention strategies and interventions to address the high risk factors affecting units. IPT members will also collaborate to develop and implement an IPP.

c. The IPT will provide a quarterly statistical analysis of risk factors to commanders of all battalions.

Chapter 13 Program Evaluation

13–1. Overview

a. Program evaluation is an integral part of ASAP program planning, decision-making, and management at all levels. Program evaluation will:

- (1) Ensure integration of all facets of the ASAP at every level of command.
- (2) Facilitate prioritizing of ASAP efforts.
- (3) Provide feedback for continuous program improvement and resource allocation.
- (4) Identify areas for possible research by HQDA.

b. Program evaluation activities are capstone activities that assess the performance and effectiveness of the ASAP or specific components of the ASAP across the Army and include periodic program manager assessments, inspections, analyses of statistical performance measures data, systematic and/or ad hoc program evaluations, evaluations of demonstration projects, and assessments of progress towards preestablished ASAP goals.

13–2. Authority

The ACSAP retains the authority to conduct all evaluations of garrison ASAPs and to delegate authority to other parties. USAMEDCOM retains the authority to conduct all evaluations of clinical ASAPs and to delegate authority to the RMCs.

13–3. Program manager assessments

a. The ADCO will complete the Management Control Evaluation Checklist at appendix C of this regulation in accordance with AR 11–2.

b. The ADCO will use the Program Evaluation Test Questions at appendix D of this regulation at least annually to facilitate an evaluation for ongoing program improvement.

c. The USAMEDCOM ASAP Clinical Program Manager will use the accreditation standards checklist in evaluating clinical programs.

13–4. Inspections

Inspection activities, when consolidated, become moving assessments of program processes Army-wide. The broad, program oversight inspections will include:

a. *The ACSAP Program Oversight Inspections.* The ACSAP will inspect installation's overall substance abuse programs at least once every 2 years. When needed, inspections may be conducted jointly with USAMEDCOM. The annual inspection schedule will be based on results of previous inspections, time elapsed since the last inspection, statistical data (ISR, DAMIS drug reports, DUI/Urinalysis quarterly reports), and requests from the DCS, G–1,

installation and garrison commanders, and IMCOM. All inspections will be coordinated through the IMCOM. Each inspection will:

- (1) Assess all functional areas of the Garrison ASAP.
- (2) Assess achievement of all program objectives.
- (3) Assess program effectiveness, efficiencies, and customer service, including commanders' and other customers' perceptions.
- (4) Evaluate the level of integration of all facets of the ASAP.
- (5) Obtain data for development of policies and procedures and determination of resources or allocations.
- (6) Determine problem areas and requirements for technical assistance at specific installations.
- (7) Determine compliance with directives.
- (8) Provide feedback as a basis for program improvement and allocation of dollar and staff resources.

b. The ACSAP Drug Testing Inspections. The ACSAP will inspect installation DTPs at least every 3 years. The inspections will focus on the entire drug testing process from individual urinalysis collections to collection point operations using the ACSAP DTP Inspection Checklist. The inspections will be conducted jointly with Program Oversight Inspections if possible. The annual inspection schedule will be based on the results of previous inspections; time elapsed since the last inspection, statistical data (ISR, DAMIS drug reports, and discrepancy rates), requests from the DCS, G-1, installation/garrison commanders and IMCOM, and funding. All inspections will be coordinated through the IMCOM. Each inspection will evaluate the following areas:

- (1) Military Urinalysis Collections.
- (2) Civilian Urinalysis Collections.
- (3) Drug Testing Collection Point Operations.
- (4) Drug Testing Program Management.

c. The medical commander inspections. The USAMEDCOM will inspect the ASAP counseling program at each installation at least annually. The regional clinical directors will conduct the inspections and provide a report to the MEDCOM Alcohol and Drug Program Manager and the Director, ASAP.

13-5. Program evaluation methods

The ACSAP will employ many different tools to evaluate the ASAP and its component parts. Methods will include—

a. Continuous evaluations such as: “moving averages” of drug positive and RRP risk incident rates at the installation, region, and Army-level; Soldier or commander assessments and feedback; ISR and Well-Being Status Report (WBSR).

b. Periodic evaluations such as: DOD Health-Related Behaviors Surveys; periodic worldwide evaluations of the ASAP program including surveys and site visits.

c. Purpose-specific evaluations such as: Assessing the effects of demonstration programs and initiatives; assessing policy changes; and responding to DOD and Army leadership requests.

d. Required reports that assess the performance and effectiveness of the ASAP, such as: the RAPR; Patient Intake Report (PIR); PPR; DUI reports; ISR measures; input of MRO reviews; and EAP screening data.

e. Comparative analyses of data in the Risk Reduction database, the DAMIS, plus Program Oversight and Drug Testing Inspections in order to identify installations that require additional program evaluation by the ACSAP.

13-6. Army Substance Abuse Program installation status report measures

a. The ISR systematically evaluates the status of installations by measuring performance against a set of Army-wide standards, and justifying and allocating resources. The DCS, G-1 is the proponent for ISR Services, Army Substance Abuse Program (ASAP) Performance Measures (Service 09), administered and managed by the ACSAP.

b. Army Substance Abuse Program performance measures track, on an annual basis, each installation's performance compared to standards that are well-grounded in regulations, policy and PL to ensure installation performance is measured against published and well-understood ASAP standards. These measures may vary from 1 year to the next depending on current program emphasis and need. ASAP performance measures are developed by the ACSAP, and are staffed throughout the Army, but primarily through IMCOM. Issues raised are addressed in an annual After Action Review (AAR) hosted by the Assistant Chief of Staff for Installation Management and attended by HQDA proponents and IMCOM representatives. Issues are resolved at the AAR and the results are presented to a Council of Colonels, which makes any final changes before forwarding its recommendations to the General Officer Steering Committee (GOSC), which has the final decision for approval of the performance measures. The ASAP representative for the Council of Colonels is the Director, ASAP. The ASAP representative for the GOSC is the Director, Human Resources Policy, DCS, G-1. Upon approval, the new performance measures go into effect in the following fiscal year for data collection.

c. The ACSAP will use the ASAP ISR performance measures to connect resources to outcomes measured against standards, and:

- (1) Determine what services should cost via Standard Service Costing.

- (2) Provide service performance data.
- (3) Use with Service Based Costing pricing measure and cost data.
- (4) Defend Base Operations program requirements.
- (5) Compare actual with expected performance.
- (6) Determine most effective business practices.

13–7. Well-being status report

a. The Well-Being Status Report (WBSR) systematically evaluates the status of near-term, mid-term and long-term objectives of the well-being functions described in the U.S. Army Well Being Action Plan (WBAP). The ACSAP is the proponent for risk reduction function, which integrates program objectives for the ASAP, the U.S. Army Suicide Prevention Program, and the Risk Reduction Program. Annual progress assessments will be completed for these objectives in accordance with guidance the DCS, G–1, Human Resources Policy Directorate’s Well Being Division. Data required for the assessments will be collected from installations through IMCOM. The ACSAP will consolidate substance abuse and risk reduction data for reporting to the Well Being Division.

b. The ACSAP will use the ASAP and RRP Well-Being Status Report measures to gauge and analyze progress toward the established objectives and institute corrective actions if required.

13–8. Army Substance Abuse Program research

a. The ASAP intends to be a streamlined ‘best practice’ program delivering effective services at reasonable costs. To do so requires constant innovation and adaptation of new concepts and procedures.

b. The ACSAP will sponsor, conduct, and collaborate on research as required and resourced. The ACSAP will seek collaborative research activities with other Army, other governmental agencies, and research institutions to leverage resources and combine information. Research topics may range from investigations of basic biological determinants of substance abuse predisposition to demonstration programs of different educational or treatment modalities.

c. Parties requesting or intending to research any of the ASAP functions will contact the ACSAP for coordination and approval.

Chapter 14 Army Substance Abuse Program Information and Records Management

Section I Introduction

14–1. Overview

a. The DAMIS is the Army’s official repository for all current and historical Army Substance Abuse Program (ASAP)-related information. This information is necessary for routine and special reports to program managers and decision makers. It serves as a vital reservoir of data from which research activities can take place. Computer processing and statistical analysis packages are used to develop these reports in convenient formats.

b. The total DAMIS data base contains sensitive patient information, urinalysis information, staffing and workload information, and access to personnel information for gathering data on current and former patients to determine long term success of Soldiers who have completed the program and remain in the Army. DAMIS provides essential management information on the ASAP at each level of command. The data generated by the DAMIS provides the capability to—

- (1) Measure the magnitude of alcohol and other drug abuse.
- (2) Measure the progress made in the ASAP prevention and risk education efforts.
- (3) Measure the progress made in the rehabilitative and medical treatment aspects of the ASAP.
- (4) Identify statistical trends to support requisite policy and procedural changes.
- (5) Identify funding and manpower requirements for the ASAP.
- (6) Reply to public, media, Congressional, or other Government agency inquiries.
- (7) Perform background checks on ASAP program military personnel. (Information will be released only to individuals who have an official need to know prior to appointing some into an ASAP-related position.)
- (8) Perform background checks on civilian corps members with prior written consent of the employee in accordance with 42CFR 290dd-2. Information will be released only to the agency designated on the DA Form 5018.

c. The data contained in the DAMIS originates from the FTDTL, ADCO, ASAP Counselor, and the integrated Total Army Personnel Data Base (iTAPDB) input.

d. Due to confidentiality requirements cited in paragraph 14–2, below, only ACSAP personnel and selected ASAP personnel may have access to DAMIS. See DA Pam 600–85 for ASAP access instructions.

14-2. Policy

The release and/or discussion of information within the Armed Forces concerning an abuse of alcohol and other drugs is governed by the restrictions contained in the 5 USC 552a, 42 USC 290dd-2, AR 40-66, and AR 340-21.

a. For Soldiers such information will be made known to those individuals within the Armed Forces who have an official need to know. The restrictions on release of information outside the Armed Forces are prescribed by the legal authorities 42 USC 290dd-2 and 42 CFR Part 2 cited, above. For additional information refer to chapter 6 of this regulation.

b. For civilian corps members, the restrictions on release of information within or outside the Armed Forces are prescribed by the legal authorities 42 USC 290dd-2 and 42CFR Part 2 cited above. For additional information refer to chapter 6 of this regulation.

Section II Reporting procedures

14-3. Army Substance Abuse Program input reports

The following are reports that will be submitted in electronic format when the data will be maintained by the DAMIS:

a. The DA Form 3711 contains ASAP management information about population served, prevention and education, manpower utilization and staffing, and obligated funds. See the DAMIS Guide for the Completion of ASAP Forms for an example of DA Form 3711 and submission requirements.

(1) Installation ADCOs, with input from the ASAP clinics, will submit the completed DA Form 3711 on the last working day of the month following the period the report covers.

(2) The ACSAP will review the electronic DA Form 3711 for accuracy and completeness and will contact the ADCO if a form is in error or incomplete. The ADCO will provide the corrections to ACSAP within 10 duty days of notification.

b. The DA Form 4465 documents all civilian corps members and Soldiers evaluated by an ASAP counselor or enrolled in the ASAP. It provides demographic and disposition data on individuals referred to the ASAP clinics. See the DAMIS Guide for the Completion of ASAP Forms for an example of DA Form 4465 and submission requirements.

(1) The CD will review the completed DA Forms 4465 submitted by counseling personnel, and ensure it is entered into DAMIS within 10 working days of the ASAP counselor's evaluation.

(2) The ACSAP will review the electronic DA Forms 4465 for accuracy and completeness and will contact the CD if a form is in error or incomplete. The CD will provide corrections to ACSAP within 10 duty days of notification. The CD has the primary responsibility for resolving problems relating to timely and accurate submission of DA Forms 4465. The installation ADCO will serve as an additional point of contact.

c. The DA Form 4466 documents specific milestones during a patient's enrollment in the ASAP clinic (for example, permanent change of station (PCS) actions, changes to diagnosis or basis for enrollment, progress evaluations, and releases from the ASAP). (See the DAMIS Guide for the Completion of ASAP Forms for an example of DA Form 4466 and submission requirements.)

(1) The CD will ensure DA Forms 4466 are completed at the occurrence of each milestone in a patient's rehabilitation and review all completed DA Forms 4466 for accuracy and completeness.

(2) The ACSAP will review incoming DA Forms 4466 for accuracy and completeness and will contact the CD if a form is found to be in error or incomplete. The CD will provide the corrections to ACSAP within 10 duty days of notification. The CD has the primary responsibility for the resolution of problems relating to timely and accurate submission of DA Forms 4466. The installation ADCO will serve as an additional point of contact.

(3) Special situations requiring completion and submission of DA Forms 4466 to the ACSAP:

(a) The CD will submit DA Forms 4466 to document PCS actions for TDY Soldiers who are absent from their permanent duty station for 31 days or more.

(b) The CD will submit DA Forms 4466 documenting PCS actions for transferred Soldiers. Exceptions are individuals who are separated/discharged from the Army and require a DA Form 4466 documenting a release from the program.

(c) The CD will submit a DA Forms 4466 documenting release from the program of military patients who are AWOL for 31 days or more (dropped from rolls (DFR)). The CD will submit a new DA Form 4465 on Soldiers returned from DFR status.

(d) The OCONUS CDs will submit DA Form 4466 documenting releases from the program for Soldiers returned to CONUS for separation.

d. The installation Employee Assistance Program Coordinators (EAPC) will input the initial counseling session into DAMIS.

e. The MRO review data will be completed and entered into DAMIS within 15 working days of the results being posted on the FTDTL's Web portal.

f. The ADAPT attendance records allow DAMIS to contain the complete record of a Soldiers ASAP program and allows the ACSAP and local ASAPs to evaluate the effectiveness of the ADAPT.

(1) The PC will submit the requested data through DAMIS within 10 days of each course completion.

(2) See the DAMIS Guide for the Completion of ASAP Forms for an example of DUI/UA report and submission requirements.

g. The DUI/UA Quarterly Report is for the collection of substance abuse related traffic violations and positive urinalysis.

(1) The ADCO will submit the data on a fiscal year quarterly basis to arrive by the last day of the month following the end of each calendar quarter. (for example, 31 January, 30 April, 31 July, and 31 October.)

(2) See the DAMIS Guide for the Completion of ASAP Forms for an example of DUI/UA report and submission requirements.

14-4. Army Substance Abuse Program request to change data stored in Drug and Alcohol Management Information System

All changes of data in DAMIS must be requested in the form of MFR on letterhead addressed to the Director, ASAP. The request must state the reason for change and will be accompanied with all supporting documentation and be signed by the ADCO.

Section III Reporting Requirements

14-5. Integrated Total Army Personnel Database reporting requirements

The DAMIS provides real time access to a Soldier's assignment data through iTABDB if the Soldier has a DAMIS record.

14-6. United States Army Medical Command reporting requirements

a. By the 10th of each month USAMEDCOM will provide the following data for both military and civilian tests to the Director, ASAP for the previous month's operations of each FTDTL:

(1) Total specimens received.

(2) Total specimens tested by drug type.

(3) Total specimens confirmed positive.

(4) Total specimens confirmed positive by drug.

(5) Total Soldiers confirmed positive.

(6) Total specimens with discrepancies that caused the specimen not to be tested, by discrepancy category.

(7) See paragraphs (1) through (6), above, by BAC/Installation.

(8) See paragraphs (1) through (7), above, by IMCOM Region.

(9) See paragraphs (1) through (8), above, on total fiscal year to date basis.

b. Notify the Director, ACSAP, and the installation ADCO immediately regarding any false positive results reported by the FTDTLs.

c. The USAMEDCOM will provide a daily download of drug testing data from the Laboratory Information Management System (LIMS) to DAMIS.

d. The USAMEDCOM will notify the Director, ASAP of any changes in the nomenclature or naming of testing data prior to making changes within the FTDTL information system.

Section IV Army Substance Abuse Program client records

14-7. Army Substance Abuse Program client records

a. ASAP client records, excluding DA Form 4465 and DA Form 4466, are governed by AR 40-66 and will consist of official forms referred to in AR 40-66. Both military and nonmilitary personnel enrolled in the ASAP will have an ASAP outpatient medical record (ASAP-OMR). ASAP records of Family members and civilians must not be entered into the AHLTA. Progress notes will be recorded only on SF 600 (Health Record – Chronological Record of Medical Care). No other official forms will be created without MTF approval. Counseling correspondence and reports from outside agencies will be maintained in the ASAP client records.

b. Every document contained in the client record will comply with the requirements of 5 USC 522a, 42 USC 290dd-2 and HIPAA to the extent applicable.

14-8. Army Substance Abuse Program client record filing procedures

a. ASAP client records will be maintained in one of the following categories:

(1) Open client case records will include clients seen on a regularly scheduled basis as well as clients in Level II programs.

(2) Closed client case records will include clients in an inactive status and those pending transfer of record. These records will be maintained as inactive records and retained in accordance with AR 25–400–2. Patients referred to as being in the inactive patient status include former employees or those screened and returned to units with no further action indicated. Former participants of ADAPT or ASAP rehabilitation are filed in the inactive records when not receiving follow-up.

b. Access to individual ASAP client records will be restricted to the following:

(1) Rehabilitation staff members.

(2) The AMEDD designated personnel involved in rehabilitation of individual patients and AMEDD evaluators who will be charged with determining the extent of compliance with this regulation. Only USAMEDCOM personnel participating as members of official inspection teams will have access.

c. Civilian and military records will be stored in separate lockable containers or drawers.

Section V

Management information feedback reports

14–9. Overview

a. Direct communication between Director, ACSAP and installation ADCOs is authorized. The ACSAP will maintain an historical database of ASAP data collected from DA Forms 3711, DA Forms 4465, and DA Forms 4466 that will be used for program management and strategic program planning.

b. The ACSAP will produce management reports for each installation ADCO and CD, Region ADCO, and the IMCOM Substance Abuse Program Manager. This information will be derived from the DA Forms 3711, DA Forms 4465, and DA Forms 4466 submitted to ACSAP.

c. The ACSAP will provide ADCOs and CDs information outlining the accuracy and timeliness of DA Forms 3711, DA Forms 4465, and DA Forms 4466 received from their installations.

14–10. Drug and Alcohol Management Information System reports

The information retained in DAMIS allows the ASAPs to obtain reports that will allow the ADCO or CD to provide accurate data on all Soldiers. Available reports include—

a. Repeat Positive Detail - By SSN.

b. Repeat Positive Detail - By BAC.

c. Drug Detail Report.

d. Deployed Drug Detail Report.

e. Unit Drug Detail Report.

f. DTP Utilization.

g. Test Basis Positives.

h. Deployed Test Basis Positives.

i. Repeat Positive Summary.

j. Screening Enrollment.

k. Rehabilitation Completion.

l. Rehabilitation Caseload.

m. MRO - Delinquent Evaluations.

n. Printable completed DA Forms 4465, 4466, 3711.

o. Other DA specific reports.

14–11. Drug and Alcohol Management Information System metrics

The ACSAP will track all reporting that is required from the ASAPs and provide feedback to those ASAPs not in compliance with this chapter.

Chapter 15

Army Substance Abuse Program in the Army National Guard

Section I

General

15–1. Scope

The ASAP policies and procedures in this regulation apply to all components of the Army, including the Army National Guard. However, due to the different laws and conditions that affect National Guardsmen when they are on state and federal duty, some additional ASAP policies and procedures also apply. This chapter establishes those specific policies, responsibilities, and procedures for implementing and managing the ASAP in the ARNG.

15–2. Applicability

a. This chapter applies to all ARNG Soldiers, except for personnel in the following duty categories, who are covered by the provisions in the other chapters of this regulation:

(1) Active duty of 30 days or more that is not for training, including AD in an Active Guard Reserve status under Title 10 USC.

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

(3) Initial AD training (IADT).

(4) Involuntary ADT of 45 days or more.

(5) Soldiers ordered to AD status during periods of partial, full, or total mobilization.

b. State employees and Federal technicians are not serving in a military duty status while employed in those capacities, and this chapter does not apply to them unless otherwise stated.

Section II

National Guard specific responsibilities

15–3. Chief Surgeon, Army Reserve National Guard

The Chief Surgeon will—

a. Provide technical consultation on all medical aspects of the ARNG ASAP.

b. Coordinate with the states to ensure they have state MROs who are trained and certified by USAMEDCOM.

15–4. Chief, National Guard Bureau Counterdrug Division

The Chief, National Guard Bureau, Counterdrug Directorate (NGB–CD) will develop policy and regulatory guidance concerning program funding, internal controls, and evaluations.

15–5. Chief, Substance Abuse Section

The Chief, Substance Abuse Section will—

a. Administer, manage, and provide direction to the ARNG ASAP.

b. Establish requirements and prepare budget requests for ARNG funds to support the ASAP.

c. Determine, allocate, and manage urinalysis quotas for the states and territories.

d. Provide liaison with HQDA and other agencies on ASAP matters.

e. Develop and provide guidance to the state MROs to ensure timely completion of medical reviews.

f. Develop and provide guidance to state Joint Substance Abuse Program Officers (JSAPOs) regarding funding requirements and drug testing quota utilization.

g. Ensure MRO findings are input into the DAMIS.

h. Coordinate ASAP policy and procedures with the ACSAP.

15–6. The State Adjutants General

State Adjutants General will—

a. Provide program management and operational supervision of the ARNG ASAP within their state or territory.

b. Ensure that state policies and standards are clearly understood and adhered to by all ARNG members.

c. Designate a JSAPO on appointment orders.

d. Designate a state MRO on appointment orders.

e. Designate a ARNG JSAPC on appointment orders.

f. Direct the establishment of an Alcohol and Drug Interdiction Council (ADIC).

15–7. Joint Substance Abuse Program Officer

Each JSAPO will—

- a. As an additional duty, act as the principal staff officer for coordinating and managing the ARNG ASAP for they respective State Adjutant General.
- b. Ensure that the state Counterdrug Coordinator is informed of all ASAP issues.
- c. Coordinate state ARNG activities in substance abuse prevention, education, training, ID, referral, follow-up, and program evaluation.
- d. Manage and allocate drug-testing quotas within the state in accordance with the policies and priorities established by the NGB and the State Adjutant General.
- e. Ensure all ASAP personnel involved in the collection or processing of urinalysis specimens are trained and certified on the procedures established in appendix E of this regulation, and that personnel who train UPLs in their collection duties are certified in accordance with paragraph 9–5e of this regulation.
- f. Provide periodic program evaluation to the State Adjutant General and required reports to the NGB.
- g. Maintain the state ASAP records and reports in accordance with AR 25–400–2 and state regulations.
- h. Identify state certified, community-based alcohol and other drug referral, counseling, and rehabilitation services and ensure that this information is made available to unit commanders for use in the referral process.
- i. Serve as a member of the ADIC.
- j. Coordinate with the ADCO of the Active Army installation(s) assigned garrison support responsibilities, the respective Clinical Director (CD), and the Regional Medical Command (RMC) regarding available ASAP support.
- k. Ensure all mobilizing company-size or larger units arrive at the mobilization station with two trained and certified UPLs and enough drug testing supplies to test 100 percent of the unit strength.
- l. Ensure that the state temporary storage site for urinalysis specimens meets the requirements of appendix E–11 of this regulation.
- m. Ensure MROs receive test results requiring review within 5 working days of their being posted on the FTDTL Web portal.
- n. Ensure that MRO determinations about the legitimate use of prescription drugs by ARNG Soldiers are entered in DAMIS within 5 working days of receiving them from the MRO.
- o. Ensure that the MRO is trained and certified for their duties in accordance with USAMEDCOM requirements (see para 9–9e).
- p. Attend and complete an NGB-approved ASAP training course within 12 months of appointment.

