

**BY ORDER OF THE  
SECRETARY OF THE AIR FORCE**

**AIR FORCE INSTRUCTION 44-121**

**11 APRIL 2011**



**Medical Operations**

**ALCOHOL AND DRUG ABUSE  
PREVENTION AND TREATMENT  
(ADAPT) PROGRAM**

**COMPLIANCE WITH THIS PUBLICATION IS MANDATORY**

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This Air Force Instruction (AFI) establishes guidance for the United States Air Force (USAF) Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program. It implements Air Force (AF) Policy Directive (AFPD) 44-1, *Medical Operations*. This instruction provides guidance for the identification, treatment and management of personnel with substance abuse (SA) problems and describes AF policy regarding alcohol and drug abuse. This instruction applies to all active duty (AD) USAF members, and to members of the USAF Reserve Command (AFRC) and Air National Guard (ANG) whenever eligible for DoD medical services, with the exception of paragraph 3.2., which applies to all Reservists at all times. The AFRC and ANG do not have separate systems to provide behavioral health treatment, including SA treatment. Clarification about AF Reserve (AFR)-specific policies, processes, and/or procedures should be directed to HQ AFRC/SG's Mental Health (MH) Consultant at Robins AFB, GA. When not eligible for DoD medical services, Air Reserve Component (ARC) members will obtain, when needed, non-military SA services at their own expense.

This Instruction prohibits the ingestion and possession of certain intoxicating substances by military personnel, including AFR and ANG. Failure to observe prohibitions and mandatory provisions of this Instruction in paragraphs **3.2.2**, or **3.2.3** by military personnel is a violation of Article 92, *Uniform Code of Military Justice* (UCMJ). Violations may result in administrative disciplinary action without regard to otherwise applicable criminal or civil sanctions for violations of related laws.

The Privacy Act of 1974 applies to this instruction. Each form that is subject to the provisions of AFI 33-332, *Privacy Act Program*, must contain a Privacy Act Statement, either in the form

itself or attached to it. The authorities to collect personal information and maintain the records listed in this instruction are Title 10, United States Code (U.S.C.) 8013, 42 U.S.C.290dd-2, et seq., and Executive Order 11478, Executive Order 9397, Numbering System for Federal Accounts Relating to Individual Persons, November 22, 1943 as amended by Executive Order 13478, Amendments to Executive Order 9397 Relating to Federal Agency Use of Social Security Numbers, November 18, 2008. System of Records Notice F044 AF SG S, *Alcohol and Drug Abuse Prevention and Treatment Program*, applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) AFMAN 33-363, *Management of Records*, and disposed of IAW the AF Records Disposition Schedule (RDS) located at <https://www.my.af.mil/afirms/afirms/afirms/rims.cfm>. Send comments and suggested improvements on AF Form 847, *Recommendation for Change of Publication* through channels to AFMOA/SGHW, 2261 Hughes Ave, Suite 153, San Antonio, TX 78236.

**SUMMARY