15–8. Joint Substance Abuse Program coordinator

Each JSAPC will —

- a. Meet the requirements for DTCs outlined in paragraph 9–5 of this regulation.
- b. Be certified by the DA Drug Test Coordinator Certification Course if they receives custody of any Soldiers' urinalysis specimens. The same requirement applies to anyone at the state level, who receives custody of Soldiers' urinalysis specimens regardless of duty title.
- c. Be an E–5 or above and be appointed in writing to serve as the JSAPC by the State Adjutant General.
- d. Complete the NGB–J3–CDO–D Substance Abuse Section Substance Abuse Program Officer/Substance Abuse Program Coordinator Course within 12 months of appointment.
- e. Perform day-to-day management of the state's Joint National Guard Substance Abuse Program (JNGSAP) to include management of substance abuse funds.
- f. Manage the state's JNGSAP automation program.
- g. Prepare random, mandatory testing, and other test rosters, as necessary, for use in conducting the state's urinalysis collections.
- h. Receive the state's drug test results from the FTDTL Web portal.
- i. Coordinate the positive result notification process through the appropriate offices ensuring that Soldiers' personal information is protected from inadvertent disclosure until it reaches the Soldier's commander.
- j. Order commanders' drug testing reports as needed.
- k. Submit requests to the FTDTL for specimens to be retained for longer than 1 year, as needed.
- l. Provide technical support and troubleshooting for the state's JNGSAP.
- m. Receive specimens from all collection sites and conduct quality control inspections of urine specimens prior to forwarding them to the FTDTL for testing. The JSAPC will not alter specimens to correct discrepancies, but may use a certificate of correction (see app E of this regulation) to correct the discrepancies if possible.
- n. Staff requests for retests of specimens, when requested, in accordance with paragraph 4–6 of this regulation.
- o. Ensure the state's JNGSAP is conducted according to proper procedures in a professional, controlled and unbiased manner.
- p. Prepare and conduct certification training for UPLs that meets the DA UPL CTP standards.
- q. Provide periodic staff assistance visits to state units.
- r. Order and maintain administrative and testing supplies.

- s. At the discretion of the JSAPO, be the state JNGSAP's liaison to the NGB-J3-CD SA section.
- t. Maintain the state's drug testing records, files, policy guidance, and correspondence in accordance with AR 25-400-2 and Privacy Act guidelines.
- u. Coordinate with the JSAPO on JNGSAP reports and tracking issues.
- v. Update the state's action plan to reduce discrepancies every month that the state's fatal discrepancy rate is over 1 percent.
- w. Maintain an updated list of state-certified drug counseling and rehabilitation facilities.

15-9. State Medical Review officer

Each state MRO will—

- a. Be appointed on orders by the State Adjutant General.
- b. In accordance with MEDCOM Regulation 40-51, be eligible to serve as MRO and trained and certified to perform MRO duties by USAMEDCCOM within the first 6 months of duty assignment (see para 9-9e).
- c. Determine if positive drug results reported by the FTDTL could have resulted from the legal use of a prescription drug for medical reasons and/or for drugs administered during surgical or dental procedures. The MRO will make the determination and notify the JSAPC within 30 days of receiving the positive result to review.
- d. If necessary, coordinate with the unit commander, who will offer the Soldier the opportunity to furnish medical evidence in the form of a medical prescription and/or statement from the Soldier's physician or dentist documenting the drug prescribed or given, date of medical or dental procedure which required prescribed drugs, and the medical reason for its use. The documentation will be marked "For Official Use Only - Personal in Nature" and will be forwarded to the MRO for evaluation. Unit commanders will not initiate an adverse action against the Soldier until the MRO had rendered an evaluation.

15-10. State Judge Advocate

The State Judge Advocate will —

- a. Monitor compliance with chain of custody collection procedures at unit level.
- b. Advise commanders, the JSAPO, the JSAPC, UPLs, and other officials and agencies on the legal aspects of the DTP.
- c. Upon request, review the state urinalysis collection SOP for legal sufficiency.

Section III

Policies and procedures

15-11. Policy

Illegal drug use is misconduct and the abuse of alcohol or the use of illicit drugs by both military and civilian personnel is inconsistent with the standards of performance, discipline, and readiness necessary to accomplish the Army's mission.

- a. The ARNG Soldiers identified as illegal drug users will be simultaneously:
 - (1) Counseled by the unit commander for possible enrollment in a state-certified, community-based alcohol or other drug counseling and rehabilitation service within 45 days of verified positive drug test.
 - (2) Processed for administrative separation within 45 days of receipt of the verified positive drug test. Soldiers may be considered for disciplinary action prior to separation.
 - (3) Evaluated for continued eligibility for access to classified information and reported to the U S Army CCF per AR 380-67.
- b. The ARNG Soldiers involved in alcohol-related misconduct such as drinking on duty, impaired on duty (see para 3-2a of this regulation), or operating a motor vehicle while impaired will be:
 - (1) Counseled by the unit commander for possible enrollment in a state-certified, community-based alcohol or other drug counseling and rehabilitation service within 45 days of being identified for possible alcohol abuse.
 - (2) Considered for administrative separation and/or disciplinary action.
 - (3) Evaluated for continued eligibility for access to classified information and reported to the U.S. Army CCF per AR 380-67.
- c. Special attention is directed to compliance with specific annual testing requirements for members specified in paragraph 4-8 of this regulation.

15-12. Funding considerations

- a. The ARNG Counterdrug Operation and Maintenance funds will be used to pay for:
 - (1) Supplies and shipping material for the collection and shipment of urinalysis specimens to the FTDTL.
 - (2) Documentation and/or Commander's Packets (see para 4-19 of this regulation) and related costs. Each state/territory will submit a request for a Litigation Packet to the FTDTL and provide a copy of the request to the Chief,

Substance Abuse Section. The Documentation Packet will be ordered by the State Judge Advocate General or state JSAPO. Counterdrug Operation and Maintenance funds may be used for payment of expert witness' fees when approved by the Chief, Substance Abuse Branch.

(3) Prevention, education, and training materials, and services for Soldiers and their families.

b. The ARNG Counterdrug Pay and Allowance funds may be used to pay for:

(1) ASAP training, including travel costs to conferences and seminars.

(2) Urinalysis collections.

(3) Administrative separation boards.

(4) ASAP administrative support.

c. Counterdrug funds will not be used to pay for alcohol and/or other drug rehabilitation for ARNG Soldiers.

15-13. Alcohol Drug Intervention Council

Chapter 7 of this regulation applies to the ARNG, except that:

a. An ADIC will be established at the state level to function in an advisory capacity to the State Adjutant General.

b. The JSAPO will provide continuous assessment of the alcohol and other drug environment within the ARNG of that state or territory.

15-14. Referral of alcohol and illegal drug abusers to a state-certified rehabilitation program

Chapter 7 of this regulation applies to the ARNG, except that—

a. When ARNG Soldiers are identified voluntarily or involuntarily as possible alcohol or other drug abusers, the unit commander or designated representative will promptly:

(1) Advise the Soldiers of their rights under the appropriate provisions of the state law pertaining to self-incrimination using the appropriate State Rights Warning Procedure/Waiver Certificate, and explain the Limited Use Policy addressed in section III, chapter 10 of this regulation.

(2) Refer Soldiers to community-based counseling and rehabilitation programs using a DA Form 4856 or another state-approved counseling form. The unit commander must provide Soldiers with a list of certified and/or approved counseling/treatment agencies that are within a reasonable commuting distance of the Soldiers' residences. Soldiers must be advised that:

(a) They must be evaluated within 30 days of the command counseling session.

(b) They are responsible for all costs incurred in any referral/rehabilitation programs. Soldiers should be encouraged to explore available rehabilitation options (for example, a sliding fee based on income, use of health insurance, Medicaid, and so forth) with rehabilitation program personnel.

(c) They must sign a consent statement that allows the rehabilitation personnel to share necessary rehabilitation information with the unit commander or designee. Soldiers must request that rehabilitation personnel provide monthly updates in writing to unit commanders, who must be kept informed regarding the progress of rehabilitation. Methadone maintenance and mandatory Disulfiram (Antabuse) treatment will not satisfy the rehabilitation requirements of this chapter. Soldiers may refuse to sign the consent statement. However, these Soldiers may be deemed not to be participating sufficiently in rehabilitation. Refusal to sign may result in their being processed for administrative separation for rehabilitation failure.

(d) Failure to participate in and successfully complete approved or ASAP rehabilitation program, or the refusal to sign a DA Form 5018 to release information to the unit commander, will result in initiation of separation proceedings under AR 135-175 or AR 135-178.

b. The ARNG Soldiers on Inactive Duty for Training or other AD of 30 days or more will use Active Army ASAP services while in an AD status or until rehabilitation is complete.

15-15. Rehabilitation

Chapter 8 of this regulation applies to ARNG members when on extended AD for more than 30 days.

a. The goal of the ARNG ASAP rehabilitation program is to return rehabilitated Soldiers to full effective duty as early as possible.

b. The ARNG unit commander must be innovative and empathetic when working with those Soldiers enrolled in rehabilitation. The unit commander must be kept informed regarding the Soldier's progress.

c. When an ARNG Soldier is detoxified at Army expense, an appropriate line of duty determination will be made in accordance with chapter 8 of this regulation.

d. Army National Guard Soldiers on Title 10 Active Duty orders may remain on AD until rehabilitation is completed at the discretion of the commander unless prohibited by other requirements.

15-16. Administratively separating drug abusers

Chapter 10 of this regulation applies to the ARNG, except that:

a. Unit commanders will process every ARNG Soldier identified as an illegal drug user for administrative separation. The separation action will be forwarded to the separation authority, which will make a final determination on separating or retaining the Soldier.

(1) Officers and Warrant Officers will be processed under the provisions AR 135–175 and applicable NGB regulations.

(2) Enlisted personnel will be processed under the provisions of AR 135–178 and applicable NGB regulations.

b. If an ARNG Soldier refuses to consent to drug testing, the unit commander or a designated representative within the Soldier's chain of command will order the Soldier to provide a specimen. Soldiers, who refuse to participate, are in violation of a direct order and may be processed under applicable code for disciplinary action in addition to processing for separation and other administrative actions outlined under this regulation.

15–17. Drug testing guidance

Chapter 4 of this regulation applies to the ARNG, except that:

a. Mandatory testing requirements include the addition of all AGR and full-time National Guard Counterdrug personnel according to National Guard Regulation (NGR) 500–2.

b. Due to the geographical separation of ARNG units and ASAP staff, all urinalysis specimens may be shipped directly from the unit to the FTDTL using the proper chain of custody and procedures.

15–18. Evaluation

Chapter 13 of this regulation does not apply to the ARNG. Program evaluation will comply with guidance provided by the Director, NGB–CD.

15–19. Drug testing rate

Company/troop commanders will randomly select and test 10 percent of their assigned Soldiers each month OR 25 percent each quarter. Special attention is directed to compliance with specific annual testing requirements for members specified in paragraph 4–8 of this regulation and Soldiers participating in counterdrug operations.

15–20. Military justice

Incidents involving alcohol or other drug abuse may also constitute a basis for violation of law and/or a military justice code. Soldiers may be processed under applicable code for disciplinary action in addition to separation and other administrative actions outlined under this regulation.

15–21. Risk Reduction Program

All policies and procedures listed in Chapter 12 apply to the Army National Guard; however the ACSAP may make modifications to accommodate the ARNG mission and organization.

Chapter 16

Army Substance Abuse Program in the U.S. Army Reserve

Section I

General

16–1. Scope

The ASAP policies and procedures in this regulation apply to all components of the Army, including the USAR. However, due to the different laws and conditions that affect Army Reservists when they are on reserve and AD, some additional ASAP policies and procedures also apply. This chapter establishes policies, responsibilities, and specific procedures for implementing and managing the ASAP.

16–2. Applicability

a. This chapter applies to USAR Soldiers while not on AD for 31 days or more in the following categories:

- (1) Troop Program unit (TPU).
- (2) Individual Mobilization Augmentee Program.
- (3) Individual Ready Reserve.

(4) Soldiers serving on various tours of ADT, Temporary Tours of AD, and AD for Special Work for less than 31 days. Soldiers performing tours of 31 days or more will comply with provisions listed for Active Army personnel.

b. This chapter does not apply to USAR Soldiers activated under a Presidential Selected Reserve Call-up, partial, full, or total mobilization. ASAP policies for Active Army Soldiers apply to these Soldiers.

Section II

United States Army Reserve specific responsibilities

16–3. Commander, U.S. Army Reserve Command

The Commander, USARC will—

- a. Establish an alcohol and other drug control office within the USARC HQ.
- b. Designate an ADCO on orders that can be filled by an AGR Soldier, Active Army member, or a civilian corps member.
- c. Designate an MRO on orders.
- d. Ensure continued support to tenant USAR units in the execution of this regulation's requirements.

16–4. U.S. Army Reserve Command Alcohol Drug Control Officer

The USARC ADCO will—

- a. Provide annual Program Budget Guidance in support of the ASAP.
- b. Publish annual guidance for audit procedures of ASAP funds.
- c. Develop an internal management control program checklist for ASAP funding execution.
- d. Manage and allocate urinalysis quotas based upon regulatory guidance to include priority Military Occupational Specialties for mandatory annual testing, and publish a monthly urinalysis statistical evaluation report.
- e. Evaluate the command's ASAP for effectiveness (see chap 13 and app D for guidance).
- f. Provide guidance for the effective operations of the subordinate commands' ASAPs.
- g. Conduct staff assistance visits to subordinate commands.
- h. Coordinate ADCO training requirements and ensure regular training programs are available to the commands.
- i. Assemble and disseminate information sources concerning Active Army ASAP and certified community-based alcohol and other drug referral, counseling, and rehabilitation services to subordinate commands.
- j. Ensure all ASAP personnel involved in the collection or processing of urinalysis specimens are trained and certified on the procedures established in appendix E of this regulation, and that personnel who train UPLs in their collection duties are certified in accordance with paragraph 9–5e of this regulation.
- k. Ensure MRO findings are input into the DAMIS within 5 working days of receiving them from the MRO.
- l. Ensure that the MRO is trained and certified for their duties in accordance with USAMEDCOM requirements (see para 9–9e).
- m. Ensure all mobilizing unit company-size or larger arrive at the mobilization station with 2 trained and certified UPLs and enough drug testing supplies to test 100 percent of the unit strength.
- n. Ensure that all temporary storage sites for urinalysis specimens used by the USARC meet the requirements of appendix E of this regulation.

16–5. Commanders of Major Subordinate Commands

Major Subordinate Commanders will—

- a. Establish an alcohol and other drug control office within their HQ.
- b. Designate the following on orders:
 - (1) An ADCO to serve as the principal staff officer, who can be an AGR Soldier, Active Army member, or a civilian corps member, for coordinating and managing the command's ASAP.
 - (2) An MRO. When it is not possible to appoint an MRO from within available personnel resources, support will be provided by the chain of command. If the MRO support crosses MSCs, a Memorandum of Understanding will be prepared and a copy provided to the next higher HQ.
 - (3) A UPL to assist the commander in managing and conducting the unit's ASAP.

16–6. Major Subordinated Command Alcohol Drug Control Officer

The MSC ADCOs will—

- a. Advise the commander on all ASAP issues.
- b. Develop and coordinate local ASAP policies and procedures.
- c. Provide data for budget and manpower planning, develop funding controls, and maintain appropriate records of all ASAP resource transactions and testing within their subordinate commands.
- d. Manage the command's DTP.
- e. Maintain drug testing records in accordance with AR 25–400–2 in separate filing cabinets.
- f. 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 commanders who ordered the tests of all positive urinalysis results in the Soldiers' records.

- g. Be prepared to testify as an expert witness about the urinalysis collection process during administrative separation boards.
- h. Ensure MROs receive test results requiring review within 5 working days of their being posted on the FTDTL Web portal.
- i. Ensure MRO findings are input into the DAMIS within 5 working days of receiving them from the MRO.
- j. Ensure that the MRO is trained and certified for their duties in accordance with USAMEDCOM requirements (see para 9–7e).
- k. Program Operation and Maintenance, USAR and Reserve Personnel, Army funding for the command’s ASAP.
- l. Assemble and disseminate information sources concerning Active Army ASAP and certified community-based alcohol and other drug referral, counseling, and rehabilitation services to subordinate commands.
- m. Restrict notification of positive test results to the Soldier’s unit commander, the MSC commander, and when requested, the supporting legal office.
- n. Ensure all mobilizing unit company-size or larger arrive at the mobilization station with two trained and certified UPLs and enough drug testing supplies to test 100 percent of the unit strength.
- o. Ensure that all temporary storage sites for urinalysis specimens used by the MSC meet the requirements of appendix E of this regulation.
- p. Ensure all ASAP personnel involved in the collection or processing of urinalysis specimens are trained and certified on the procedures established in appendix E of this regulation, and that personnel who train UPLs in their collection duties are certified in accordance with paragraph 9–5e of this regulation.

16–7. U.S. Army Reserve Medical Review Officers

U.S. Army Reserve MROs will—

- a. Be appointed on orders.
- b. In accordance with MEDCOM Regulation 40–51, be eligible to serve as MRO and trained and certified to perform MRO duties by USAMEDCOM within the first 6 months of duty assignment (see para 9–9e).
- c. Determine if positive drug results reported by the FTDTL could have resulted from the legal use of a prescription drug for medical reasons and/or for drugs administered during surgical or dental procedures.
- d. If necessary, coordinate with the unit commander, who will offer the Soldier the opportunity to furnish medical evidence in the form of a medical prescription and/or statement from the Soldier’s physician or dentist documenting the drug prescribed or given, date of medical or dental procedure which required prescribed drugs, and the medical reason for its use. The MRO will make the determination and notify the ADCO within 30 days of receiving the positive result to review. The documentation will be marked “For Official Use Only - Personal in Nature” and will be forwarded to the MRO for evaluation. Unit commanders will not initiate an adverse action against the Soldier until the MRO had rendered an evaluation.
 - (1) If the MRO verifies legitimate use, they will notify the ADCO, the unit commander and the MSC military personnel officer. No further action is required.
 - (2) If the MRO confirms the drug use was not legitimate, the MRO will notify the ADCO, the unit commander and the MSC military personnel officer. The unit commander will counsel the Soldier in accordance with paragraph 16–8 of this regulation and process the Soldier for separation through the military personnel office to the separation authority.

Section III Policies and procedures

16–8. Policy

The objective of the USAR program is to sustain a well disciplined, mission capable force ready for mobilization. As deployability is dependent upon a drug free membership, abuse of alcohol or other drugs is incompatible with service in the USAR. Well organized and effective programs in urinalysis testing and alcohol and other drug prevention and education are critical to achieving this objective.

- a. The USAR Soldiers identified as drug abusers will be—
 - (1) Counseled by the unit commander, in person or by certified mail for possible enrollment in the USAR ASAP. Command counseling sessions will be conducted within 30 calendar days, or by the close of the next drill session, after the receipt of MRO-verified positive drug test report.
 - (2) Flagged immediately in accordance with AR 600–8–2 using DA Form 268 (Report to Suspend Favorable Personnel Actions (Flag)) to suspend favorable personnel actions until separation procedures for misconduct are adjudicated.
 - (3) Processed for administrative separation. Administrative separation will be initiated and processed to the separation authority for decision on any Soldier with a positive drug test that could not have resulted from legitimate medical use of a drug. Processing will be initiated within 30 calendar days of receipt of a positive drug test or if the case

requires MRO review, within 30 calendar days of receipt of the MRO-verified positive drug test report. In addition, Soldiers may be considered for disciplinary action under the UCMJ if use on AD can be validated.

(4) Evaluated for continued eligibility for access to classified information and reported to the U.S. Army CCF per AR 380-67.

b. Commanders will not release information on positive drug results or initiate administrative actions until an MRO review is completed if one is required.

c. Company/troop commanders will randomly select and test 10 percent of their assigned Soldiers each month or 25 percent each quarter. Special attention is directed to compliance with specific annual testing requirements for members specified in paragraph 4-8 of this regulation and Soldiers participating in counterdrug operations.

d. The USAR Soldiers involved in alcohol related misconduct such as drinking/impaired on duty (see para 3-2a of this regulation) or operating a motor vehicle while impaired will be—

(1) Counseled by the unit commander for possible enrollment in the USAR ASAP. Command counseling will occur within 30 calendar days of the Soldier's ID for possible alcohol related abuse, if operationally possible.

(2) Flagged (using DA Form 268) immediately in accordance with AR 600-8-2 until separation procedures under appropriate regulations for misconduct are adjudicated if a Soldier has two serious incidents of alcohol related misconduct in a year.

(3) Have their current duty assignment reviewed, and be relieved from duty if warranted. Commanders will ensure relief for cause is recorded.

(4) Have their Service record reviewed by the MSC commander to determine if one or more of the following actions are warranted:

(a) Administrative reduction in rank for inefficiency under the provisions of AR 600-8-19.

(b) Bar to reenlistment.

(c) Relief for Cause evaluation report.

(d) Administrative discharge/or disciplinary action under UCMJ, if applicable.

(e) General Officer Memorandum of Reprimand.

(5) Evaluated for continued eligibility for access to classified information and reported to the U.S. Army CCF per AR 380-67.

16-9. Funding considerations

Chapter 18 of this regulation applies to the USAR, except that:

a. Counterdrug Operation and Maintenance funds will be used to pay for:

(1) Supplies and shipping material for the collection and shipment of urinalysis specimens to the FTDTL.

(2) Documentation or Commander's Packets (see para 4-19 of this regulation) and related costs. Each MSC will submit a request for a Documentation Packet to the FTDTL and provide a copy of the request to the supporting Reserve Readiness Command (RRC)/ Regional Readiness Support Command (RRSC) ADCO. Counterdrug Operation and Maintenance Funds may be used for payment of expert witness' fees when approved by the MSC ADCO.

(3) Prevention education and training materials for Soldiers and their families.

(4) Travel costs to Army medical treatment facilities for Soldiers on Active Duty for 30 days or longer, who test positive for illicit drugs and require screening and/or counseling.

b. Counterdrug Pay and Allowance funds may be used to pay for:

(1) ASAP training, including travel costs to conferences and seminars.

(2) Urinalysis collections when travel is required because no unit UPL is available.

(3) Administrative separation boards for drug cases only.

c. Counterdrug funds will not be used to pay for alcohol and/or other drug rehabilitation for USAR Soldiers.

16-10. Prevention

Chapter 9 of this regulation applies to the USAR, except that:

a. The USAR will establish ASAP prevention and education programs at the lowest command level which emphasize the incompatibility of substance abuse and continued service in the USAR. The USAR ASAP is a commander's program, and MSC commanders are encouraged to establish ADICs at the lowest possible command level. The mission of the ADIC will be to outline the command's substance abuse prevention strategies and evaluate the program's effectiveness within the command.

b. The MSC will include USAR Soldiers' Family members. The MSC's Family Readiness Program Manager will coordinate Family member involvement in their ADIC counterpart as well as Drug Demand Reduction (DDR) Programs.

16-11. Referral of alcohol and illegal drug users in the U.S. Army Reserve Army Substance Abuse Program

Chapter 7 of this regulation applies to the USAR, except that—

a. When the unit commander believes the Limited Use Policy applies, the unit commander should consult with the ADCO and the supporting legal advisor. The unit commander may then explain Limited Use Policy if applicable to the particular circumstances. If the unit commander determines the Limited Use Policy does not apply, the commander should then advise the Soldier suspected of drug or alcohol abuse of the rights under UCMJ, Article 31 (b) and MRE 305, and if available ask the Soldier to sign the DA Form 3881 (Rights Warning Procedure/Waiver Certificate).

b. Refer the Soldier to a community-based, -certified counseling and rehabilitation program using DA Form 4856. The commander must provide the Soldier with a list of -certified and/or approved counseling agencies that are within a reasonable commuting distance of the Soldier's residence. (The USAR will not provide transportation or any counseling services to include evaluation, rehabilitation and follow-up services.) Additionally, Soldiers will be advised that they:

(1) Must promptly arrange for an evaluation, which should take place not later than 30 days from date of the command counseling session.

(2) Sign a consent statement for release of counseling information, which allows the counseling personnel to share necessary information with the commander or designee. The commander must be kept informed regarding the progress of rehabilitation. Soldiers must request that counseling personnel provide written monthly updates to the commander. Methadone maintenance and mandatory Disulfiram (Antabuse) treatment will not satisfy the rehabilitation requirements of this chapter. Soldiers may refuse to sign the consent statement. However, these Soldiers may be deemed not to be participating sufficiently in rehabilitation. Refusal to sign may result in their being processed for separation for rehabilitation failure.

(3) Must understand that failure to seek counseling, refusal to sign a consent to release information to the commander, or to participate and complete rehabilitation successfully, will result in initiation of separation proceedings under appropriate officer or enlisted separation regulations.

16–12. Rehabilitation

Chapter 8 of this regulation applies to USAR members when on extended AD for more than 30 days.

a. The goal of the USAR ASAP rehabilitation program is to return rehabilitated Soldiers to full effective duty as early as possible.

b. The USAR unit commander must be innovative and empathetic when working with those Soldiers enrolled in rehabilitation. The unit commander must be kept informed regarding the Soldier's progress.

c. When an USAR Soldier is detoxified at Army expense, an appropriate line of duty determination will be made in accordance with chapter 8 of this regulation.

d. The USAR Soldiers on AD orders may remain on AD until rehabilitation is completed at the discretion of the commander unless prohibited by other requirements.

16–13. Drug testing guidance

Chapter 4 of this regulation applies to the USAR, except that:

a. The MSC commander, unit commander, or their designated representatives will randomly identify individual Soldiers, parts of units, or entire units for random drug testing. Random drug testing quota requests will be in writing and approved by the MSC commander. All random drug tests will be unannounced.

b. Due to the geographical separation of USAR units and MSC ASAP ADCO staff, all urine specimens may be shipped directly from the unit that is administering drug testing to the appropriate supporting FTDTL. Proper chain of custody procedures are required (see app E of this regulation for details).

16–14. Management information system

Chapter 14 of this regulation and the following additional requirements apply to the USAR. MSC ADCOs will maintain individual files on Soldiers referred to community-based counseling and rehabilitation centers which track the beginning dates, completion dates, and reasons for disenrollment from rehabilitation, to include reasons for failure to meet the rehabilitation standards.

16–15. Evaluation

Chapter 13 of this regulation does not apply to the USAR. The operation of the USAR ASAP must include a comprehensive program of evaluation to determine program effectiveness, progress and attainment of specific goals and objectives established by the CAR. Technical support and program evaluation of the USAR ASAP will be conducted through the MSC ADCOs. The MSC ADCO will forward a summary report of their ASAP program effectiveness to the program manager at USARC, who will analyze for overall program effectiveness in the USAR. The MSC ADCOs will make periodic visits to the MSC units to evaluate their overall ASAP effectiveness and progress, and will further provide training assistance support to enhance the ASAP as necessary. Minimum evaluation standards should:

a. Stress the impact of the USAR's ASAP policies, goals and objectives on all USAR Soldiers and civilians employed by the USAR.

b. Seek comparisons of the relative effectiveness concerning the various approaches on ASAP prevention and education techniques in the MSCs. Direct USAR ADCOs to use evaluation questionnaires and checklists available in appendix D of this regulation and at the ACSAP Web site for assessing all functional areas of the ASAP, as deemed appropriate.

c. Obtain AARs on the effectiveness, usefulness, and efficiency of different supporting agencies.

d. Determine the overall effectiveness of various ASAP approaches to various target groups within the MSC.

e. Ensure full integration on all facets of the USAR ASAP at each command. This will be for the purposes of consistency of prevention, education, and training, and substance abuse testing controls and measures for urinalysis chain of custody procedures and reporting. The intent is to alleviate high urinalysis dump rates at the supporting FTDTL due to inaccurate data on the chain of custody.

f. Provide feedback and recommended improvements and/or changes to the MSC ASAP or the MSC commanders, to include economy of funding and staffing resources, program effectiveness, program trends, and recommended changes to goals and objectives as they are met.

g. Identify possible areas for research by the CAR.

16–16. Military justice

Incidents involving alcohol or other drug abuse may also constitute a basis for violation of local, , and Federal laws. The processing of recommendations for disciplinary/or nonjudicial punishment for actions regarding alcohol abuse, alcohol related incidents of misconduct, or drug abuse will be according to local, , or Federal codes, and the provisions of the UCMJ and applicable s.

16–17. Risk Reduction Program

All policies and procedures listed in chapter 12 apply to the USAR; however, the ACSAP may make modifications to accommodate the USAR mission and organization.

Chapter 17

Awards and Campaigns

Section I

Department of Defense awards

17–1. General

The DOD and DA awards in the substance abuse field are designed to foster mission accomplishment by recognizing excellence in individuals, programs, and communities.

17–2. Director, Army Substance Abuse Program awards for the Army Drug Control Office, prevention control, Employee Assistance Program coordinator, Risk Reduction Program coordinator, and drug testing coordinator of the year

a. These annual awards are designed to recognize outstanding achievements by ASAP personnel and to motivate the field to high levels of performance. An individual must occupy one of the positions in the ASAP to be eligible for consideration.

b. The award program is administered by the Director, ASAP. At the end of each calendar year, the Director announces by memorandum the opening of the awards program. Detailed instructions and applicant templates are included in the announcement. Completed applications are reviewed by a board comprised of employees from each branch of the ACSAP. The Director reviews the board's recommendations and selects a winner in each category.

c. The award eligibility criteria for each position include the following:

- (1) Duties and achievements limited to a specific calendar year.
- (2) Each applicant may only apply in one category.
- (3) Accomplishments documented and quantified by measurable standards.

d. The Garrison Commander must sign and forward the nomination packet, which must be sent through the HQ, IMCOM ADCO to the Director, ASAP.

e. Director, ASAP Award for the Reserve ADCO of the Year

f. This award is designed to recognize outstanding achievements of MSC ADCOs in the USAR.

g. The award program is administered by the Director, ASAP. At the end of each calendar year, the Director announces by memorandum the opening of the awards program. Detailed instructions and applicant templates are included in the announcement. Completed applications are reviewed by a board comprised of employees from each branch of the ACSAP. The Director reviews the board's recommendations and selects a winner.

h. The award eligibility criteria include the following:

- (1) Duties and achievements limited to a specific calendar year.
- (2) Accomplishments documented and quantified by measurable standards.
- (3) All ADCO functional areas addressed, as cited in paragraph 16–6 of this regulation.
 - i. The USARC must endorse the nomination packet.

17–3. Director, Army Substance Abuse Program award for the Army National Guard Joint Substance Abuse Program Officer of the year

- a. This award is designed to recognize outstanding achievements of JSAPOs in the Army National Guard.
- b. The award program is administered by the Director, ASAP. At the end of each calendar year, the Director announces by memorandum the opening of the awards program. Detailed instructions and applicant templates are included in the announcement. Completed applications are reviewed by a board comprised of employees from each branch of the ACSAP. The Director reviews the board's recommendations and selects a winner.
- c. The award eligibility criteria include the following:
 - (1) Duties and achievements limited to a specific calendar year.
 - (2) Accomplishments documented and quantified by measurable standards.
 - (3) All JSAPO functional areas addressed, as cited in paragraph 15–7 of this regulation.
- d. The and National Guard Bureau must endorse the nomination packet.
- e. All nominated JSAPOs must be in the Army National Guard.

17–4. 20/30 Year Army Substance Abuse Program award

The Director, ASAP recognizes ASAP personnel who have served within the ASAP for 20 and 30 years. Applicants must complete the ASAP Service Time Documentation Form available on the ACSAP Web site to be considered for this award.

Section II

Secretary of Defense awards

17–5. Community drug awareness award

The Secretary of Defense Community Drug Awareness Award is presented annually to the best drug demand reduction effort for the previous year within each Service, the National Guard Bureau and the Defense Agencies. The award was established in 1990 by the DOD in an effort to promote community drug awareness efforts in the DOD community. The Award is presented as part of the DOD annual Red Ribbon Campaign. The primary eligibility requirement is documentation of the local Red Ribbon Campaign participation. (See the ACSAP Web site for details.)

17–6. Fulcrum Shield award

The Secretary of Defense Fulcrum Shield Award is an annual award designed to promote community drug awareness efforts by youth programs associated with the Military Services, Defense Agencies, and the National Guard Bureau. The Award is presented as part of the DOD annual Red Ribbon Campaign. The primary eligibility requirement is documentation of the local Red Ribbon Campaign participation. (See the ACSAP Web site for details.)

Section III

Campaigns

17–7. General

Alcohol and other drug-related campaigns involve the community in substance abuse deterrence and awareness. Soldiers, civilian employees, and Family members are provided information on risk factors and resources in the area of substance abuse prevention. Campaigns are a collaboration of diverse resources in the local community.

17–8. Community campaigns

- a. Installation ADCOs will select a minimum of two substance abuse related campaigns a year for the ASAP staff to coordinate/support. Some campaigns may be long-term while others are time-limited.
- b. Installation ADCOs will—
 - (1) Institute written standing operating procedures (SOP) designed to enhance effective local campaigns.
 - (2) Evaluate campaigns regarding the potential for collaboration between local and installation resources.
 - (3) Coordinate with the Garrison Commander and other community resources regarding the implementation of a campaign.
- c. The ASAP program is authorized to purchase promotional items in support of substance abuse prevention campaigns. These items may be used to support local or Army-sponsored prevention campaigns. The promotional products should not indicate the Army endorses a particular product or private organization.
- d. Some key community campaigns includes—

- (1) Alcohol Awareness Month.
- (2) Red Ribbon Week.
- (3) National Drunk and Drugged Driving (3D) Awareness Month.
- (4) Tie One on for Safety For a more complete list, see the ACSAP Web site at <http://acsap.army.mil>.

Chapter 18

Army Substance Abuse Program Resource Management

18-1. General

The Director, ACSAP is responsible for the provision of resources to the ASAP. The ACSAP oversees MDEPs QAAP, MDEP Code for the ASAP Funds (QFMD), the DDR Program, and the VCND which are the sources of ASAP funding. The FTDTL operations, MRO services, and clinical counseling services do not fall under the ACSAP Director's responsibility for funding, management, or oversight.

18-2. Policy

a. The QAAP is the only source of funding in the ASAP that is authorized to pay for alcohol-related substance abuse services for Soldiers and civilian corps members. The QAAP funds may be used to cover the costs of drug-abuse related services when DOD Counter-narcotics funds are insufficient or have been exhausted.

b. The QFMD funds may not be used to pay for any costs other than the Family Member Substance Abuse Program.

c. The U.S. Congress has restricted the use of VCND funds to DOD counter-narcotics missions. Army usage of VCND funds is restricted to providing drug abuse-related services. No VCND funds can be expended on alcohol abuse-related services or any other similar service. Army DDR VCND funds are fenced and their usage is limited to the following services:

(1) Urinalysis testing of Active Duty Soldiers (including the costs of collection, supplies, shipment, analyses, reporting, administrative overhead, travel, civilian pay, staff training and certification, and contractual support).

(2) Urinalysis testing of civilian corps members subject to the requirements of Executive Order 12564 (for example, those civilians in Testing Designated Positions) and the requirements of DOT mandates for vehicle drivers.

(3) Urinalysis of USAR and Army National Guard Soldiers using DDR Operations and Maintenance Army Appropriations Funding.

(4) Education and training of Soldiers and civilian corps members on the dangers of drug abuse (includes administrative overhead, civilian pay, marketing/education materials, travel, and contractual support).

(5) Education, training, and counseling of dependents on the dangers of drug abuse.

(6) In-patient and out-patient care of drug abusers and all Soldiers who self-refer for drug abuse.

d. The VCND funds can fund demand reduction programs and initiatives directed toward the non-military residents near military installations as a means of community outreach, when funds are available.

e. Installations may use VCND funds to purchase promotional items with little intrinsic value that convey an anti-drug message. Such items may include, but are not limited to balloons, pencils, pennants, ribbons, pins, stickers, and caps.

18-3. Funding sources and their uses

Two financial sources fund the Army Substance Abuse Program (ASAP): base operations support (BOS) and DOD Counter-narcotics.

a. Base operations support funds include MDEPs QAAP (the Army Substance Abuse Program) and QFMD (the Family Member Substance Abuse Program). The Army proponent office for BOS funding is the Assistant Chief of Staff, Installation Management.

b. The QAAP Substance Abuse Program funds.

(1) Funds installation substance abuse program services for Soldiers and civilian corps members. Services funded include testing/ID; prevention, education and training; counseling and rehabilitative treatment.

(2) Civilian testing requirements include DOT testing mandates for vehicle drivers and Drug-Free Workplace mandated testing of employees in Testing Designated Positions. Prevention education and training includes Soldier, leader/supervisor, and Family members. HQDA substance abuse services include support for the Risk Reduction Program, the DAMIS, initial skill and certification training for installation ASAP personnel, and product development and distribution to Soldiers designated as Unit Prevention Leaders.

c. The QFMD.

(1) These funds are specifically intended to fund Family member substance abuse services.

(2) The VCND funds project code(s) supporting the Army's DDR Program.

(a) The DDR protects our Soldiers, families and civilian corps members through drug abuse deterrence, prevention, education and rehabilitation. Suppressing drug abuse in the Army enhances Army well-being and directly contributes to

unit readiness. There are three components to the Army's DDR program: Deterrence and Detection (testing); Education and Prevention; and Rehabilitation.

(b) The VCND funds are not actually programmed by the Army. They are DOD funds.

d. General Guidance for ASAP Resource Management

(1) Pay people first and correctly.

(a) Fund civilian corps member salaries in accordance with the MDEPs identified with each authorized position on the authorization document. For example, if an ADCO is identified on the installation's ASAP Table of Distribution and Allowances (TDA) as a QAAP position, then that person should be paid with QAAP dollars.

(b) Dollar requirements and justifications made at Army level for civilian pay are based on TDA documentation. There can be major repercussions throughout the program due to the over- or under-execution of civilian pay in one MDEP or the other.

(2) All DTC salaries should be funded with DOD counter-narcotics funds (VCND).

(3) Maximize execution of funds: commit funds early so that funds are obligated by the end of the fiscal year.

(4) Avoid fraud, waste, or abuse of funds, or the appearance thereof.

(5) Make direct contact with individuals involved in the ASAP budget process.

(6) Learn the budget audit trail and track ASAP funds monthly-as a minimum.

(7) Provide accurate inputs on the DA Form 3711. Submit the Resource and Performance Report (RAPR) on time every month.

(8) Develop accurate budgets based on historical execution, legitimate requirements, and Army and command priorities.

Appendix A References

Section I Required Publications

DOD Instructions and Directives are available at <http://www.dtic.mil/whs/directives/>; National Guard publications can be found at www.ngbpdc.ngb.army.mil/pubfiles/.

AR 11-2

Management Control (Cited in paras 2-18, 13-3.)

AR 25-400-2

Army Records Management Information System (ARIMS) (Cited in paras 2-18, 2-21, 2-23, 4-7, 4-21, 6-7, 14-8, 15-7, 15-8, and 16-6.)

AR 40-66

Medical Record Administration and Health Care Documentation (Cited in paras 6-7, 6-9, 10-1, 10-15, 10-16, 14-2, and 14-7.)

AR 40-501

Standards of Medical Fitness (Cited in para 4-8.)

AR 50-5

Nuclear Surety (Cited in paras 4-8, 5-8, 5-11, and 5-21.)

AR 50-6

Chemical Surety (Cited in paras 4-8, 5-8, 5-11, and 5-21.)

AR 135-175

Separation of Officers (Cited in paras 15-4, 15-16.)

AR 135-178

Enlisted Administrative Separations (Cited in paras 15-14, 15-16.)

AR 190-5

Motor Vehicle Traffic Supervision (Cited in para 3-3.)

AR 195-2

Criminal Investigation Activities (Cited in paras 2-11, 10-11.)

AR 215-1

Military Morale, Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities (Cited in paras 3-2, 3-4.)

AR 340-21

The Army Privacy Program (Cited in paras 10-1, 10-15, 10-16, 10-24, and 14-2.)

AR 380-67

The Department of the Army Personnel Security Program (Cited in paras 4-8, 5-11, 5-21, 10-5, 10-6, 15-11, and 16-8.)

AR 600-8-2

Suspension of Favorable Personnel Actions (Flags) (Cited in para 16-8.)

AR 600-8-10

Leaves and Passes (Cited in para 10-7.)

AR 600-8-24

Officer Transfers and Discharges (Cited in paras 2-31, 2-32, 3-2, 7-3, 7-12, 10-6, and table 12-1.)

AR 600–20

Army Command Policy (Cited in para 4–2.)

AR 614–30

Overseas Service (Cited in para 10–9.)

AR 635–200

Active Duty Enlisted Administrative Separations (Cited in paras 2–31, 2–32, 3–2, 3–3, 4–2, 7–3, 7–12, 10–6, 10–8, and table 12–1.)

DA Pam 600–85

Army Substance Abuse Program Civilian Services (Cited in paras 2–20, 2–29, 2–35, 3–11, 5–1, 5–6, 5–8, 5–9, 5–16, 5–17, 5–24, 5–25, 5–26, 5–27, 5–31, 5–33, 6–1, 6–5, 6–7, 7–4, 7–5, 7–6, 8–3, 12–18, 14–1.)

DODD 1010.1

Military Personnel Drug Abuse Testing Program (Cited in paras 1–5, 4–5, and 4–15.)

DODD 1010.9

DOD Civilian Employees Drug Abuse Testing Program (Cited in paras 1–5, 5–20, and 10–31.)

DODI 1010.16

Technical Procedures for Military Personnel Drug Abuse Testing Program (Cited in paras 4–4, 4–15, 11–1, and E–3.)

DODI 4000.19

Interservice and Intragovernmental Support Mandatory Guidelines for Federal Workplace DTPs, published by DHHS, which includes Scientific and technical Requirements and Certification of laboratories Engaged in Urine Drug Testing, 53 Fed. Reg. 11970 (1988) as amended by 59 Fed Reg. 29908 (1994) (Cited in para 1–9.) (Available at <http://www.workplace.samhsa.gov/DrugTesting.aspx>) Mandatory Guidelines for Federal Workplace DTPs, published by DHHS, which includes Scientific and Technical Requirements and Certification of Laboratories Engaged in Urine Drug Testing, 53 Fed. Reg. 11970 (1988) as amended by 59 Fed. Reg. 29908 (1994) (Available at <http://workplace.samhsa.gov/DrugTesting/DTesting.aspx>). Urine Specimen Collection handbook for Federal Workplace DTPs, Division of Workplace Programs, Center for Substance Abuse and Mental Health Services Administration, the U.S. DHHS (Available at <http://www.workplace.samhsa.gov/DrugTesting/DTesting.aspx>)

Executive Order 12564

Drug-free Federal Workplace, September 15, 1986 (Cited in paras 5–2, 5–5, 5–6, 5–8, 10–31, and 18–2.) (Available at <http://www.archives.gov/federal-register/index.html>.)

MEDCOM Regulation 40–51

Medical Review Officers and Review of Positive Urinalysis Drug Testing Results (Cited in paras 2–15, 4–14, 15–9, and 16–7.)

DFAR Supplement

(Available at <http://www.acq.osd.mil/dpap/dars/dfars/index.htm>) (Cited in para 5–13.)

NGR 500–2

National Guard Counterdrug Support Regulation (Cited in para 15–17.) (Available at <http://www.ngbpdc.ngb.army.mil>.)

49 CFR 40

Procedures for Transportation Workplace Drug and Alcohol Testing Programs (Cited in paras 3–13, 5–28, 5–30, 5–31, 5–32, and 9–8.) (Available at <http://ecfr.gpoaccess.gov>.)

Section II**Related Publications**

A related publication is a source of additional information. The user does not have to read it to understand this publication. DOD Instructions and Directives are available at <http://www.dtic.mil/whs/directives/>; National Guard publications can be found at www.ngbpdc.ngb.army.mil/pubfiles/; citations to the United States Code, public laws, and the Congressional Record are available at <http://www.gpoaccess.gov/>; and Federal Acquisition Regulations are available at <http://www.arnet.gov/>.

AR 15-1
Committee Management

AR 10-78
United States Army Drug and Alcohol Technical Activity

AR 40-68
Clinical Quality Management

AR 140-111
U.S. Army Reserve Reenlistment Program

AR 190-30
Military Police Investigations

AR 195-5
Evidence Procedures

AR 350-1
Army Training and Leader Development

AR 360-1
The Army Public Affairs Program

AR 600-8-1
Army Casualty Program

AR 600-8-19
Enlisted Promotions and Reductions

AR 600-105
Aviation Service of Rated Army Officers

AR 601-280
Army Retention Program

AR 623-3
Evaluation Reporting System

AR 635-5
Separation Documents

DODD 6025.13
Medical Quality Assurance (MQA) in the Military Health System (MHS)

NGR (AR) 600-5
The Active Guard Reserve (AGR) Program, Title 32, Full-Time National Guard Duty (FTNGD)

NGR (AR) 600-200
Enlisted Personnel Management (ECM) and Fiscal Year (FY) Enlisted Criteria Memorandum

5 CFR 752
Adverse Actions

42 CFR 2
Confidentiality of Records

5 USC 552(a)
The Privacy Act

42 USC 290dd-2

Confidentiality of Alcohol and Drug Abuse Patient Records

PL 91-616

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970

PL 92-129

Amendments to the Military Selective Service Act of 1967

PL 92-255

Drug Abuse Treatment Act of 1972

PL 95-454

Civil Service Reform Act of 1978

PL 99-570

Federal Employees Substance Abuse Education and Treatment Act of 1986

PL 100-71, 503, 5 USC 7301 note

Supplemental Appropriations Act, 1987

PL 100-690

Drug-Free Workplace Act of 1988

PL 102-143, Title V

Omnibus Transportation Employee Testing Act of 1991

FAR 23.5

Drug-Free Workplace

FAR 52.223-6

Drug-Free Workplace (May 2001)

ADAPT Manual

Army Center for Substance Abuse Programs (Available at <https://ssob.acsap.hqda.pentagon.mil/sso/pages/public/adapt.jsp>)

Alcohol and Drug Control Officer Guidebook

Army Center for Substance Abuse Programs (Available at <https://ssob.acsap.hqda.pentagon.mil/sso/pages/index.jsp>)

Commander

Army Center for Substance Abuse Programs (Available at https://sso.acsap.hqda.pentagon.mil/sso/pages/public/promotional_materials.jsp)

Employee Assistance Program Coordinator (EAPC) Guidebook

Army Center for Substance Abuse Programs (Available at https://ssob.acsap.hqda.pentagon.mil/sso/pages/public/eap_guide.jsp)

Installation Biochemical Test Coordinator Guidebook

Army Center for Substance Abuse Programs (Available at <https://ssob.acsap.hqda.pentagon.mil/sso/pages/index.jsp>)

Prevention Coordinator Guidebook

Army Center for Substance Abuse Programs (Available at <https://ssob.acsap.hqda.pentagon.mil/sso/pages/index.jsp>)

Guide to the Completion of ASAP Forms

Army Center for Substance Abuse Programs

Section III

Prescribed Forms

DA Form 5018–R

ADAPCP Client’s Consent Statement for Release of Treatment Information (Prescribed in para 10–28e.)

Section IV

Referenced Forms

DA Form 11–2–R

Management Control Evaluation Certification Statement

DA Form 268

Report to Suspend Favorable Personnel Actions (FLAG)

DA Form 3711

Army Substance Abuse Program (ASAP) Resource and Performance Report (RAPR)

DA Form 3881

Rights Warning Procedure/Waiver Certificate

DA Form 3997

Military Police Desk Blotter

DA Form 4465

Patient Intake/Screening Record (PIR)

DA Form 4466

Patient Progress Report (PPR)

DA Form 4856

Developmental Counseling Form

DA Form 5019

Condition of Employment for Certain Civilian Positions Identified Critical under the Department of the Army Drug–Free Federal Workplace Program

DA Form 5440–58

Delineation of Clinical Privileges–Substance Abuse Rehabilitation

DA Form 5513

Key Control Register and Inventory

DA Form 7412

Condition of Employment for Certain Civilian Positions Identified Safety–Sensitive under the Department of Transportation, Federal Highway Administration Rules on Drug and Alcohol Testing

DA Form 8003

Army Substance Abuse Program (ASAP) Enrollment

DD Form 2624

Specimen Custody Document–Drug Testing

SF 66

Official Personnel Folder

SF 513

Medical Record–Consultation Sheet

SF 600

Health Record–Chronological Record of Medical Care

SF 702

Security Container Check Sheet

AFIP Form 1323

AFIP/Division of Forensic Toxicology–Toxicological Request Form

ASAP Service Time Documentation Form

U.S. Department of Transportation (DOT) Alcohol Tasting Form

DOT Data Collection Form

U.S. Department of Transportation Drug and Alcohol Testing MIS Data Collection Form (Available at <http://dot.gov/>.)

Appendix B

Unit Commander's Guide to the Army Substance Abuse Program (ASAP)

This guide provides basic information to unit commanders about the Army Substance Abuse Program (ASAP). The following questions and figures provide a quick overview of the unit commander's responsibilities, resources, and procedures necessary to participate in and fully support the ASAP prescribed by AR 600–85.

B–1. What is the Army Substance Abuse Program?

Response 1: The Army Substance Abuse Program, or ASAP, is a comprehensive program, which combines substance abuse deterrence, prevention, ID, and rehabilitation designed to strengthen the overall fitness and effectiveness of the Army and to enhance the combat readiness of its personnel and units by eliminating alcohol and/or other drug abuse. (ASAP mission and objectives are listed in para 1–5, AR 600–85.)

B–2. What is the unit commander's role in the ASAP?

Response 2: Commander's actions to prevent, deter, and reduce alcohol and other drug abuse are the keys to ASAP success. Unit commanders must observe their Soldiers' behavior and intervene early to identify possible alcohol and/or other drug abusers, refer these Soldiers for evaluation by trained medical personnel, recommend enrollment in rehabilitation programs, monitor each Soldier's rehabilitation progress, and when appropriate, process Soldiers for separation. (More information on the unit commander's role in ASAP can be found in paras 2–31 and 2–32.)

B–3. What specifically must the unit commander do?

Response 3: The major actions a unit commander must accomplish are: appointing the Unit Prevention Leaders, establishing the Unit Drug Testing and the Prevention and Education Programs, and enforcing the Army Substance Abuse Program policies. The commander will implement and maintain, even while deployed, a unit substance abuse program. (A complete list of the unit commander's responsibilities is contained in paras 2–31 and 2–32.)

a. Appoint on orders at least two officers or NCOs to be trained and certified as the Unit Prevention Leader (UPL) and alternate(s). The UPL will assist the commander in the designing and implementing the unit prevention plan, administering the unit DTP, and keeping the commander informed of trends in alcohol and other drug abuse in the unit. (See paras 2–34 and 2–35 for a detailed list of UPL responsibilities.)

b. Ensure that the Unit Substance Abuse Program SOP and policies are up to date, reviewed annually and signed by the current unit commander.

c. Conduct random, unpredictable urinalysis at a rate of 4 percent of the battalion's assigned and attached strength per week. The drug and alcohol testing program facilitates early ID of substance abuse in the unit, and enables the commander to assess the security, military fitness, and good order and discipline of their unit. (See chap 4, AR 600–85 for more information on drug testing).

d. Refer all identified drug or alcohol abusers to the ASAP for evaluation.

e. Discipline, as appropriate, all identified substance abusers, underage drinkers, and Soldiers who provide alcohol to underage Soldiers.

f. Initiate separation action on ALL Soldiers identified as drug abusers or who are involved in two serious incidents of alcohol-related misconduct within 12 months.

g. Prevent, deter, and reduce the abuse of substances to the lowest extent possible through education, community involvement, and deglamorization of alcohol (ensure that alcohol is never the focus of any unit event). While there are many prevention strategies available, the unit commander should provide education and training to Soldiers on the effects and consequences of alcohol and other drug abuse, along with the rehabilitation services which are available at the installation. (See Response 4 and chap 9, AR 600–85 for information on prevention policies and strategies.)

(1) Ensure that the required training and briefings are provided annually.

(2) Brief all newly assigned Soldiers on local and command ASAP policies and services.

(3) Immediately report all offenses involving illegal possession, use, sale, or trafficking in drugs or drug paraphernalia to the Provost Marshal for investigation or referral to the USACIDC. This includes all positive test results that do not require a medical review as directed by USAMEDCOM. Positive tests that require MRO review will not be reported until receipt of verified illegitimate use by the MRO.

(4) Assess programs and provide feedback to the Installation Risk Reduction Program Coordinator and Installation Prevention Team for program improvements.

h. Maintain contact with both the counseling and garrison ASAP staff to stay abreast of:

(1) New training and educational materials, Risk Reduction data, drug and alcohol trends, and statistics within the local community or area of deployment.

(2) The status of Soldiers enrolled in rehabilitation.

(3) Changes in regulations or policies, programs and campaigns within the military community.

i. Use the Risk Reduction Program and work with the Risk Reduction Program Coordinator and the IPT to design and prevent high risk behavior and intervene when necessary.

j. Direct Soldiers to complete the Reintegration Unit Risk Inventory (R-URI) 90–180 days after returning from a deployment.

B-4. Who are the ASAP key players?

Response 4:

a. Garrison ASAP.

(1) You as a commander have the key role in the Army's substance abuse program (see paras 2-31 and 2-32).

(2) The Unit Prevention Leader is your primary POC at the unit for ASAP issues (see paras 2-34 and 2-35).

(3) The ADCO is in charge of all garrison ASAP functions and is your primary POC for ASAP issues (see para 2-18).

(4) The PC is responsible for prevention and training programs on your installation to include unit level training and the training of UPLs (see para 2-19).

(5) The DTC is the installation subject matter expert for drug testing procedures. The DTC operates a forensically secure installation DTP collection point, ensures quality control of the specimens sent to the Forensic Toxicology Drug Testing Laboratory (FTDTL), provides technical assistance and support for the UPL certification training program, and advises unit commanders on program utilization, test results and supplies (see para 2-21).

(6) The Employee Assistance Program Coordinator (EAPC) is the primary POC for civilian employees in need of assistance (see para 2-20).

(7) The Risk Reduction Program Coordinator (RRPC) is the primary POC for the Risk Reduction Program statistics, Unit Risk Inventory and Reintegration-Unit Risk Inventory surveys (see para 2-22).

(8) The BACM supervises the ASAP program for a MSC in certain deployed areas that have been assigned a BAC (see para 4-7d).

b. Counseling ASAP: The local ASAP Counseling Center provides the unit commander with a wide range of counselors to evaluate and counsel alcohol and/or other drug abusers.

(1) The Clinical Director is in charge of the counseling portion of the ASAP and is your POC for counseling and rehabilitation services (see para 2-23).

(2) Counselors evaluate Soldiers with potential substance abuse problems and provide rehabilitation.

c. Other Personnel Supporting the ASAP.

(1) The MRO reviews positive drug test results that could be due to authorized prescription medication or medical or dental treatment. They will determine if the use was legitimate (see para 4-14 and fig 4-2).

(2) The Staff Judge Advocate (SJA) is your legal advisor for drug and alcohol cases (see para 2-27).

(3) The MP and the CID provide blotter reports and investigate drug cases.

B-5. What process should be followed if a unit commander suspects a Soldier of alcohol and/or other drug abuse?

Response 5: Figure B-1 provides an outline of the process. If a unit commander has some reasonable suspicion (the chain of command has noticed unusual or aberrant behavior by the Soldier), but not sufficient evidence for PO to suspect a Soldier of drug or alcohol abuse, and if the unit commander believes the Limited Use Policy applies (see paras 10-12 through 10-14), the unit commander should consult with the supporting legal advisor before discussing the Limited Use Policy with the Soldier. If appropriate, the unit commander may then explain the Limited Use Policy to the Soldier. If a unit commander has PO to suspect a Soldier of drug or alcohol abuse (the chain of command has good reason to suspect that drugs are within the Soldier's body), the commander should consult with the supporting legal advisor and if appropriate advise the Soldier of their rights under UCMJ Article 31(b) using DA Form 3881. The commander may then also order the Soldier to submit a PO urine specimen. If the Soldier waives their rights, the commander may then question the Soldier about alcohol or drug abuse. If there is less than PO, the commander may

still refer the Soldier for a professional evaluation by the ASAP counseling personnel, or the commander may decide that the Soldier should simply be returned to duty.

B-6. What does the unit commander do when notified that a Soldier has tested positive during a drug test?

Response 6: Figure B-2 provides an outline of the process. When a unit commander is notified that a Soldier tested positive during a urinalysis, the unit commander's actions are determined by the type of drug identified. If the drug does not have a legitimate medical use as determined by USAMEDCOM, the commander will consult with law enforcement to determine whether law enforcement desires to conduct an investigation. The commander will also flag the Soldier and consult with the trial counsel who supports the unit. If law enforcement declines to conduct an investigation, the commander must conduct his or her own preliminary inquiry into the alleged offense. The commander must advise the Soldier of his or her legal rights under UCMJ Article 31 (b) using DA Form 3881. If the Soldier waives his or her rights, the commander may then question the Soldier about drug abuse. After completing the inquiry or investigation, the commander should consider the full range of actions in accordance with the Rule for Courts Martial 306 of the Manual for Court Martial. The commander must initiate administrative separation within 30 calendar days of receipt of a positive drug test report or if the case requires MRO review, within 30 calendar days of receipt of the MRO-verified positive drug test report. In cases where the chain of command has referred the matter to a trial by court-martial, administrative separation proceedings will be delayed until the completion of the court-martial process. The commander may initiate action under the UCMJ and start administrative separation processing simultaneously. Regardless of the action taken, the Soldier must be referred to the ASAP.

B-7. What can I expect when a Soldier is enrolled for Army Substance Abuse Program rehabilitation?

Response 7: When the Soldier is enrolled in the ASAP, the rehabilitation team, which includes the unit commander or First Sergeant, the Soldier, and counselor, will meet to confirm that rehabilitation is warranted for the Soldier and what the rehabilitation plan will include. Both the commander and the Soldier must dedicate time and effort to the process. Depending on the severity of abuse, the rehabilitation plan may include the Soldier's participation in any/all of the following:

- a. At least 12 hours of ADAPT in accordance with TRADOC Reg 350-70.
- b. Weekly individual or group counseling sessions.
- c. A two- to four-week partial inpatient care program.
- d. Attendance at self-help groups such as AA or Narcotics Anonymous (NA).
- e. Unannounced rehabilitation drug or alcohol testing intended to determine if the Soldier is still abusing drugs or alcohol. Unless hospitalized, the Soldier is expected to participate in normal unit operations (for example, field training exercises, CQ or similar duties, and deployments) while receiving the care listed above.

B-8. How is a commander involved in a Soldier's rehabilitation?

Response 8: The commander will—

- a. Participate as a key member in the Rehabilitation Team meetings with the ASAP counseling staff. (chapter 8 of this regulation addresses the rehabilitation process.)
- b. Evaluate and provide periodic feedback to the counselor about the Soldier's duty performance during care.
- c. Review ongoing evaluations of the Soldier's progress and participation provided by the ASAP counselor and meet with the Soldier to discuss the evaluation.
- d. Ensure the Soldier's rehabilitation testing is conducted in accordance with the rehabilitation plan.
- e. Make the final determination of the success or failure of the Soldier's rehabilitation (normally within 3 to 6 months of initial enrollment). If unsuccessful, the commander will initiate separation action for rehabilitation failure.

B-9. How should a unit commander prepare for a deployment?

Response 9: The commander will —

- a. Contact the installation or USAR MSC ADCO or JSAPO for guidance, especially on what BAC to use when testing in the deployed area.
- b. Ensure the unit has at least two trained UPLs that will deploy and two that will stay behind with the rear detachment, if necessary. Units that will be geographically dispersed in the deployment area may need additional trained UPLs. UPL certification lasts for 12 months.
- c. Obtain and pack enough drug testing supplies to test 100 percent of the Soldiers that will deploy. (Replacement supplies will be ordered in the deployment theater, but may take some time to reach the unit.)
- d. Deploy with the DOD DTP software, a current unit roster, and an alternate means of randomly choosing Soldiers for testing (see chapter 4 for details).
- e. Ensure the UPLs know how to perform quality control, packing, and shipping procedures for the urinalysis specimens because these tasks are usually done by a DTC or JSAPC, and the UPL will ship directly to the drug testing lab from the deployment area. Ensure the UPLs have the supplies needed to pack and ship the urine specimens.

f. Check with the postal officer to determine how to ship urinalysis specimens from the deployed area to the lab for testing.

B-10. What is the Limited Use Policy?

Response 10: The objective of the Limited Use Policy is to facilitate the ID of alcohol and other drug abusers by encouraging self-referral. In addition, the policy is designed to facilitate the rehabilitation of those abusers who demonstrate the potential for both rehabilitation and retention. In short, the Limited Use policy allows a Soldier to get help and make a new start without being punished for past offenses. It is not intended to protect a Soldier who is attempting to avoid disciplinary or adverse administrative action. When applied properly, the Limited Use Policy does not conflict with the Army's mission or standards of discipline. Soldiers may seek help for their own alcohol or other drug problem from their unit commander, a physician at the MTF, or any agency or individual described in chapter 7 of this regulation. This is a complicated policy that your supporting legal advisor can help you apply. Additional guidance is in paras 10-12 to 10-14.

B-11. How do I get a UPL certified and how do I get the required Army Substance Abuse Program training for my unit?

Response 11:

a. Contact your ADCO or PC to schedule your UPL candidate to take the 40-hour UPL Certification course. Your UPL should receive a copy of the UPL CTP CD-ROM that includes all the training resources for the course. If you are deployed and need to certify a new UPL or to recertify a current UPL, contact the ACSAP at biochem@acsap.army.mil for instructions. See paragraph 9-6 for more information.

b. Once certified, your UPL, with help from the ASAP staff, the UPL CTP CD and the ACSAP Web site, should be able to provide or schedule your alcohol and other drug awareness training. With prior coordination, the PC can provide some of the required training. See paragraph 9-11 for more information.

B-12. What is smart testing?

Response 12:

a. Definition of Smart Testing: The process where drug testing is conducted in such a manner that it is not predictable to the tested population. If your unit is conducting random smart testing, then every Soldier should believe that they can and may be tested on any given day at any given time.

b. Why is Smart Testing important? The urinalysis program is designed to be a deterrence program. If a Soldier believes that they will be tested at any time and that they will receive negative consequences for testing positive, then they will be less likely to use drugs. If a Soldier can predict when they will be tested, then they may try to beat the test, and the deterrent effect is lost.

c. DO's of Smart Testing:

- (1) Back-to-back testing (for example, Friday/Monday)
- (2) Weekend/Holiday testing
- (3) During field exercises
- (4) At the end of the duty day
- (5) During afternoon PT

d. 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. Figure B-1 Figure B-2

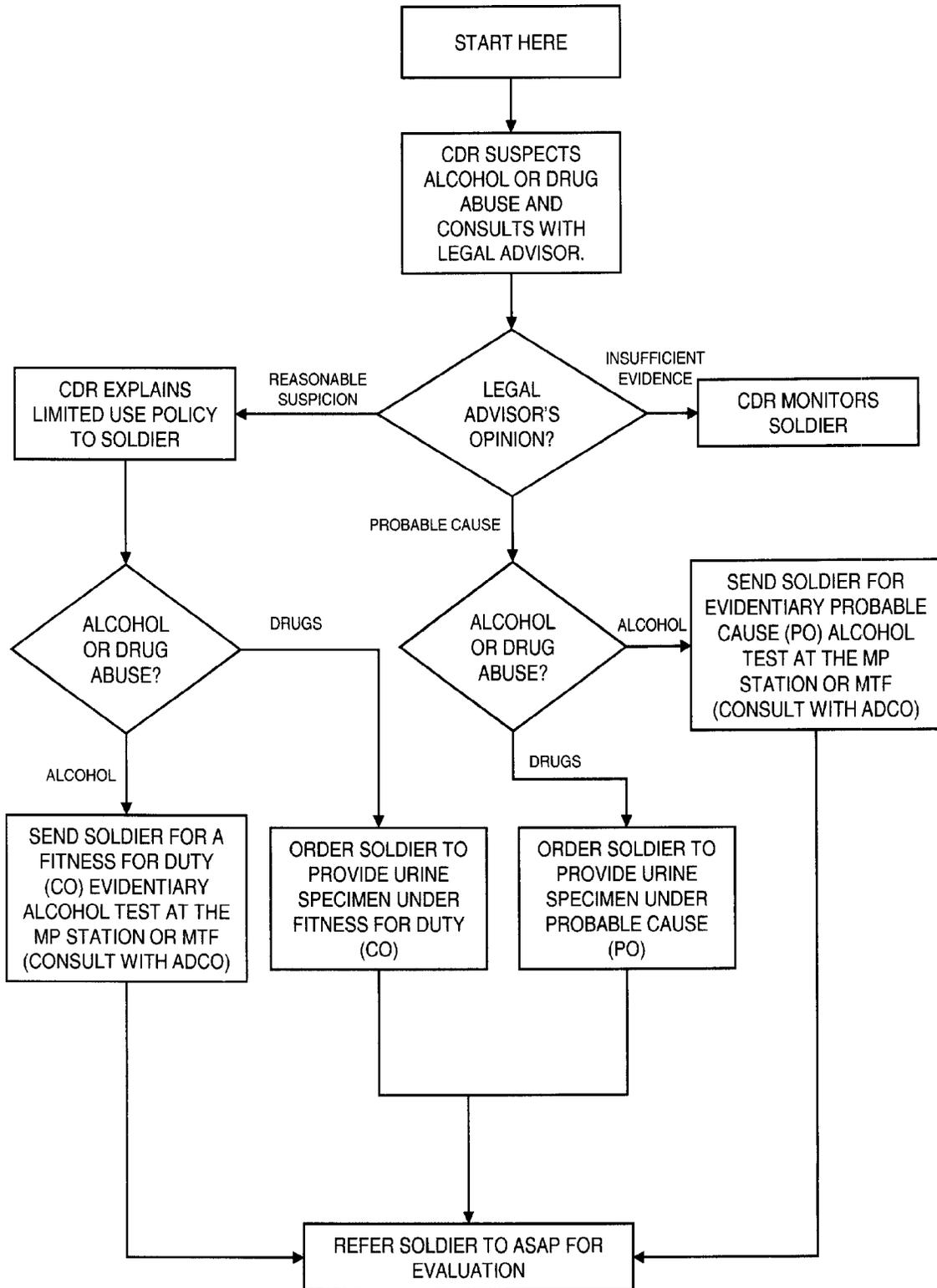


Figure B-1. A Commander's Actions When a Soldier is Suspected of Abusing Drugs or Alcohol

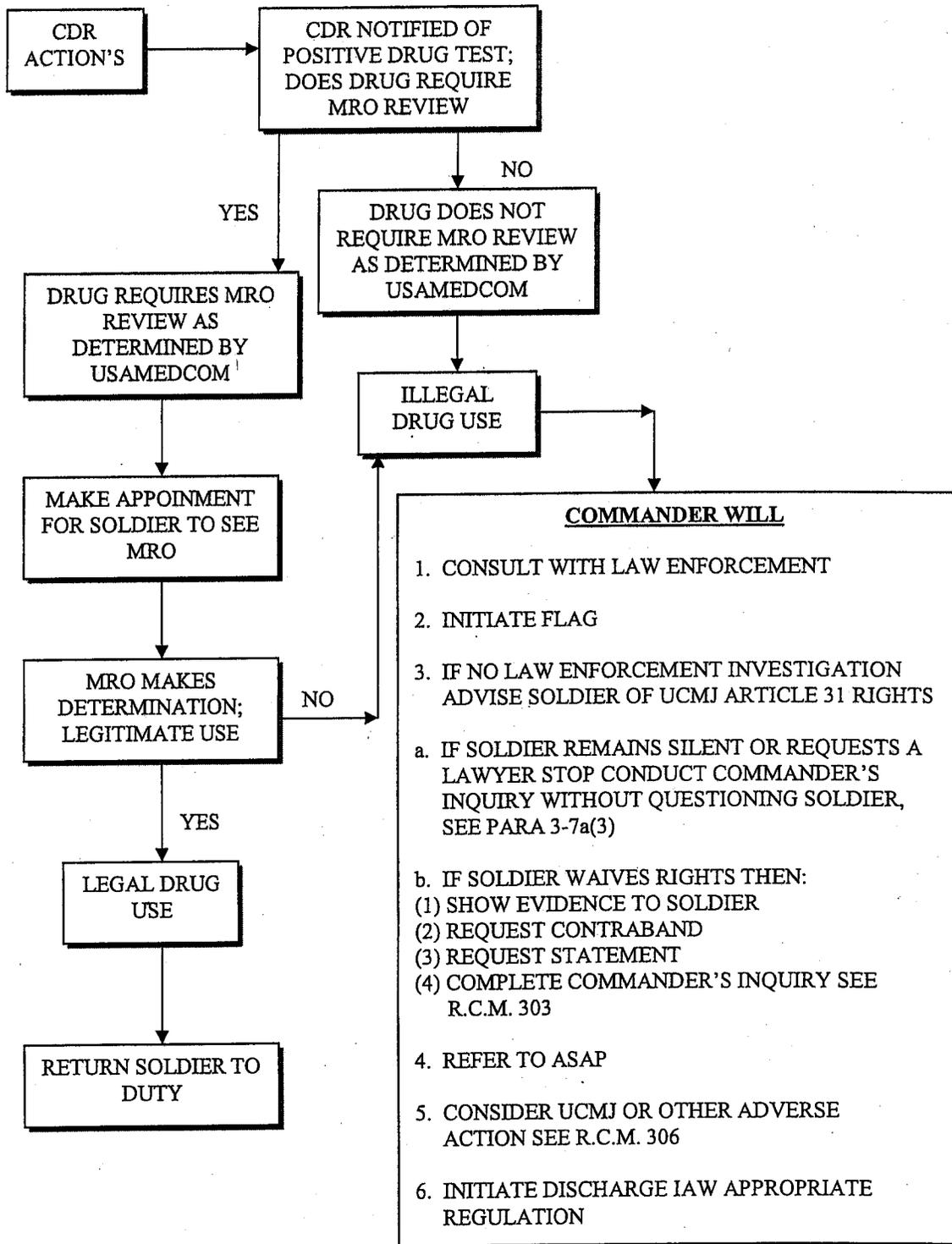


Figure B-2. Commander's Actions Upon Receiving a Positive Drug Test Result

Appendix C Army Substance Abuse Program Clinical Code of Ethics

C-1. Introduction

The ASAP is comprised of treatment providers who have responsibility for providing clinical counseling to clients suffering the effects of alcohol and other drug abuse. The term "ASAP Clinical Staff," as used in this document, refers to all ASAP clinical staff, even though the job title may be "Clinical Director," "Social Worker," or some other designated title. ASAP Clinicians believe in the dignity and worth of their clients as human beings and accept responsibility for providing competent, quality treatment, consistent with their education, experience, and job assignment. In the practice of their profession, ASAP Clinical Staff dedicate themselves to promoting the best interest of their employing institution, their society, their clients, the profession, and their colleagues. In practicing these principles, Clinical Staff are governed by a set of ethical standards referred to as the "ASAP Clinical Code of Ethics." A violation of the ASAP Clinical Code of Ethics can result in disciplinary actions and/or revocation, denial, or suspension of clinical certification. Nothing in these ethical standards precludes the initiation of appropriate disciplinary actions at the local or level.

C-2. Ethical Responsibilities of ASAP Clinical Staff to their Clients. Pre-eminent principles guiding the ethical responsibilities of the client-counselor relationship are as follows

a. Principle 1.1: ASAP Clinical Staff will protect and value the welfare and dignity of the client at all times. ASAP Clinical Staff influence people whose lives are negatively affected by misuse/abuse of alcohol and/or other substances. In most situations, clients are vulnerable and open to suggestion. Therefore, ASAP Clinical Staff have an ethical obligation to protect and promote the best interest of their clients and Family members at all times.

b. Responsibility 1.1.1: ASAP Clinical Staff will not violate the rights of clients. The department of Army defines and establishes client rights which are to be observed, respected, and protected at all times. Clinical Staff will adhere to Army regulations and policies and safeguard clients' rights.

c. Responsibility 1.1.2: ASAP Clinical Staff will not physically abuse their clients. Physical contact by Clinical Staff to control, coerce, or detain clients will be considered unprofessional, except where ordered by a qualified physician and/or where determined necessary to prevent clients from injuring themselves or others.

d. Responsibility 1.1.3: ASAP Clinical Staff will not use offensive or abusive verbalizations when communicating with their clients. Comments which a client could interpret as demeaning, undermining, or cruel in nature are considered abusive. Examples include: name-calling, racial or ethnic slurs, derogatory remarks about physical characteristics, remarks about intelligence, or demeaning comments regarding heritage. Since clients come from diverse backgrounds, Clinical Staff employ many forms of conversation. Profanity, vulgar, and suggestive language are never considered professional and will not be used.

e. Responsibility 1.1.4: ASAP Clinical Staff will not sexually exploit their clients. Clinical Staff will not engage in sexual relationships with clients. Clinical Staff are expected to protect and promote the welfare of their clients. During the course of treatment, a relationship of trust, based on professional objectivity and judgment, is to develop between the counselor and the client. Any exploitation of this relationship of trust is unethical. The risk of sexual exploitation by a counselor does not end when a client's treatment terminates; nor does the clinical staff's obligation to protect the welfare of the client. Sexual relationships with former clients are forbidden.

f. Responsibility 1.1.5: ASAP Clinical Staff will neither condone nor engage in sexual harassment.

g. Sexual harassment is defined as deliberate or repeated unwanted comments, gestures, or physical contact of a sexual nature.

h. Responsibility 1.1.6: ASAP Clinical Staff will not financially exploit their clients. It is unethical to enter into any personal financial dealings with a client. Any personal financial involvements or dealings with clients distort and confuse the role of the counselor as seen by the client. Further, such financial interrelationships can impair counselor judgment in the counseling situation. It is unethical to solicit, borrow, or lend money when dealing with clients, or to solicit clients to buy raffle tickets, discount books, or any other products.

i. Principle 1.2: ASAP Clinical Staff establish and maintain counselor/client relationships characterized by professionalism, respect, and objectivity.

j. Responsibility 1.2.1: ASAP Clinical Staff will not discriminate against their clients in any way.

k. ASAP Clinical Staff must gain rapport with clients who have different backgrounds, experiences, and heritage. ASAP Clinical Staff will not discriminate against clients on the basis of age, sex, race, color, religion, sexual orientation, national origin, marital status, political belief, mental or physical handicap, or any other characteristic. Nor

will the counselor practice, condone, facilitate, or collaborate in any form of discrimination. The ASAP Counselor will seek consultation with their supervisor when they find that they cannot relate objectively to a client.

l. Responsibility 1.2.2: ASAP Clinical Staff must incorporate culturally relevant techniques into their practice. ASAP Clinical Staff who counsel clients from cultures different from their own must gain knowledge, personal awareness, and sensitivity pertinent to the client populations served and must incorporate culturally relevant techniques into their practice.

m. Responsibility 1.2.3: ASAP Clinical Staff will ensure that services are offered in a respectful manner in an appropriate clinical environment. This responsibility is designed to protect both the client and the ASAP Clinical Staff from harm. It also serves to protect the reputation/image of the counseling profession.

n. The ASAP Clinical Staff's appearance, affect, and behavior should be professional and respectful when dealing with clients. Attire will be neat, clean, non-provocative, and appropriate to the professional counseling relationship. Counseling sessions will take place in an office/room that is private and free from distractions, and never in public areas that may compromise a client's privacy or confidentiality.

o. Responsibility 1.2.4: ASAP Clinical Staff will avoid continuing a counseling relationship (maintaining a case) for personal or program gain or satisfaction beyond the point where it is clear that the client does not need/is not benefiting from the relationship. Programs that require a specified length of stay will not be interpreted as violating this rule. However, circumstances may arise in which the ASAP Counselor feels that their client is not benefiting from treatment in a program with a required length of stay. It is the ethical responsibility of the counselor to make an accurate assessment and convey it to the appropriate authority.

p. Responsibility 1.2.5: ASAP Clinical Staff will not give or receive a commission, rebate, or any other form of payment for the referral of clients. The above does not preclude Clinical Staff's participation in ASAP clinic events, such as open houses, reunions, and so forth, to familiarize others with ASAP services. Such publicity is appropriate and ethical when carried out in a professional manner.

q. Responsibility 1.2.6: ASAP Clinical Staff must refuse a private fee, gifts, or other remuneration for consultation or counseling with persons who are entitled to these services through the DA. Should the clients desire private counseling or consulting services, they must be apprised of other options available to them. ASAP Clinical Staff must not divert to their private practices, legitimate clients of their employing program or the institution with which they are affiliated.

r. Principle 1.3: The ASAP Counselor's responsibility is to provide competent, professional service.

s. Responsibility 1.3.1: ASAP Clinical Staff will not offer services outside the boundaries of their job descriptions and/or professions. ASAP Clinical Staff will adhere to their job descriptions, standards, and scopes of practice; they must function within those limits. For example, the ASAP Clinical Staff will not function as an ADCO. Nor will they prescribe/dispense medications, or offer financial/legal advice.

t. Responsibility 1.3.2: ASAP Clinical Staff will not offer services outside their range of competency or professionalism. To provide competent, professional service, it is essential that the clinical staff be knowledgeable regarding their own job description responsibilities and their respective limitations as a treatment professional. ASAP Clinical Staff must stay within those limits. The ASAP Clinical Staff must understand their own value system, as it influences their judgment of others. ASAP Clinical Staff will refrain from undertaking any counseling activity where prejudice or bias would impair the counseling relationship. Since personal difficulties may blind the ASAP Clinical Staff member to their own limitations or weaknesses in counseling, it is important for each to have available and to seek adequate clinical supervision.

u. Principle 1.4: ASAP Clinical Staff will respect, preserve, and protect professional confidences and the client's right to confidentiality (for example, HIPPA).

v. Responsibility 1.4.1: ASAP Clinical Staff will comply with Federal Law and all DOD rules and regulations, including those pertaining to client confidentiality. Client confidentiality must be maintained (in accordance with the Army guidelines) in order to preserve and protect the dignity and integrity of the client. The DOD rules and regulations establish the nature and requirements for the disclosure of information about a client. ASAP Clinical Staff will be thoroughly familiar with these regulations and Federal Law, and comply with them at all times.

w. Principle 1.5: ASAP Clinical Staff will seek quality professional services to meet identified needs of their clients.

x. Responsibility 1.5.1: Clinical Staff are responsible for seeking adequate and appropriate professional services to meet identified needs of their clients. It is the professional obligation of the ASAP Counselor to seek the best possible professional services for their client's needs. This responsibility is not absolved if the counselor does not work in a setting where diverse professional services are readily available. The counselor will employ the following guidelines in securing adequate services for clients.

y. Responsibility 1.5.2: ASAP Clinical Staff must refer their clients to an appropriate specialist when the client's problem(s) fall outside the boundaries of their competency, authority, job description or profession. When recommending other needed services to the client, Clinical Staff will always seek to represent and promote the best interest of the client. Personality preferences, friendships, personal relationships, or other such loyalties will not dictate referrals.

ASAP Clinical Staff have the professional responsibility to recommend to clients only those persons who are qualified and authorized to deliver such services.

C–3. Ethical Responsibilities of ASAP Certified Clinical Staff Regarding Personal Use of Alcohol and Other Mood-Altering Substances

a. Principle 2.1: ASAP Clinical Staff will show respect and regard for all laws, in particular those dealing with alcohol consumption and other drug use. They recognize that violations of legal standards may damage their own reputation, as well as that of the profession or the ASAP. This principle is the basis of the ethical guidelines for the use of alcohol and other mood-altering substances. Effective functioning of the counselor requires development and maintenance of a public image of maturity, responsibility, and credibility. The counselor has an obligation to maintain this public image. The ASAP Clinical Staff, by the very nature of their work, assumes the role of educator and counselor on issues of alcohol and other drug use. The ASAP Clinical Staff also assume the responsibility of serving as role models to the client, community, and to their profession. The ASAP clinician does not cease to be a treatment professional when they are off duty from the treatment setting. Therefore, to abuse alcohol or any other mood-altering substance is to diminish the credibility of all professional substance abuse Clinical Staff. To possess and/or use any illegal substance is contrary to what it means to be an ASAP Counselor. One must adhere strictly to all licensure requirements, including self-reporting of all illegal substance use/abuse, behavioral health or medical conditions, or others which the professional regulations require to be reported.

b. Responsibility 2.1.1: ASAP Clinical Staff will not abuse alcohol. For our purposes, alcohol abuse will be interpreted to mean alcohol use leading to impairment as describe in chapter 3 of this regulation .

c. Responsibility 2.1.2: ASAP Clinical Staff will not abuse legal drugs. Evidence of the abuse of legal drugs will be considered as verified: also, use of another’s prescription medication; use in excess of prescribed dosages; or, in the case of over-the-counter drugs, intentional use contrary to label instructions.

d. Responsibility 2.1.3: It may become necessary for an ASAP Clinician to be prescribed mood-altering drugs for necessary and appropriate medical reasons. In such circumstances, the ASAP Clinician should weigh their ability to serve in counseling relationships. In situations such as the above, the ASAP Clinical Staff will consult with the supervisor on this issue before continuing direct and immediate clinical work and report same to the Board of Professional Regulation as required. Failure to do so is an ethical violation.

e. Responsibility 2.1.4: ASAP Clinical Staff will not possess or use any illegal drug in any circumstance.

f. It is the obligation of the ASAP Clinical Staff to uphold and obey the laws of the community and DOD regulations. It is the professional obligation of the ASAP Clinical Staff to uphold laws prohibiting the possession, use and/or distribution of illegal substances.

g. Responsibility 2.1.5: ASAP Clinical Staff will not provide clients with alcohol, other mood-altering substances, or any over-the-counter medications.

h. Responsibility 2.1.6: ASAP Clinical Staff will not provide/serve alcohol or cigarettes to minors.

C–4. Ethical Responsibilities of ASAP Clinical Staff to Family Members and Significant Others of the Client

This section of the handbook pertains to the ethical responsibilities of the ASAP Clinical Staff to Family members/significant others of the substance abuser when the Service member is the primary client. (It is understood that Family members/significant others may be the primary clients. In such cases, all ethical responsibilities of the ASAP Clinical Staff in clinical staff/client relationships also apply.)

a. Principle 3.1: ASAP Clinical Staff accept and understand that alcoholism and other drug dependence is a disease that affects the impaired person’s Family members and significant others. Therefore, ASAP Clinical Staff will demonstrate concern and respect for the welfare of the families and significant others.

b. Responsibility 3.1.1: ASAP Clinical Staff will work to involve the Family/significant others in treatment whenever possible. Alcoholism/other drug abuse are a Family disease. All members of the Family are affected by the disease and need to be involved in treatment. The ASAP Clinical Staff understands that the client’s chances for recovery are enhanced when Family members are involved in treatment. When working with the clients’ families and significant others, ASAP Clinical Staff will avoid partisanship, and refrain from taking sides among Family members. An exception to this occurs in intervention. The ASAP Clinical Staff, in the best interest of the client, may guide the significant others in an intervention to take sides to move the client toward treatment. In this area, as in others, good clinical reasoning will govern the ASAP Clinical Staff’s actions.

c. Responsibility 3.1.2: ASAP Clinical Staff will promptly inform their supervisors and/or the proper authorities when they suspect that their client has been involved in child maltreatment, or other domestic violence. Child abuse and neglect are serious crimes. It is estimated that at least half of all child abuse is alcohol-related. It is essential, then, that the ASAP Counselor respect the seriousness of the offense of child abuse and conform to reporting requirements. Abuse in the Family does not involve children alone. Domestic violence of all kinds (spouse abuse, elder abuse, and so forth) is not unusual in families suffering from alcohol and other drug abuse. All ASAP Clinical Staff should know the

provisions of relevant laws and regulations and clearly inform their clients of their obligations to report before beginning counseling.

C-5. ASAP Clinical Staff in Professional Relationships

a. Principle 4.1: ASAP Clinical Staff will treat colleagues with respect, courtesy, and fairness, and should afford the same professional courtesy to other professionals. ASAP Clinical Staff do not work in isolation. Therefore, high standards of conduct in professional relationships must be maintained. Clinical Staff will not tape-record nor repeat/release colleagues' statements nor correspondence/information through e-mail or other media without the consent of the colleague(s) involved. While ASAP Clinical Staff are required to treat their colleagues and other professionals with respect, the manner in which evaluations are made and presented requires ethical consideration and observance. Additionally, this ethical responsibility pertaining to professional relationships will not be interpreted to prohibit, nor discourage, ASAP Clinical Staff from reporting to appropriate authority, incompetent or unethical behavior. When professional conflicts and disagreements occur, it is the ethical responsibility of the ASAP Clinical Staff to work within s and to safeguard the welfare and best interest of the clients. When professional conflicts and disagreements occur, ASAP Clinical Staff will not engage in disparaging remarks (about their employing institution, colleagues, or clients), or inappropriate "child-like" communication or physical behaviors, nor allow themselves to become involved in power struggles to the detriment of the patients/clients and professional relationships.

b. Responsibility 4.1.1: ASAP Clinical Staff will respect confidences shared

c. by other colleagues/professionals, except when there is a legal obligation to report.

d. Responsibility 4.1.2: When working on the treatment team or with other professionals, ASAP Clinical Staff will not abdicate their responsibility to protect and promote the welfare and best interests of the client and the employing institution. Professional boundaries will not be used to subvert this ethical responsibility.

e. Responsibility 4.1.3: When working on a treatment team, ASAP Clinical Staff will work to support the decisions made by the team. This does not mean that the ASAP Counselor must agree with and not question decisions made by the team. If the ASAP Counselor firmly believes that the team is not acting in the best interest of the client, they should report these concerns to the appropriate clinical supervisor. If no remedy can be found at this level, they may request that the matter be presented at a quality improvement/assurance meeting at which the CC is present. If this does not resolve the matter, the ASAP Counselor may request to be excused from the case.

C-6. Ethical Responsibilities to the Public and the Profession

a. Principle 5.1: When making recommendations for positions, advancements, or similar actions, ASAP Clinical Staff will put the welfare of the public and the

b. profession before the needs of the individual concerned.

c. Responsibility 5.1.1: When making professional recommendations, such recommendations will be made on the basis of honest and objective evaluation.

d. Responsibility 5.1.2: ASAP Clinical Staff will not use another professional as a reference without first obtaining that person's permission.

e. Principle 5.2: Employee/Supervisor relationships must be maintained on a professional basis.

f. Responsibility 5.2.1: ASAP Clinical Staff will establish and maintain an employer/supervisor relationship characterized by professionalism and respect for the program's regulations and policies.

g. Principle 5.3: ASAP Clinical Staff will strive at all times to maintain high standards in the services they offer.

h. Responsibility 5.3.1: The maintenance of high standards of competence is a responsibility shared by all ASAP Clinical Staff. ASAP clinicians must be honest and have the confidence and trust of the client and the employing institution. In turn, the profession of counseling must have the confidence of the public. Such confidence is achieved through maintaining high standards of competence and professionalism, such as licensure and rehabilitation certification. Maintaining an independent license and advanced certification/re-certification is the responsibility of the counselor.

i. Responsibility 5.3.2: Clinical Staff are obligated to report violations of Ethical Standards.

j. ASAP Clinical Staff will insist upon high ethical standards and upon professional competency in persons with whom they are directly associated professionally. Concerning oneself with the behavior of others is difficult and may present one with situations that are awkward or embarrassing. Clinical Staff are encouraged first to discuss the concerns with the individual, unless there are extenuating circumstances, such as fear of retaliation or other danger. If issues/concerns are not resolved, they will be reported to the Quality Improvement Committee. The counselor's concern for high standards of competence is to the benefit of the client. If associates cannot be helped to achieve minimal standards, the ASAP Counselor should end the professional association, if possible. ASAP Clinical Staff should continuously strive to improve, through reading, attending professional training, and so forth, to keep abreast of new developments in the field, and to apply those that are empirically supported in the published literature, in accordance with Army guidelines.

k. Responsibility 5.3.3: The counselor recognizes the effect of impairment on professional performance and should

seek appropriate treatment for him/her self, or for a colleague. The counselor should support Peer-Assistance Programs in this respect.

l. Principle 5.4: In representing ASAP counseling services, ASAP Clinical Staff concern themselves with accuracy, fairness, and the dignity of the profession. The act of misrepresentation, and/or aiding and abetting the act of misrepresentation, constitutes a serious disservice to those ASAP Clinical Staff who have validly obtained their credentials and who seek to uphold their professional designation. Misrepresentation implies disrespect for the credential and for the client. It is unethical for ASAP Clinical Staff to claim, either directly or by implication, professional qualifications and affiliations that exceed those actually attained. ASAP Clinical Staff will not represent themselves as being certified or licensed when they are not. An applicant for certification or licensure will not represent him/herself as such before the credential is officially awarded, nor after it has been suspended or revoked. ASAP Clinical Staff is responsible for correcting other ASAP Clinical Staff who misrepresent their professional qualifications.

m. Responsibility 5.4.2.: ASAP Clinical Staff are required to submit accurate and honest information for the purpose of obtaining and maintaining their own license and certification, and for recommending someone for certification. When applying for certification or licensure, ASAP Clinical Staff is required to submit accurate, honest, and current information. Similarly, ASAP Clinical Staff are required to present/submit accurate/honest and current information to maintain licensure and certification. Applicants for certification and licensure, or recertification are required to obtain evaluations from their supervisor(s). ASAP Clinical Staff must also submit accurate/honest and current information when applying for ASAP positions and when discussing education and qualification issues with others.

n. Responsibility 5.4.3.: ASAP Clinical Staff will not participate in a licensure or certification exam under the auspices of eligibility ascribed to another person. Applicants are responsible for ensuring that no other person participates in examinations through the eligibility specifically assigned to the applicant.

o. Responsibility 5.4.4.: ASAP Clinical Staff participating in a professional exam must refrain from the use of behaviors and/or materials which would afford them unfair advantage for performance on the examination.

p. Principle 5.5.: In representing ASAP counseling services, ASAP Clinical Staff concern themselves with accuracy, fairness, and the dignity of the profession. Many times ASAP Clinical Staff are asked to make presentations on alcoholism, drug abuse, and/or services provided in treatment. In such presentations, it is the ethical responsibility of the ASAP Counselor to make accurate statements and to avoid any form of misrepresentation. In preparing articles for a journal, ASAP Clinical Staff should check the reputation, credibility, and editorial policy of that journal. In publishing, the ASAP Counselor is advised to seek permission to review the article prior to its distribution. In the event that misleading information is released, the ASAP Counselor should act quickly to rectify the situation.

C-7. Ethical Responsibility of ASAP Clinical Staff Engaged in Research

Principle 6.1: In the conduct of research, ASAP Clinical Staff should adhere to high standards and follow appropriate scientific and regulatory procedures. Under no circumstances will ASAP clinical staff conduct research using ASAP clients or their data without first gaining approval through the Clinical Investigations Committee. The ASAP Clinician has ethical responsibilities to fellow Clinical Staff and others involved in research efforts. They should take credit only for work actually done and acknowledge others' contributions.

C-8. Ethical Responsibilities of ASAP Clinical Staff in Teaching

a. ASAP Clinical Staff are called upon to share their knowledge and skills with others in a variety of settings. Whatever the setting, it is the ethical responsibility of the ASAP Counselor to enter into such teaching/supervisory relationships with the intent of maintaining high standards and with a concern and regard for the student/trainee.

b. Principle 7.1: When ASAP Clinical Staff accept teaching or supervising responsibilities, they should discharge these responsibilities with the same regard for standards required of all other professional activities. In teaching and/or supervising, the ASAP Counselor should have the same regard for the welfare of the student/trainee as they do for clients. This includes concern and regard for the well-being and dignity of the student/trainee. It is essential for the Clinical Staff acting as teacher and/or supervisor to be as fair and objective as possible. Personality conflicts will play no part in evaluations.

C-9. Ethical Responsibilities of the ASAP Clinical Staff as Authors/Editors

Principle 8.1.: As authors or editors, ASAP Clinical Staff will adhere to high standards, abiding by the traditions established in the academic arena. As author, the ASAP clinician will acknowledge the sources and contributions to their ideas and materials. In publishing, ASAP Clinical Staff will disguise the identity of subjects beyond possibility of recognition. Best pre-publication practices require ASAP Clinical Staff to obtain the consent of the person about whom the material is written prior to publication. ASAP Clinical Staff should make it clear that the privacy and confidentiality of the client will be carefully protected. Without the permission of the subject, ASAP Clinical Staff should not publish the work. The ASAP Clinical Staff's ethical responsibilities in writing and publishing are more far-reaching than just to their work. They may be called upon to review the works of other Clinical Staff or asked to support and encourage such works. When reviewing the work of another, Clinical Staff will critique objectively. The counselor will

address the issue of the adequacy of the work, not the ability of the author. The DA/MEDCOM approval will be sought and the author will delineate their relationship to the Army/MEDCOM.

C-10. Recovering Persons as ASAP Clinical Staff

- a.* Special circumstances arise for recovering persons working in the addictions/codependency treatment field.
- b.* Principle 9.1: In the context of alcoholism and chemical dependency, recovering ASAP Clinical Staff will maintain a sobriety program which enhances their recovery.
- c.* Responsibility 9.1.1: In these circumstances, the recovering ASAP clinician will not allow employment in the prevention/treatment field to jeopardize their recovery. The recovering ASAP Clinician will not be expected to perform additional duties just because he or she is recovering.
- d.* Principle 9.2: While recovering, ASAP Clinicians may choose to be a member of a variety of self-help groups (for example, AA, NA, CA, ACOA groups, FA, overeaters anonymous (OA)). They are not obligated, nor will they be required, to disclose these associations as a condition for employment or continuing employment.
- e.* Responsibility 9.2.1: While recovering, ASAP Clinicians may be members of self-help groups. However, they will avoid participation as recovering persons at meetings held at their place of employment. This is to avoid role confusion among peers and clients. Disclosure of the ASAP Clinician in recovery is the prerogative of that clinician. Similarly, recovering ASAP Clinicians will not be singled out to facilitate all self-help related activities. ASAP Clinicians will avoid dual relationships with other recovering clients. It is not the professional duty of recovering or other ASAP Clinicians to carry a personal spiritual message to their clients. It will not be the sole responsibility of recovering ASAP Clinicians to educate other staff members about the meaning and function of self-help groups.
- f.* Principle 9.3: All ASAP Clinicians, due to the nature of their work, must respect the Twelve Traditions/Steps of self-help groups.
- g.* Principle 9.4: ASAP Clinicians will define the nature and direction of loyalties and responsibilities and keep all concerned parties informed of these commitments and responsibilities.
- h.* Principle 9.5: If unavoidable, ASAP Clinicians may occasionally attend self-help meetings that are also attended by ASAP clients. ASAP Clinical Staff will not disclose client information obtained at these meetings or will ASAP Clinicians breach the confidentiality or anonymity of any other members.

Appendix D Army Substance Abuse Program Assessment Checklist

D-1. Objective

The objective of the ASAP Assessment Checklist is to assist ADCOs and Clinical Directors (CDs) in evaluating the ASAP. The ADCOs may assess a different one of the four areas of responsibility below each quarter of the fiscal year as long as all areas are assessed annually. CDs may assess their area at any time each fiscal year. All results of these assessments must be recorded on a MFR and retained in accordance with AR 25-400-2, ARIMS.

D-2. Program management

- a.* Is an ADCO position authorized on the TDA and filled full-time to implement the ASAP?
- b.* Does the ADCO brief the Installation or Garrison Commander quarterly on the overall ASAP status?
- c.* Are new commanders and First Sergeants briefed on the ASAP upon assuming their positions?
- d.* Are appropriate reports (MP blotters, Serious Incident Reports) reviewed by the ADCO on a daily/weekly basis?
- e.* Has a community needs assessment survey been conducted within the last 3 years?
- f.* Are DA Forms 4465 and 4466 completed and entered in DAMIS?
- g.* Are DUI/UA Positive Reports completed and forwarded to ACSAP on a quarterly basis?
- h.* Are referral utilization trends shared with the garrison and applicable mission chains of command?
- h.* Are ISRs completed correctly and submitted on time?
- i.* Have effective procedures been implemented to ensure that the ADCO is provided all data required for completion of the DA Form 3711?
- j.* Have monthly reports been entered in DAMIS on DA Form 3711 to provide the statistical status of the ASAP?
- k.* Have local statistics been maintained and analyzed for program needs and trends?
- l.* Has an IPT or HRC or similar forum been established to review current installation issues and trends?
- m.* Does the Installation Prevention Team (or similar forum) meet, at a minimum, on a quarterly basis?
- n.* Does the ADCO prepare and track the Garrison ASAP budget and review it with their supervisor and the Garrison Resource Manager?
- o.* Does the ADCO prepare an internal control checklist (app C, AR 600-85)?

- p.* Has the ADCO implemented a plan to monitor and assess command utilization of and satisfaction with all aspects of the program (for example, prevention, ID, and rehabilitation)?
- q.* Has the ADCO considered nominating members of the ASAP staff for ACSAP Director's Awards?

D-3. Prevention/Employee Assistance Program

- a.* Are elements of prevention included in the ADCO position description?
- b.* Have goals and objectives been formulated in a written IPP?
- c.* Are the following essential prevention activities fully functional? (Note: Prevention activities are based on an installation's needs assessment.)
 - (1) Educating commanders and First Sergeants about the ASAP?
 - (2) Garrison ASAP professional staff development and certification?
 - (3) Civilian employee and supervisor ASAP education?
 - (4) Family member ASAP education?
 - (5) Community awareness education on the ASAP?
 - (6) Unit education programs on the ASAP
- d.* Is ADAPT implemented in accordance with AR 600-85 and ACSAP standards?
- e.* Is ADAPT offered a minimum of once monthly?
- f.* Are "pre" and "post" tests utilized for ADAPT to assist in determining effectiveness of training?
- g.* Have a variety of media been utilized (installation newspaper, radio, television, electronic media announcements) to support and inform personnel about the ASAP and its programs?
- h.* Has each unit commander ensured that their Soldiers were provided 4 or more hours of drug/alcohol training in the past year? Has the ASAP provided at least one hour of the training? Is the PC receiving training class rosters from units and maintaining a database of training by unit?
- i.* Has each civilian employee received 2 or more hours of drug/alcohol training in the past year?
- j.* Are all supervisors trained at least annually on techniques for identifying abusers, the dangers of "enabling" and the referral process? Have supervisors of civilian employees in TDPs received training on civilian drug testing and how to properly notify their employees of a urinalysis?
- k.* Were prevention campaigns conducted, such as Drunk and Drugged Driving Prevention and Red Ribbon Week?
- l.* Are evaluation forms on instructor performance and course content used for all training?
- m.* Have civilian employees occupying Testing Designated Positions (TDPs) under the Drug-Free Workplace Program received civilian drug testing training prior to being included in the TDP pool?
- n.* Is the Federal Drug-Free Workplace Annual Survey Report prepared and forwarded to ACSAP annually? Are all EAP files maintained and secured separately from other files?
- o.* Is the ACSAP Annual Prevention Report completed with a copy sent to the IMCOM HQs?
- p.* Are the PC and EAPC certified? Is the requirement to be certified written in their job descriptions?
- q.* Does the PC maintain a by-SSN list of all ADAPT attendees?

D-4. Risk Reduction Program

- a.* Does the installation have an IPT or Human Resources Council or similar organization? Who coordinates the IPT meetings?
- b.* Is the IPT held as a stand-alone meeting?
- c.* Have IPT members attended Installation Prevention Team Training (IPTT)?
- d.* Does the IPT meet quarterly to discuss Risk Reduction Program trends and to formulate recommendations for commanders to reduce high-risk behaviors?
- e.* Are minutes taken at the IPT meetings?
- f.* Who chairs the IPT meetings?
- g.* Is the IPT visible and productive on the installation?
- h.* Does the ADCO or a designated ASAP staff member consolidate data and enter it into the Risk Reduction Application Portal?
- i.* Do installation sources readily provide data? Is there a system in place to ensure all providers submit the required data?
- j.* Do members of the IPT have access to the Risk Reduction Web system and are their using it?
- k.* Do commanders on the installation have access to the system?
- l.* Based on the identified risk, do specific IPT members brief commanders (brigade/battalion) quarterly on risk reduction or are these briefings conducted by the ADCO?
- m.* Does the ASAP use unit ranking (provided in the Risk Reduction application) to determine which units are briefed and which units receive intervention?
- n.* Based on results from trend analyses, are interventions provided to units as required?

- o.* Does the ADCO brief the Garrison Commander and/or the Commanding General on Risk Reduction on a quarterly basis?
- p.* How do battalion/brigade commanders respond to the Risk Reduction Program? Do they find it helpful in identifying high risk units?
- q.* Does the garrison commander support Risk Reduction?
- r.* Based on trend analysis results, can the ASAP identify the installation/brigade/battalion top three high-risk behaviors?
- s.* What other information does the ASAP use, aside from Risk Reduction data, to determine high-risk behaviors?
- t.* Do you find the Risk reports useful and informative?
- u.* Does the installation use the Unit Risk Inventory (URI)?
- v.* Does the installation use the Re-Integration URI? Is there a system in place to ensure that all deployed Soldiers are administered the R-URI between 90 and 180 days after redeploying?
- w.* Does the ADCO compare/cross-reference data from the URIs and data from the shot groups (bull's eyes)?
- x.* Are there improvements that can be made to Risk Reduction?

D-5. Drug testing

- a.* Is there a DTC and alternate DTC appointed on orders signed by the ADCO?
- b.* Have the DTC and alternate DTC been certified by the ACSAP DTC Certification Course within the last 3 years?
- c.* Are there units without two Unit Prevention Leaders, who have been certified during the last year?
- d.* Are there written installation SOPs outlining both military and civilian collections that are approved by the SJA within the last year?
- e.* Is there a written SOP that covers DTC administrative and operational procedures?
- f.* Has the ASAP evidence storage area passed a physical security inspection within the past 2 years?
- g.* Has the ASAP passed a safety inspection within the past year?
- h.* Are battalion collections inspected a minimum of once annually by the DTC or designee?
- i.* Have commanders been trained in "smart testing" techniques?
- j.* Is there a notification procedure for Soldiers that includes the DTC sending laboratory positives for MRO-reviewable drugs to the MRO for determination of legitimate versus not legitimate use? Do the procedures ensure that the MRO notifies the DTC of their determination, and that the DTC notifies the commander and updates DAMIS?
- k.* Is the MRO appointed on orders signed by the MTF Commander?
- l.* Has the MRO been certified by USAMEDCOM within 6 months of assuming their duties?
- m.* Are MRO dispositions current (within working 15 days) and updated in the DAMIS?
- n.* Have effective procedures been implemented to ensure that rehabilitation urinalysis is accomplished on all Soldiers enrolled in the ASAP?
- o.* Are ALL Soldiers in rehabilitation being periodically drug tested?
- p.* Are rehabilitation drug tests properly coded on the chain of custody form?
- q.* Does the civilian corps member DTP meet the DA-required testing rates?
- r.* Is the EAPC involved in the donor selection process?
- s.* Has a DA Form 5019 and/or a DA Form 7412 been signed by all civilians occupying a position requiring alcohol and/or other drug testing?
- t.* Has the DFW Program Report that provides statistical information on the civilian DTP been submitted to the ACSAP?
- u.* For military personnel, does the DTC check DAMIS and notify the commander of all previous positive urinalysis results and rehabilitation when they notify the commander of a current positive result?

D-6. Counseling Program (to be completed by the Clinical Director)

- a.* Are all patients identified through medical channels with a drug- or alcohol-related diagnosis or related incident resulting in medical treatment referred to the ASAP?
- b.* Have effective procedures been implemented to ensure that DA Forms 4465 and 4466 are both filed and entered in DAMIS?
- c.* Have effective procedures been implemented to ensure that the ADCO is provided a copy of this rehabilitation and treatment review?
- d.* Are copies of DA Form 4465, DA Form 4466; and data for completion of DA Form 3711 provided to the ADCO by the counseling staff?
- e.* Are face-to-face rehabilitation team meetings conducted with commanders for each Soldier evaluated?
- f.* Has an effective monitoring procedure been implemented to ensure that results of all rehabilitation urinalysis are provided to the appropriate counselor and commander?

- g. Does the ASAP check the DAMIS for prior enrollment information on Soldiers currently evaluated and/or enrolled?
- h. Is a DA Form 4466 completed and entered in DAMIS for each Soldier in a PCS loss or gain status?
- i. Has an effective monitoring procedure been implemented to ensure that open file cases on Soldiers who are in a PCS status are forwarded to the gaining ASAP?
- j. Does the counseling staff provide timely input to the ADCO for completion of the quarterly DUI/UA Report?

Appendix E

Standing Operating Procedures (SOP) For Urinalysis Collection, Processing, and Shipping

E-1. General

This SOP provides guidance and standardizes urinalysis collections throughout the U.S. Army. (The DTC Guidebook and Commander's Guide and UPL Urinalysis Collection handbook contain additional guidance and DA requirements. These handbooks are designed to assist the unit commander, UPL and DTC by providing detailed information on collection, handling, processing and shipping procedures for urinalysis specimens.)

E-2. Applicability

This SOP is applicable to all urinalysis collections conducted on all Soldiers, regardless of component.

E-3. Related material

The ACSAP Commanders Guide and UPL Urinalysis Collection handbook, ACSAP DTC Guidebook and DOD Instruction 1010.16, Technical Procedures for Military Personnel Drug Abuse Testing Program.

E-4. Pre-collection procedures

- a. The unit commander will—
 - (1) Direct that a urine test be conducted, identify individual Soldiers, parts of the unit, and/or the entire unit for testing, and ensure identified Soldiers are available for testing.
 - (2) Select an adequate location for testing and a holding area for Soldiers waiting to render a urinalysis specimen.
 - (3) Ensure the UPL is certified to collect urinalysis specimens for drug testing.
- b. The UPL obtains supplies for testing—
 - (1) The DOD prescribed urine specimen bottles with boxes.
 - (2) Optional wide mouth collection cup (for females).
 - (3) Tamper evident tape.
 - (4) Specimen bottle labels.
 - (5) Unit ledger (unit ledger).
 - (6) DD Forms 2624.
 - (7) Disposable rubber gloves.
 - (8) Disinfectant for disinfecting specimen collection area.
 - (9) References: AR 600-85, ACOM/ASCC/DRU SOP, Installation SOP, Unit SOP, and Commander's Guide and UPL Urinalysis Collection handbook.
- c. Personnel to be tested are notified. Notification will take place no more than 2 hours prior to reporting time.
- d. Commander appoints Observers, E-5 or above, of the same gender as Soldier being tested, (no more than 3 observers will be assigned to each UPL at any given time) and a holding area NCO/officer, E-5 or above, to maintain control of personnel waiting to be tested.
- e. The UPL will brief observers on their duties and responsibilities and demonstrate the observers' tasks (see fig E-4 for an example). The observers will sign an affidavit to acknowledge understanding of their duties and responsibilities as observers.
- f. The UPL will inspect latrines and post "Off Limits" signs on them; they will also post signs for "Holding Area" and "UPL Testing Station" at those locations.
- g. Commander or designated representative will brief all Soldiers selected for testing (see fig E-2 for an example).
- h. The UPL will brief the selected Soldiers on the specimen collection procedure (see fig E-3 for an example).
- i. Each Soldier will remain in the holding area until a specimen is provided unless the commander temporarily permits the Soldier to leave and an NCO or officer escorts the Soldier.
- j. If more than one UPL conducts the collection, avoid having each DD Form 2624 handled by more than one UPL (see paragraph E-7b).

E-5. Collection procedures

All steps of this procedure must be followed in the correct sequence.

- a.* The UPL puts on disposable rubber gloves.
- b.* Soldier approaches the UPL station with their military ID card when prepared to give a urinalysis specimen. If the Soldier does not have an ID card in their possession, the commander (or 1SG or XO) will positively identify the Soldier and verify the Soldier's SSN by a reliable method (see paragraph E-12a).
- c.* Soldier will remove excess outer garments such as battle dress uniform or Army combat uniform jackets, coats, or sweat tops.
- d.* The UPL initiates all required paperwork (if preprinted forms and labels are used, the UPL will verify all information with the military ID Card). If a clerical mistake is made while filling out entries on the DD Form 2624, the specimen bottle label, or the unit ledger prior to the discrepancy inspection required by the DTC, the mistake may be corrected by its maker by lining through (single line) the mistake, placing the corrected information above the mistake, initialing and dating the corrected entry. No other method of correction is authorized except by memorandum, titled "Certificate of Correction," as described in paragraph E-8b.
 - (1) The UPL prepares label with the following information:
 - (a)* Date Specimen Collected (YYYYMMDD).
 - (b)* BAC.
 - (c)* Soldier's SSN.
 - (2) The UPL prepares a DD Form 2624 with the following information (See the Commanders' Guide and UPL Urinalysis Collection handbook for specific guidance on completing the DD Form 2624):
 - (a)* Block 1 will have the unit information for the unit conducting the collection.
 - (b)* Block 2 will have the installation ASAP (in garrison), state JSAPC/O (NG units in garrison), RSC (USAR units in garrison), or BACM information (all deployed units).
 - (c)* BAC (block 3). This is the unique code for reporting results.
 - (d)* Unit Identification Code (UIC) (block 4).
 - (e)* Document/Batch Number (block 5). Begin with batch '0001' each day.
 - (f)* Date Specimen Collected (YYYYMMDD) (block 6).
 - (g)* Soldier's SSN (block 8).
 - (h)* Test Basis (block 9). For each DD Form 2624, use only one appropriate code (IR, IU, IO, CO, PO, RO, MO, AO, VO, NO, OO) (see para 4-5).
 - (i)* Test Information (block 10). Designate letter "A" for E-4 and below and letter "B" for E-5 and above and officers. Leave the remaining rows blank if less than 12 specimens are collected.
- (3) UPL prepares the unit ledger with the following information (see the Commanders Guide and UPL Urinalysis Collection handbook for specific guidance on completing the DD Form 2624):
 - (a)* Date Specimen Collected.
 - (b)* Batch and Specimen number (blocks 5 and 7 from DD Form 2624).
 - (c)* Soldier's Rank.
 - (d)* Soldier's printed name (Soldier will sign upon completion of specimen collection procedure).
 - (e)* Soldier's SSN.
 - (f)* Test basis.
 - (g)* Observer will print and sign their name on the unit ledger upon completion of specimen collection procedure.
 - (h)* Comments and Disposition.
- e.* The UPL directs the Soldier to verify the information on the specimen bottle label, unit ledger, and DD Form 2624. The Soldier will then initial the specimen bottle label indicating that all data is correct.
- f.* The UPL will remove a new specimen bottle from the box in front of the Soldier and replace it with the Soldier's military ID Card. The UPL will then affix the label to the specimen bottle, in full view of both the Soldier and the observer, and hand it to the Soldier. The UPL will remind the observer not to take possession of the specimen bottle and to constantly maintain direct eye contact with the bottle until the UPL places it in the collection box.
- g.* The Soldier will ensure that the observer has full view of the specimen bottle at all times until the UPL takes custody of the specimen. At no time will the observer take custody of the urine specimen.
- h.* If the Soldier is female, the optional wide mouth collection cup will be issued to the Soldier at this time.
- i.* The Soldier and observer will move to a secure latrine; the Soldier will walk in the front with the specimen bottle held above their shoulder to keep it in full view of the observer. The observer will keep the specimen bottle in sight at all times.
- j.* Once in the latrine, the observer will direct the Soldier to wash their hands without the use of soap. The Soldier will then move to the appropriate facility (urinal or toilet) to collect the specimen.
- k.* The Soldier will remove the cap of the specimen bottle in full view of the observer, and will hold it or place it face up on a clean surface. The specimen bottle and cap must be in full view of the observer.

l. The Soldier will then fill the specimen bottle with at least 30 mL of urine (approximately half the specimen bottle). The observer must see urine leaving the Soldier's body and entering the specimen bottle (or collection cup). The Soldier will recap the specimen bottle in full view of the observer.

m. The following procedure applies to female Soldiers who utilize the wide mouth collection cups:

(1) The Soldier will remove the cap from the collection cup, and provide the specimen. The observer will keep the wide mouth collection cup and the specimen bottle in full view and directly observe urine leaving the body and entering the collection cup.

(2) The Soldier will then open the specimen bottle, and pour the urine from the wide mouth collection cup into the specimen bottle. The Soldier will recap the specimen bottle in full view of the observer. The observer will watch this entire procedure.

n. The specimen bottle must contain at least 30 mL of urine (regardless of specimen volume collected, the specimen bottle must be returned to the UPL). See paragraph E-12*b* for instructions on insufficient volume.

o. The Soldier should wash their hands with soap after recapping the specimen as described in steps *l* and *m* above, but the Soldier and observer must keep the specimen in full view.

p. The observer and the Soldier will return to the UPL's station. The Soldier will walk in front with the specimen bottle held above their shoulder. The observer will keep the specimen bottle in sight at all times.

q. The Soldier will hand the specimen bottle containing their specimen to the UPL; both the Soldier and observer will continue to keep the specimen bottle in sight at all times until the UPL places the specimen in the collection box.

r. The UPL will take the specimen bottle, verify that the cap is secure, and inspect the specimen for sufficient volume and possible adulteration. If adulteration is suspected, the UPL will secure the specimen, order the Soldier to stand fast, and ensure that the commander is notified (see para E-12*d*).

s. The UPL will then place tamper evident tape across the specimen bottle cap. The tape will be one continuous piece that runs across the top of the specimen bottle and touches the label on both ends without obscuring any information.

t. The UPL will then initial the specimen bottle label. The UPL's initials signify that they have received the specimen from the Soldier, checked the specimen for adulteration and sufficient volume, ensured the cap was secure, and placed tamper evident tape across the cap.

u. The UPL will place the specimen in the collection box and remove the Soldier's ID card. The UPL retains the Soldier's ID Card until the Soldier signs the unit ledger.

v. The observer will then sign the unit ledger in front of the UPL and Soldier to verify they complied with the collection process and directly observed the Soldier provide the specimen and maintained eye contact with the specimen bottle from the time it was handed to the Soldier until it was placed in the collection box.

w. The Soldier will then sign the unit ledger in front of both the observer and UPL verifying that they provided the urine in the specimen bottle and that they observed the specimen being sealed with tamper evident tape and placed into the collection box. The UPL should check the specimen bottle label, unit ledger, and DD Form 2624 and correct errors before releasing the Soldier.

x. The ID Card will be returned to the Soldier at this time, and they are released from testing.

E-6. Post-collection procedures

After all specimens have been collected the UPL will—

a. Verify that all SSNs on the unit ledgers, DD Forms 2624 and specimen bottle labels match.

b. Ensure that all required information, signatures, and initials are on the specimen bottle labels, unit ledgers, and DD Forms 2624.

c. Place each DD Form 2624 into the corresponding specimen shipping container(s).

d. Disinfect the specimen handling area and close down the collection station.

e. Transport all specimens to the DTCP as soon as possible (normally the same duty day).

f. If unable to transport to the DTCP immediately, the specimens, DD Forms 2624, and unit ledgers will be placed into temporary storage at the unit as described in paragraph E-11.

E-7. Specimen Chain of Custody (Back side of DD Form 2624)

a. Once the UPL accepted a complete specimen from the Soldier, the specimen chain of custody began. This chain of custody must remain continuously and forensically intact until the specimens are received by the courier/shipping agency and subsequently the drug testing laboratory (FTDTL).

b. If two or more UPLs conduct the collection, avoid having each DD Form 2624 handled by more than one UPL. A change of custody should be done only on a completed batch of specimens and its DD Form 2624. If the UPL cannot complete their batch due to an emergency, the DD Form 2624 (front) should be closed-out, and a change of custody to an alternate UPL should be initiated on the back side of the DD Form 2624. The alternate UPL should prepare a new DD Form 2624 with a new batch to collect specimens from the remaining Soldiers.

c. Each change of custody must be annotated at the time of the occurrence; do not predate or postdate the event.

When the specimens are transferred from one specimen custodian to another or to temporary storage or shipping agency, correct and complete information must be annotated in block 12a, b, c, and d on the back side of DD Form 2624 as following:

- (1) Block 12a-Date of specimen custody transfer (use U.S. date format YYMMDD to avoid confusions,).
- (2) Block 12b-Name and signature of the person or temporary storage facility (building and room) releasing custody.
- (3) Block 12c-Name and signature of the person or temporary storage facility (building and room) accepting custody.
- (4) Block 12d-Reason for transfer/change of custody (for example, "Specimens transferred to primary UPL", "Specimens placed in Temporary Storage", "Specimens retrieved from Temporary Storage", "Specimens received by DTC", "Specimens mailed to FTDTL", and so forth).

E-8. Transfer of specimens at the DTCP

a. At the DTCP, the unsealed specimen boxes will be opened by the DTC or the DTC's designated representative. The actions of the DTC outlined below may be performed by the DTC's designated representative. If there is no DTC, the actions will be performed by the person designated by the ADCO. The UPL (or the last person on the chain of custody before transferring specimens to the DTC) will observe the entire specimen transfer process until the DTC signs the DD Forms 2624 accepting the custody of specimens. The DTC will conduct the quality control check of the specimen (Note: a deployed UPL or a UPL without a local ASAP may have to perform this quality control check):

- (1) Ensure that the information contained on the front side of each DD Form 2624 is correct.
 - (a) Complete address of submitting unit (address of the Installation ASAP or battalion-level command or above).
 - (b) Additional Service Information (Name of unit that conducted testing and contact information (for example, phone number, e-mail address, and so forth)).
 - (c) Base area code.
 - (d) Date Specimens Collected.
 - (e) Social Security Number.
 - (f) Test Basis (Correct code for the type of urinalysis and only one code per DD Form 2624).
 - (g) Test Information.
- (2) Ensure that the information contained on the unit ledger is correct and corresponding with the information on the DD Form 2624:
 - (a) Name of unit that conducted testing (block 2 on DD Form 2624—Additional Service Information).
 - (b) Unit UIC.
 - (c) Date Specimens Collected.
 - (d) Batch and specimen numbers.
 - (e) Rank, Name, SSN, and signatures of the Soldiers.
 - (f) Test Basis.
 - (g) Names and signatures of the observers.
 - (h) Comments and disposition (unusual circumstances and/or testing status of a Soldier or specimen).
- (3) Ensure that the information contained on the specimen bottle label is correct and corresponding with information on the DD Form 2624. At a minimum, each specimen bottle label must contain the Date Specimen Collected, SSN, BAC, Soldier's initials and UPL's initials.
- (4) Ensure minimum 30 mL of urine is contained in each specimen bottle and that an unbroken piece of tamper evident tape is correctly placed on each specimen bottle.
- (5) Ensure the chain of custody (back side) on the DD Form 2624 is complete and accurate. Each event of change of custody must be annotated:
 - (a) Correct dates of change of custody.
 - (b) Names and Signatures of UPL or temporary storage releasing custodian.
 - (c) Names and Signatures of UPL or temporary storage accepting custodian.
 - (d) The "Purpose of change/remarks" column clearly explains each change of custody.

b. If a discrepancy is found during the check, the DTC shall initiate appropriate action to correct the discrepancy or error, if possible. All discrepancies that can be corrected must be explained in a memorandum titled, "Certificate of Correction," which explains:

- (1) The discrepancy.
- (2) The circumstances.
- (3) The corrective action taken.
 - (a) All personnel involved including the person(s) who made the error and the DTC must sign this certificate.
 - (b) If the error is a missed entry or an incorrect entry either on the specimen bottle label or on the DD Form 2624, corrections will not be made on the label or on the form. The evidence that a correction was made will be the memorandum titled, "Certificate of Correction" (see fig E-1).

(c) The memorandum titled "Certificate of Correction," will be attached to the original and all copies of the DD Form 2624. The memorandum titled "Certificate of Correction," will be attached to the DTC's DD Form 2624 until destruction date.

c. If no discrepancies are noted, or all discrepancies have been corrected with a memorandum titled "Certificate of Correction," the UPL will enter:

- (1) The date the specimens were delivered in block 12a
- (2) Print their name and sign in block 12b
- (3) Print "Specimens released by UPL to DTC" in block 12d
- (4) Ensure that the DTC prints and signs in block 12c to document receipt of the specimens.

d. After the DD Form 2624 is completed it will be placed in a business size envelope.

e. Liquid absorbent pads will be placed in each specimen box (containing up to 12 specimens) to absorb any leakage that may occur. Either the UPL or the DTC may complete this step. The specimen box will be sealed with adhesive tape over all open sides, edges and flaps. The UPL or the DTC then signs his or her signature across the tape on the top and bottom of each container, and secures the unsealed envelope, with DD Form 2624 enclosed, to the outside of the specimen container. For complete packing instructions, see the Commander's Guide and UPL handbook.

E-9. Shipping to the FTDTL

a. All urinalysis specimens will be forwarded to the supporting FTDTL.

b. If the DTC is going to ship the specimens to the FTDTL on the day received from the UPL then they will—

- (1) Sign each DD Form 2624 releasing it for shipment to the FTDTL. Properly complete block 12a to 12d.
 - (a) Date the specimens delivered to carrier (block 12a).
 - (b) Name and Signature of person releasing custody to carrier (block 12b).
 - (c) Name of carrier/shipper if known (for example, USPS). If actual shipping mode is unknown, write "Shipper." (block 12b)

(d) Purpose of change (for example, "Specimens shipped to FTDTL by USPS") (block 12d).

(2) Prepare the specimen boxes as required for shipment.

(a) All specimen containers will be wrapped for shipping.

(b) Ensure that each DD Form 2624 remains inside an envelope taped to the specimen container.

(c) Place specimen container inside a leak proof bag.

(d) Package the outermost shipping container according to the carrier's requirements and local policy. Hand write or affix a label that says "Diagnostic Specimens" near the mailing address.

(3) Ship containers to the drug testing laboratory by transportation priority one. One of the following transportation modes will be used:

(a) Registered mail.

(b) US Postal Service by First Class Mail.

(c) Hand-carried by surface transportation.

(d) Military aircraft transportation system.

(e) US flag commercial air freight, air express, and air freight forwarder.

(f) When none of the above satisfies the movement required, by foreign flag air carrier.

c. If the DTC is unable to ship the specimens until the next duty day, the specimens must be placed in temporary storage and the DD Form 2624 annotated. The temporary storage must be a limited access area. The facility will meet the physical security requirements for evidence storage as described in paragraph E-10. This will include a biennial physical security evaluation by qualified personnel, a posted access roster, and an access log to annotate all personnel entering the limited access area.

E-10. Temporary storage of urine specimens at the DTCP

The following describe the minimum requirements for temporary storage of urinalysis specimens at the installation level. This is the preferred site for temporary storage.

a. Windows to the specimen storage room that are accessible from the exterior of the room will be covered with steel or iron bars or steel mesh as follows:

(1) When bars are used, they will be at least 3/8-inch thick and vertical bars will not be more than 4-inches apart. Horizontal bars will be welded to the vertical bars and spaced so those openings do not exceed 32 square inches. Ends of the bars will be securely embedded in the wall or welded to a steel channel frame fastened securely to the window casing.

(2) Acceptable steel mesh will be made from high carbon manganese steel no less than 15/100-inch thick, with a grid of not more than 2-inches from center to center. 6-gauge steel mesh with a 2-inch diamond grid may be used when high carbon manganese steel is not readily available. The steel mesh will be welded or secured to a steel channel frame and fastened to the building by smooth headed bolts that go through the entire window casing. It will be spot welded or branded on the interior, or cemented into the structure itself to prevent easy forced entry.

- (3) Air conditioners may be installed in windows or outside walls provided equivalent security measures are taken.
- b. Doorways: There must be only one doorway that allows access to and from the specimen storage room.
- c. Additional Requirements:
- (1) Method 1 (Evidence Room) - allows specimens to be stored inside the interior of the room, when not in full view of the specimen custodian.
- (a) Construction: Walls must extend from the floor to the ceiling. Walls and ceilings may be made of masonry or wood. Walls or ceiling that are of wooden stud construction must have a combined exterior and interior thickness of at least 1-inch. Permanently installed flooring (other than masonry) may be used, if the floor cannot be breached without causing considerable damage to the building structure.
- (b) Entrance into the room will require opening two successive doors.
- (c) When an interior steel mesh cage is used, the door to the cage will serve as the second door. In this case, the outer door will be of solid core wood or metal.
- (d) When a steel mesh cage is not used two doors hung one behind the other will be used. One door may be of steel mesh welded to a steel frame. The second door may be of solid core wood or steel; or it may be a hollow wooden door with the exterior reinforced with a steel plate not less than 1/8-inch thick.
- (e) If a barred door is used, the vertical steel bars will be at least 3/8-inch thick and spaced no more than 4-inches apart. Horizontal bars will be welded to the vertical bars and spaced so that openings do not exceed 32 square inches.
- (f) Either door may be hung on the outside of the doorway. They will be hung so that the doorframe is not separated from the door casing.
- (g) Door hinges will be installed so that doors cannot be removed without seriously damaging the door or door jam. All exposed hinge pins will be spot welded or branded to prevent removal. This is not required when safety stud hinges are used or when the hinge pins are on the inside of the doors. (A safety hinge has a metal stud on the face of one hinge leaf and a hole in the other leaf. As the door closes, the stud enters the hole and goes through the full thickness of the leaf. This creates a "bolting" or "locking" effect).
- (h) The outer door will be secured by one high security, key-opened padlock. These padlocks will conform to military specifications MIL-P43607 (GL) (High Security Padlock). The changeable combination padlock for the inner door will conform to requirements of military specification FF-P-110 (S&G 8077A and 8078A series). This changeable combination padlock is intended only as an indoor or protected area reusable seal. It is not intended for use on the outer door or for protection against forced entry.
- (i) All locks will be used with a heavy steel hasp and staple. The hasp and staple will be attached with smooth headed bolts or rivets that go through the entire thickness of the door or door jam. They will be spot welded or branded on the inside of the door. Heavy duty hasps and staples attached so that they cannot be removed when the doors are closed are acceptable.
- (2) Method 2 (Evidence Container) - specimens must be stored within a safe or cabinet, when not in full view of the specimen custodian.
- (a) One door will be hung that is made of solid core wood or metal or a barred door. The solid door will, at a minimum, have a high security dead bolt lock.
- (b) Inside the room will be a safe, filing cabinet or metal wall locker that weighs at least 500 pounds or is secured to the structure of the building with a chain.
- (c) If a filing cabinet is used, then a metal bar hasp will be attached to run the entire height of the cabinet. This bar will be locked with a 200 series padlock (key-opened with 2 keys, no combination lock). Note: a hasp may be welded to the top drawer, but then only the top drawer may be utilized for temporary storage.
- (d) All opening/closing of the safe/cabinet will be annotated on a SF 702 (Security Container Check Sheet).
- d. Key and combination control of the temporary storage.
- (1) Only primary and alternate custodians will know the combinations of inner door locks of the evidence room. However, copies of all combinations will be recorded on SF 700 and kept in sealed envelopes (signed by the specimen custodian, across the seal) in the safe of the appropriate supervisor.
- (2) Each key-operated lock will have two keys. One key to each lock will always be kept by the primary custodian. The duplicate key will be put in a separate sealed envelope (signed by the specimen custodian, across the seal) and secured in the safe of the appropriate supervisor.
- (3) Lock combinations will be changed when the primary or alternate custodian changes. All combinations and key locks will be changed upon possible compromise.
- (4) Keys will be transferred from the primary to the alternate custodian only if the primary custodian is to be absent for more than 1 duty day or 3 non-duty days. The transfer of keys will be documented on the Key Control Register and Inventory, DA Form 5513.
- (5) Master key padlocks or set locks will never be used in the evidence room.
- e. Each event involving temporary storage of specimens must be written on the chain of custody (back of DD Form 2624, see paragraph E-7).

E-11. Temporary storage of urine specimens at the unit level (by the unit prevention leader)

a. A safe, secure filing cabinet, or metal wall locker will be used to store specimens. This container must be in a lockable room or office.

b. The safe, filing cabinet, or metal wall locker must weigh at least 500 pounds or be attached to the structure of the building with a chain or heavy duty bolts.

c. If a filing cabinet is used, then a metal bar hasp will be attached to run the entire height of the cabinet. A hasp may be welded to the top drawer, but then only the top drawer may be utilized for temporary storage.

d. The safe or filing cabinet will have a 200 series padlock (with only 2 keys, no combination lock), which is used to secure the hasp.

e. One key will be issued to the primary UPL, the other key will be secured in a sealed envelope (signed by the UPL across the seal) and issued to the commander's safe. Both keys will be issued in accordance with paragraph E-10*d* of this regulation and key control SOPs.

f. All opening/closing of the safe/cabinet will be annotated on a SF 702.

g. Each event involving temporary storage of specimens must be written on the chain of custody (back of DD Form 2624) (see para E-7).

h. Commanders in deployed areas where facilities are not available to fully comply with the preceding temporary storage guidelines will make every attempt to ensure that specimens requiring temporary storage are properly secured to avoid any tampering or perception thereof. This may include locking them in a foot locker or similar container using a padlock to which the primary UPL has the only key and storing that foot locker in the unit's tactical operations center or other area under constant surveillance.

E-12. Unusual Circumstances

All unusual circumstances will be written on the unit ledger (Unit ledger).

a. If the Soldier does not have an ID card in their possession, the commander (or ISG, XO) will positively identify the Soldier and verify the Soldier's SSN against a reliable personnel roster or record. The UPL will write that the Soldier had no ID card and how the ID was verified in the "Remarks" section of the unit ledger and/or in a MFR that is attached to the unit ledger.

b. If less than 30 mL of urine is collected, the entire specimen will be discarded and the specimen bottle will be destroyed by crushing (after obliteration of the SSN on the specimen bottle label). The Soldier will be sent back to the holding area until they can provide a full specimen. The Soldier will be allowed to drink 8 ounces of water every 30 minutes but not to exceed a total volume of 40 ounces in 3 hours. The holding area NCO/officer will monitor each Soldier's water consumption to prevent the Soldier from encountering any health hazards. When the Soldier is ready to provide a specimen, the procedure will begin at step E-5*b*, original entries on the DD Form 2624 and unit ledger may be utilized for the second specimen collected.

c. If a Soldier refuses to provide a specimen, the appropriate command authority will be notified. The Soldier's chain of command should give the Soldier a direct order to provide a specimen. If the Soldier refuses, it will be a violation of a direct order, which may subject the Soldier to disciplinary action.

d. If adulteration is suspected, the UPL will secure the specimen, order the Soldier to stand fast, and send someone to notify the commander. When the commander verifies the evidence of a possible adulteration and after consulting the supporting legal advisor, they may immediately pursue testing the Soldier under "PO" with the collection being observed by a different observer. A second specimen will be submitted for testing on a separate DD Form 2624. The first specimen will be submitted and the circumstance written on the unit ledger.

e. If the tamper evident tape breaks in such a fashion that it does not touch both sides of the specimen bottle label, apply a second piece of tape across the bottle cap and touching the label on both sides, but not directly over the tamper evident tape that broke and annotate on the unit ledger that a second piece of tape was applied and that the Soldier observed this process; prepare a MFR and/or Certificate of Correction after the collection and attach it to the original DD Form 2624.

E-13. Legal Provisions

The provisions of this appendix 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. In no case will failure to comply with the provisions of this appendix be used to invalidate an otherwise valid and legally sufficient adverse administrative or disciplinary action.

**Certificate of Correction
(Blank)**

CERTIFICATE OF CORRECTION

MEMORANDUM FOR:

SUBJECT: Certificate of Correction

1. This letter is to certify the following corrections were made as indicated below for urine specimen enclosed with this shipment for testing.

2. REFERENCE: () BOTTLE LABEL () DD FORM 2624

DOCUMENT/BATCH _____ SPECIMEN _____

READS AS:
CORRECTED TO READ AS:

SIGNATURE: _____

DATE: _____

TITLE: _____

VERIFIED BY: _____

DATE: _____

TITLE: _____

Figure E-1. Certification of Correction Example

Certificate of correction
(Example)

CERTIFICATE OF CORRECTION

MEMORANDUM FOR: The FTDTL for your installation, street address, city, state, zip code

SUBJECT: Certificate of Correction

1. This letter is to certify the following corrections were made as indicated below for urine specimen enclosed with this shipment for testing.

2. REFERENCE: () BOTTLE LABEL (X) DD FORM 2624

DOCUMENT/BATCH 02 SPECIMEN 05

READS AS: <i>110-54-4224</i>
CORRECTED TO READ AS: <i>118-54-4224</i>

SIGNATURE: Alan R. York
Date: 8 Jan 99
TITLE: UPL, HQ BN

VERIFIED BY: Edward B. Commander
Date: 8 Jan 99
TITLE: Commander, HQ BN

Figure E-1. Certification of Correction Example-Continued

Commander's Briefing

Today our Unit will be drug tested for illegal substance use. The primary purpose of this test is to ensure our unit's military fitness, and that we are maintaining proper standards of readiness.

Individuals in this unit have been selected on a random basis for drug testing. There is no probable cause or reasonable suspicion that anyone in the unit is using or abusing drugs or a controlled substance.

Everyone selected for testing will be tested. Anyone not present will be rescheduled for testing at a later date.

Every specimen collected will be tested for Marijuana (THC), Cocaine, Amphetamines (which includes methamphetamines, MDMA (ecstasy), MDA, and MDEA), heroin, plus one to three other drugs. The additional drug(s) will be chosen by the lab on a rotational basis from a group that includes Opiates (which includes morphine and codeine), PCP and synthetic opiates (Oxycodone/oxymorphone known commonly as OxyContin).

Testing procedures outlined in AR 600-85 will be followed.

All Soldiers must be aware that all verbal orders connected with the testing are lawful and are to be followed as such.

A refusal to comply with orders relating to this test; subjects the Soldier to punitive or administrative actions under AR 600-85, AR 135-18, AR 135-178, and AR 635-10.

DOES ANYONE HAVE ANY QUESTIONS?

The UPL will now provide you with details about the drug testing procedures that will be used today.

Figure E-2. Commander's Urinalysis Briefing

UPL UNIT BRIEF

You have four major responsibilities during the collection procedure:

1. Initial the specimen bottle label verifying your personal data is correct
2. Provide more than 30ml of specimen.
3. Keep specimen bottle in full sight until sealed with tamper evident tape.
4. Sign your payroll signature to verify that the specimen was yours and you watch it be sealed by the UPL with tamper evident tape and placed in the collection box.

Your urine specimen will be provided in a labeled plastic bottle (an optional wide mouth collection cup is available for females).

Each bottle will have a label affixed to it with today's date that identifies you by your SSN. Do not accept a bottle that does not have a completed label affixed with your correct SSN and today's date.

Collection of the specimen will be conducted using direct observation in full view of an observer. Do not go to the UPL station until you feel you are ready to provide at least 30ml (approximately ½ bottle) of urine. If you are unable to provide a specimen or an adequate quantity of urine, you will be held in the holding area until you are able to provide a specimen. You will be provided an adequate amount of liquid to help facilitate the collection process. You will not be released from duty today until you have provided a proper specimen.

Your tasks include:

You will provide your military ID card. If you do not have your military ID card or other photo identification, the commander will be called to verify your identification.

Remove excess outer garments such as ACU/BDU jackets and coats or PT jacket.

You will initial the bottle label after you verify your SSN, full name, and date on the Unit Urinalysis Ledger; verify SSN on DD Form 2624; and verify the date and your SSN on the bottle label.

Provide a urine specimen under direct observation.

Sign your payroll signature on the Unit Urinalysis Ledger verifying that the urine specimen provided was yours, the specimen was sealed with tamper evident tape and was placed into the collection box.

Note: I do not need to know if you are taking or have taken prescription medications. If your specimen result comes back from the laboratory as positive for a drug that could have been a result of prescription medication, a medical doctor will review the result before any other actions are taken. The doctor will review your medical record, any prescriptions from outside providers, and possibly interview you, prior to making a medical determination of valid

Figure E-3. Unit Prevention Leader's Urinalysis Briefing

prescription use or illegal use. If the doctor determines the drug positive was a result of valid prescription medication, then no actions will be taken against you.

Are there any questions? Any questions about the collection procedure will be directed to me or your observer.

Figure E-3. Unit Prevention Leader's Urinalysis Briefing-Continued

MEMORANDUM FOR OBSERVERS

SUBJECT: Responsibilities of Observers During Drug Testing

General:

1. Observers are a critical link in the process of collecting urine specimens to be tested for substance abuse. Instances have occurred in the past where observers did not follow proper collection procedures and positive drug tests were not usable in legal and/or administrative actions. In order to prevent similar occurrences in the future, the observer will read and sign this Memorandum for Record.
2. The testing procedures do not violate a Soldier's Fourth or Fifth Amendment rights, nor does the observation procedure violate the right to privacy. A refusal to produce a specimen is a violation of a direct order and may result in the Soldier being processed for separation.
3. The results of tests may be used in legal proceedings and consequently the urine specimen may be considered as evidence. A valid chain of custody is mandatory for a successful prosecution. As an observer, you may be asked to provide testimony at legal or administrative proceedings. You may be subject to UCMJ or administrative action if it is discovered that the specimen was altered in any way while it was under your control. Actions may include, but are not limited to the following:

Article 92: Knowingly failing to obey a lawful general order or regulation by not maintaining direct line of sight of the urine into the bottle.

Article 107: Making a false official statement in signing the UPL's urinalysis ledger acknowledging the urination process was directly observed and no tampering occurred.

Article 134: False swearing by authenticating that no substitution or tampering of the urine sample occurred.

Criteria for Observers:

1. Be an Officer or NCO in the rank of E-5 or above.
2. Be of the same gender as the Soldier being tested.
3. Possess sufficient maturity and integrity to preserve the dignity of the Soldier being observed.
4. Not be currently enrolled within the ASAP Rehabilitation Program or currently be under investigation for any substance abuse related offenses.

Responsibilities: As outlined in AR 600-85, an observer must follow protocol during urinalysis collection procedures.

Figure E-4. Urinalysis Observer's Briefing and Memorandum

SUBJECT: Responsibilities of Observers During Drug Testing

Once assigned to a specific Soldier:

1. Observer controls the urine collection process at all times.
2. Maintains visual contact with the bottle at all times.
3. Ensures the Soldier washes his/her hands with water only, no soap, prior to providing a specimen.
4. Ensures that the specimen provided is not contaminated or altered.
5. Directly observes the Soldier (one Soldier at a time per observer) voiding urine into the specimen bottle. (When the optional wide mouth specimen collection container is used, immediately after the collection and while still under direct observation of the observer, the urine must be poured into the currently approved urine specimen bottle and tightly capped by the Soldier providing the specimen.)
6. Ensures direct observation of the flow of urine from the Soldier's body into the bottle.
7. Supervises the Soldier tightly capping the bottle.
8. Ensures the bottle is not reopened after the cap is tightened.
9. Escorts the Soldier back to the UPL station/table with bottle in full view.
10. Observes the UPL placing tamper evident tape over the top of the bottle, and across the label. Not to cover printed information.
11. Observes the UPL place the specimen in the collection box.
12. The observer will sign the unit ledger in front of the UPL and Soldier verifying the collection process and direct observation was conducted.

OBSERVER AFFIDAVIT: I have read and understand this document. I will comply with the responsibilities as stated above and will report anything out of the ordinary immediately to the UPL or Commander.

_____ Observer's Printed Name	_____ Observer's Signature	_____ Date
_____ UPL's Printed Name	_____ UPL's Signature	_____ Date

Figure E-4. Urinalysis Observer's Briefing and Memorandum-Continued

Appendix F Drug Testing Supplies

F-1. Required military collection supplies

The following supplies are required in order to conduct a military urinalysis collection:

Table F-1
Required military urinalysis collection supplies

Description	National Stock Number (NSN)
Urine Specimen Bottles (1 case=10 boxes)		6640-00-165-5778
Specimen Collection Cups (Female collection cups)		6530-01-048-0855
Mailing Pouch, Specimen (leak proof bag)		6530-01-304-9762
Liquid Absorbent Pouch (Dry absorb packs)		6530-01-304-9754	
Tamper Evident Seal (tape), roll of 500		 		 		 		 		 			6530-01-C57-0478
Tamper Evident Seal (tape), 60 sheets	6640-01-204-2654
Labels (Avery 5163 or other 2x4)	7530-01-514-4903
Exam Gloves	Various NSNs or local purchase
Envelopes, Plain White (business)	Various NSNs or local purchase
Tape, Gummed Activated w/water	Various NSNs or local purchase
Tape, Tape, Masking	Various NSNs or local purchase
Pen, Ball Point (blue pen recommended)	Various NSNs or local purchase
Paper Towels	Various NSNs or local purchase

F-2. Required civilian collection supplies

The following supplies are required in order to conduct a civilian urinalysis collection.

Table F-2
Required civilian urinalysis collection supplies

Description/Product Number	Source
Civilian Collection Kits (Single or Split)	FTDTL, Fort Meade, MD 301-677-7085 Kit include CCF, collection cup, specimen container, biohazard bags w/absorbent & shipping box
Blue Dye Tablets (100 tablets per bottle)/#01657	Lynn Peavey Company 1-800-255-6499
Blue Dye Powder/#01658	Lynn Peavey Company 1-800-255-6499

Appendix G
Army Substance Abuse Program Professional Code of Ethics

G-1. Preamble

The ASAP Professional Code of Ethics serves as a code of conduct for ASAP Professionals in their behavior at work and in the community. In cooperation with military and civilian leadership, ASAP Professionals’ primary objective is to provide the most effective drug and alcohol services to Soldiers, Civilians and their families suffering from emotional, behavioral, alcohol and drug-related problems. The following principles are in accord with this goal to educate ASAP Professionals regarding ethical professional conduct. ASAP Professionals affirm their endorsement of the Code of Ethics and commitment to uphold these principles while they perform their professional duties.

G-2. Professional responsibility

ASAP Professionals help protect military and civilian leadership and the communities they serve against unethical practices by an individual or organization engaged in drug and alcohol education programs, employee assistance programs, rehabilitation, or consultation activities. When an ASAP Professional knows of an apparent ethical violation by another ASAP Professional, it becomes their ethical responsibility to attempt to resolve the matter by bringing that alleged unethical behavior to the other member’s attention. If a resolution of ethical matters between members is not

achieved, further informal consultation with colleagues and/or civilian personnel is recommended prior to any formalized inspector general or other government review of a member's complaint.

G-3. Confidentiality

ASAP Professionals treat Soldier, civilian and Family member information as confidential. Members inform clients fully about their rights regarding the scope and limitations of confidential communications elicited during the education, assessment, referral, and rehabilitation process. They do not disclose information without client consent except where failure to disclose would violate a court order or other valid obligation to disclose under relevant law and regulations.

G-4. Professional competency

ASAP Professionals are expected to possess knowledge of the Army as a whole as well as the organizations they serve; applicable Federal, DOD, and Army policies and procedures, as well as their specific duties and responsibilities. All members acknowledge the necessity of continuing experience, education and training to maintain and enhance proficiency. While membership in any specific professional organization may not be used to suggest professional competency, attaining the status of a Certified Employee Assistance Professional (CEAP), Certified Senior Prevention Professional (CSPP), or certified DTC does attest to meeting the requisite standard of knowledge for competency in practice.

G-5. Consumer protection

ASAP Professionals do not discriminate because of a client's race, religion, national origin, physical handicap, or gender. ASAP Professionals make full disclosure of the functions and purposes of each of their programs. ASAP Professionals do not give or receive financial consideration for using certain services or products, for referring clients to particular therapists or rehabilitation programs. They do not engage in sexual conduct with clients and do not act in any manner which compromises a professional relationship.

G-6. Public responsibility and professional relations

ASAP Professionals agree that all members of the ASAP, whether practitioners, including non-degreed recovering persons, or other professionals, form a partnership in providing drug and alcohol services. As such, members are responsible for educating and fostering the professional development of trainees; are encouraged to promote the Army Substance Abuse Program to commanders and civilian leadership and to provide statements based on objective information; and are expected to work cooperatively within their professional communities. Cooperation within a professional community precludes denigrating other professionals to promote one's own interests, and requires that one's professional qualifications be presented to the public in an accurate and truthful manner. ASAP Professionals are encouraged to assist another member to seek counseling if that member's professional functioning becomes impaired through the use of alcohol, drugs, and/or behavioral illness.

Appendix H Management Control Evaluation Checklist

H-1. Function

The function covered by this checklist is the administration of the Army Substance Abuse Program (ASAP).

H-2. Purpose

The purpose of this checklist is to assist ADCOs in evaluating the ASAP in accordance with AR 11-2.

H-3. Instructions

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R (Management Control Evaluation Certification Statement). A copy of DA Form 11-2-R is available on the Army Electronic Library CD-ROM (EM0001) and on the USAPD Web site (www.apd.army.mil). Additional questions at appendix D should be considered when evaluating the ASAP program.

H-4. Test questions

- a. Is an ADCO position authorized on the Table of Distribution and Allowances and filled full time to implement the ASAP?
- b. Are new commanders briefed on the ASAP upon assuming command?

- c.* Have Unit Prevention Leaders been identified and certified in accordance with paragraph 9–6 of this regulation?
- d.* Is there a DTC and alternate DTC appointed on orders signed by the ADCO and are certified by the Army Center for Substance Abuse Programs' DTC Certification Course?
- e.* Are there written military and civilian urinalysis collection Standing Operating Procedures (SOPs) approved by the SJA within the last year?
- f.* Is there a notification procedure for military personnel that include the DTC sending laboratory positives for MRO-reviewable drugs to the MRO for a determination of legitimate use versus not legitimate use? Do the procedures ensure that the MRO notifies the DTC of their determination, and that the DTC notifies the commander and updates DAMIS?
- g.* Are commanders conducting Smart Testing of assigned and attached personnel on a truly random basis?
- h.* Is the installation or command conducting random urinalysis of civilian corps members in TDPs at the DA-directed testing rate? Has a DA Form 5019 and/or a DA Form 7412 been signed by all civilians occupying a position requiring alcohol and/or other drug testing?
- i.* Has the ADCO developed and implemented a plan to monitor and assess command utilization of and satisfaction with all aspects of the program (for example, prevention, ID, and rehabilitation)?
- j.* Has the ADCO developed and implemented a prevention education program that coordinates and tracks substance abuse prevention efforts and required annual training for Soldiers and civilian corps members?
- k.* Are ASAP civilian salaries funded in accordance with the MDEPs identified with each authorization listed on the installation TDA? Is the DTC's salary funded by VCND?

H–5. Supersession

This checklist replaces the checklist for the Alcohol/Drug Program previously published in DA Circular 11–89–1.

H–6. Comments

Submit comments to: Director, ACSAP, 4501 Ford Avenue, Suite 320, Alexandria, VA 22302–1460.

Glossary

Section I Abbreviations

AA

alcoholics anonymous

AAR

after action review

ABMD

alcohol breath measuring device

ACOA

adult children of alcoholics

ACOM

Army Command

ACS

Army Community Service

ACSAP

Army Center for Substance Abuse Programs

AD

active duty

ADAPT

alcohol drug abuse prevention training

ADCO

alcohol drug control officer

ADIC

Alcohol Drug Intervention Council

ADT

active duty for training

AFIP

Armed Forces Institute of Pathology

AG

adjutant general

AMEDD

Army Medical Department

AMEDDC&S

Army Medical Department Center and School

AO

Mishap or Safety Inspection

AR

Army Regulation

ARIMS

Army Records Information Management System

ARNG

Army National Guard

ASAP

Army Substance Abuse Program

ASAP EP

Army Substance Abuse Program Evaluation Plan

ASCC

Army Service Component Command

ATF

alcohol test form

ATTN

attention

AWOL

absent without leave

BAC

base area code

BACM

base area code manager

BAT

breath alcohol technician

BOS

base operations support

BPL

battalion prevention leader

CAR

Chief, Army Reserve

CCF

central clearance facility

CC

clinical consultant

CD

clinical director

CDR

commander

CEAP

Certified Employee Assistance Program

CFR

Code of Federal Regulations

CID

Criminal Investigation Division

CNGB

Chief, National Guard Bureau

CONUS

Continental United States

CO

competence for duty

COPS

Centralized Operations Police Suite

COR

contracting officer's representative

CPAC

Civilian Personnel Advisory Center

CPOC

Civilian Personnel Operations Center

CSM

command sergeant major

CSP

collection site person

CSSP

certified senior prevention professional

CTP

Certification Training Program

DA

Department of the Army

DAMIS

Drug and Alcohol Management Information System (Army)

DA PAM

Department of Army Pamphlet

DASAF

Director of Army Safety

DCPDS

Defense Civilian Personnel Data System

DCS, G-1

Deputy Chief of Staff, G-1

DDR

drug demand reduction

DFARS

Defense Federal Acquisition Regulation Supplement

DFR

dropped from rolls

DFW

Drug-Free Federal Workplace

DHHS

Department of Health and Human Services

DHRP

Director of Human Resources Policy

DMO

designated management official

DOD

Department of Defense

DODD

Department of Defense Directive

DODI

Department of Defense Instruction

DOT

Department of Transportation

DRU

Direct Reporting Unit

DTC

drug testing coordinator

DTCP

drug testing collection point

DTP

Drug Testing Program (software)

DUI

driving under the influence

DWI

driving while intoxicated

EACC

Employee Assistance Certification Commission

EAP

Employee Assistance Program

EAPA

Employee Assistance Program administrator

EAPC

Employee Assistance Program coordinator

EO

Executive Order

ER

emergency room

FAA

Federal Aviation Administration

FAP

Family Advocacy Program

FAR

Federal Acquisition Regulation

FedEx

Federal Express

FHWA

Federal Highway Administration

FMCSA

Federal Motor Carrier Safety Administration

FTDL

Forensic Toxicology Drug Testing Laboratory

GC/MS

gas chromatography/mass spectrometry

GO

general officer

GOSC

General Officer Steering Committee

GS

general schedule

HIPAA

Health Insurance Portability and Accountability Act

HQ

Headquarters

HQDA

Headquarters, Department of the Army

HRC

U.S. Army Human Resources Command

IADT

initial active duty training

IAW

in accordance with

IBAT

installation breath alcohol technician

ID

identification

IDT

inactive duty training

IHCPC

Impair Health Care Provider Committee

IHCPP

Impair Health Care Provider Program

IMCOM

Installation Management Command

IO

inspection other

IPP

installation prevention plan

IPT

installation prevention team

IPTT

installation prevention team training

IR

inspection random

ISR

installation status report

iTAPDB

integrated Total Army Personnel Database

IU

inspection unit

JCAHO

Joint Commission on Accreditation of Healthcare Organizations

JNGSAP

Joint National Guard Substance Abuse Program

JSAPC

Joint Substance Abuse Program Coordinator

JSAPO

Joint Substance Abuse Program officer

LIMS

Laboratory Information Management System

LPN

licensed practical nurse

LSD

Lysergic Acid Diethylamide

LVN

licensed veterinary nurse

MDEP

management decision package

MEDCEN

medical center

MEDCOM

medical command

MEDDAC

medical department activity

METT-TC

Mission, Enemy, Terrain and Weather, Troops and support available, Time available, and Civil considerations

MFR

memorandum for record

MIS

Management Information System

MO

medical examination

MOA

memorandum of agreement

MOS

military occupational specialty

MP

military police

MPRS

Military Police Reporting System

MRE

Military Rules of Evidence

MRO

medical review officer

MSC

Major Subordinate Command

MTF

medical treatment facility

MWR

Moral, Welfare, and Recreation

NCO

noncommissioned officer

ng/ml

nanograms per milliliter

NGB

National Guard Bureau

NGB-CD

National Guard Bureau, Counterdrug Directorate

NGR

National Guard Regulation

NLCP

National Laboratory Certification Program

NO

new entrant

NSN

national stock number

NSPS

National Security Personnel System

OA

overeaters anonymous

OCONUS

outside continental United States

ONDCP

Office of National Drug Control Policy

OPF

official personnel folder

OTJAG

Office of the Judge Advocate General

PC

prevention coordinator

PCP

Phencyclidine

PCS

permanent change of station

PROFIS

Professional Officer Filler System

PIR

patient intake report

PL

Public Law

PM

Provost Marshal

PMO

Provost Marshal officer

PO

probable cause

POC

point of contact

POM

program objective memorandum

PPR

patient progress report

PRP

Personnel Reliability Program

PT

physical training

QAAP

management decision package code for the Army Substance Abuse Program funds

QFMD

management decision package code for adolescent substance abuse counseling services funds

RAPR

resource and performance report

RMC

regional medical command

RO

Rehabilitation

RRP

Risk Reduction Program

RRPC

Risk Reduction Program coordinator

RRSC

regional readiness support command

R-URI

Reintegration Unit Risk Inventory

SAMHSA

Substance Abuse and Mental Health Services Administration

SAP

substance abuse professional

SAV

site assistance visit

SCI

sensitive compartmented information

SES

Senior Executive Service

SF

standard form

SJA

Staff Judge Advocate

SOP

standing operating procedures

SPL

squadron prevention leaders

SSN

social security number

STD

standard

STT

screening test technician

TDA

table of distribution and allowances

TDP

testing designated position

TDY

temporary duty

THC

Tetrahydrocannabinol

TJAG

The Judge Advocate General

TRADOC

U.S. Army Training and Doctrine Command

TSG

The Surgeon General

UA

urinalysis

UCMJ

Uniform Code of Military Justice

UPL

unit prevention leader

UPS

United Parcel Service

URI

Unit Risk inventory

U.S.

United States

USAAC

United States Army Accessions Command

USAAMA

United States Army Aero-Medical Activity

USAAMC

United States Army Aero-Medical Center

USACE

United States Army Corps of Engineers

USACIDC

United States Army Criminal Investigation Division Command

USADATA

United States Army Drug and Alcohol Technical Activity

USAMEDCOM

United States Army Medical Command

USAR

United States Army Reserve

USARC

United States Army Reserve Command

USC

United States Code

USPS

United States Postal Service

VA

Veterans Administration

VCND

management decision packages code for Department of Defense Counternarcotics funds

VO

consent

WBAP

well-being action plan

WBSR

well-being status report

Section II**Terms****Adult Living Problems**

Family, medical, stress or other related issues that may affect adult employees or their adult Family members.

Adulterated Specimen

A urine specimen containing a substance that is not a normal constituent or containing an endogenous substance at a concentration that is not a normal physiological concentration.

Air blank

A reading by an evidentiary breath test of ambient air containing no alcohol.

Alcohol abuse

Any irresponsible use of an alcoholic beverage which leads to misconduct, unacceptable social behavior, or impairment of an individual's performance of duty, physical or behavioral health, financial responsibility, or personal relationships.

Alcohol level

The alcohol in a volume of breath expressed in terms of grams of alcohol per 210 liters of breath as indicated by an

evidentiary breath test. For example, a breath alcohol concentration of 0.04 means 0.04 grams (four one-hundredths of one gram) of alcohol in 210 liters of expired deep lung air.

Alcoholism

A treatable, progressive condition or illness characterized by excessive consumption of alcohol to the extent that the individual's physical and behavioral health, personal relationships, social conduct, or job performance are impaired.

Alcohol and Drug Control Officer (ADCO)

The person having staff responsibility for implementing the ASAP at IMCOM, ACOM, ASCC, DRU, or installation level.

Aliquot

A fractional part of a specimen used for testing. It is taken as a sample representing the whole specimen.

Army Substance Abuse Program (ASAP)

A personnel program that includes prevention, ID, education, and rehabilitation services. The program includes nonresidential and partial inpatient care programs. The ASAP is responsive to the chain of command and supports the combat readiness of the Army.

ASAP records

Forms, records, or other documents required by this regulation. This includes any information, whether recorded or not, relating to a patient or client which is received or acquired in connection with any function of the ASAP, including evaluation for possible enrollment in the ASAP. Creation or maintenance of alcohol or other drug abuse records that would identify an individual as a client/patient of the ASAP, other than as required by this regulation, is prohibited.

Career

For the purposes of this regulation, an Army career is defined as inclusive of all periods of service, including officer and enlisted Service or a combination of both, when the Soldier is subject to the UCMJ or a or territory military code of justice.

Chain of custody

Procedures to account for the integrity of each urine specimen or aliquot, by tracking, handling, and storing from point of specimen collection to the final disposition of the specimen. Documentation of this process must include the date and purpose each time a specimen or aliquot is handled or transferred and ID of each individual in the chain of custody.

Commerce

An interchange of goods or commodities

Commercial Motor Vehicle

A commercial vehicle with a gross vehicle weight rating of 26,001 or more pounds; or is designed to transport 16 or more occupants (to include the driver); or is of any size and is used in the transport of hazardous materials that require the vehicle to be placarded.

Collection Site Person

The CSP is the individual trained to collect urinalysis specimens from civilian corps members as part of the civilian DTP. The CSP is often a certified DTC, though this need not be the case. A CSP performs similar duties for civilian corps members that the UPLs perform for Soldiers.

Confirmation

The process of using an analytical procedure to identify the presence of a specific drug or metabolite that is independent of an initial test and which uses a different technique and chemical principle from that of an initial test in order ensure reliability and accuracy.

Designated Management Official

The DMO is the one person on an installation that is responsible for administering the civilian DTP. In most cases, this is the installation ADCO.

Director, ASAP

The Director of the Army Substance Abuse Program is responsible to the DCS, G-1 for the performance of the overall

ASAP. The Director, ASAP is also the Director, ACSAP. The Director, ACSAP manages the personnel and operations of the organization known as the ACSAP.

DFW Program follow-up testing

Unannounced testing that each employee who has been referred to the EAP through the administrative channels to undergo counseling or rehabilitation for illegal drug use will be subject such testing for period of 1 year upon the completion of the counseling or rehabilitation programs. Frequency of such testing may be stipulated in the abeyance contract or at a frequency determined by the supervisor. Such testing is distinct from testing which may be imposed as part of the counseling or rehabilitation programs

DOT follow-up testing

Unannounced or alcohol testing that is required for any employee who has committed a DOT drug or alcohol regulation violation, and who seeks to resume the performance of safety-sensitive functions. At a minimum the employee must undergo six follow-up testes within the 12 month period following the employees resuming the performance of safety-sensitive duties. These tests are not to be confused with follow-up testing that is actually part of the counseling or rehabilitative process. Other tests such as random or post-accident testing cannot be submitted for the required follow-up testing

Drug abuse

The use or possession of controlled substances, or illegal drugs, or the nonmedical or improper use of other drugs (for example, prescription and over the counter drugs) that are packaged with a recommended safe dosage. This includes the use of substances for other than their intended use (for example, glue and gasoline fume sniffing or steroid use for other than that which is specifically prescribed by competent medical authority.)

DTP

The DOD DTP is software designed to manage and automate a unit-level substance abuse program. The UPL uses the software to maintain a list of personnel in the unit, randomly select Soldiers for drug testing, and print required forms and bottle labels. CSPs may also use the DOD DTP for managing civilian drug testing.

Employee Assistance Program short-term counseling

The process whereby the Employee Assistance Program Coordinator provides short-term guidance, advice, education, and mediation to civilian employees for the resolution of employee problems and issues.

Enrollment

The formal action taken by an ASAP counselor, in consultation with the commander, to enter a Soldier into the ASAP.

Evidentiary

Meeting the legal requirements to be introduced in a court of law as evidence.

Evidentiary breath testing (EBT) device

A device approved by the National Highway Traffic Safety Administration (NHTSA) for the evidentiary testing of breath and placed on NHTSA's "Conforming Products List (CPL) of Evidentiary Breath Measurement Devices."

Family Member

Spouse or minor children of a Soldier, or a civilian corps member employee. Use of term in this regulation is intended to include only persons eligible for ASAP services by law or regulation.

Forensic

Suitable for a court of law, public debate, or argument.

GC/MS

Gas Chromatography/Mass Spectrometry is the chemical process where a drug in urine is positively identified and quantified.

Initial test

A screening test to identify those specimens that are negative for the presence of drugs of their metabolites. When negative, these specimens need no further examination and need not undergo a more costly confirmation test.

Installation Breath Alcohol Technician (IBAT)

An trained individual, who assists employees/applicants in the alcohol testing process and operates an evidentiary breath test device.

JSAPO/JSAPC

The JSAPO and JSAPC manage the ASAP for a Army National Guard.

Limited Use

Protection from the use of certain information, determined to be confidential by Federal regulation, to support disciplinary action under the UCMJ or administrative separation with a less than honorable discharge.

Medical evaluation

Examination of an individual by a physician to determine whether there is evidence of alcohol or other drug abuse or dependency.

Medical review officer (MRO)

A licensed physician responsible for receiving laboratory results generated from a drug test who has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate Soldiers'/employees'/applicants' confirmed positive tests results together with their medical histories and any other relevant biomedical information.

Prevention procedures

Those actions designed to increase the likelihood that individuals will make responsible decisions regarding the use of alcohol or other drugs. Those actions taken to eliminate to the extent possible abuse or misuse of alcohol or other drugs.

Probable Cause

A reasonable ground in fact and circumstance for a belief in the existence of certain circumstances (as that an offense has been or is being committed, that a person is guilty of an offense, that a particular search will uncover contraband, that an item to be seized is in a particular place, or that a specific fact or cause of action exists).

Professional program management:

Minimum 1 year paid experience in managing a clinical program and managing workload accountability, administrative accountability, personnel management, and clinical oversight. The managerial job must have included budget planning and fiduciary analysis, implementation of Office of Personnel Management standards and the Merit Systems Protection Board guidelines while conducting personnel hiring actions, supervisory training, disciplinary actions, conducting conflict and problem resolution, conducting quality control program reviews, performing workload and outcome analyses, preparation and submission of statistical reports in federal or corporate work environments, instituting and maintaining performance improvement initiatives, and the preparing and delivering formal briefings at the corporate or higher HQ levels.

R-URI

The Reintegration Unit Risk Inventory is an anonymous questionnaire completed by Soldiers of a unit between 90 and 180 days after returning from an operational (not training) deployment. The questionnaire is designed to identify the risky behaviors Soldiers are participating in after a deployment.

Random testing

A scientifically valid system of selecting a portion of a command for drug testing without individualized suspicion that a particular individual is using illicit drugs. Each Soldier or civilian corps member will have an equal chance of being selected for drug testing each time this type of inspection is conducted.

Reasonable suspicion

An objectively justifiable suspicion that is based on specific facts or circumstances and that justifies stopping and sometimes searching (as by frisking) a person.

Rehabilitation team

A coordinating group consisting of the Soldier, the unit commander and/or First Sergeant, the ASAP counselor, and other appropriate personnel as required (for example, clinical director, chaplain, physician, and so forth). The team reviews all pertinent information about the Soldier and recommends to the commander when rehabilitation is warranted

or required. It selects the appropriate rehabilitation methods and assists the commander in setting standards of behavior and goals for evaluation of the Soldier's progress in rehabilitation.

Sensitive position

Any position within DA in which the occupant could cause, by virtue of the nature of the position, a materially adverse effect on the national security.

Serious Incident (of alcohol-related misconduct)

Any offense of a civil or military nature that is punishable under the UCMJ by death or confinement for a term exceeding 1 year.

Split specimen

An additional specimen collected with the original specimen to be tested in the event the original specimen tests positive.

Substance Abuse Professional

A person who evaluates employees who have violated a DOT drug and alcohol regulation and makes recommendations concerning education, treatment, follow-up testing, and aftercare.

Testing Designated Position (TDP) employee

A DA employee who holds a position identified by the Army as having critical safety or security responsibilities related to the Army mission.

URI

A Unit Risk Inventory is an anonymous questionnaire completed by all Soldiers of a unit at any time, and is designed to identify the risky behaviors Soldiers are participating in

Section III

Special Abbreviations and Terms

There are no entries in this section.

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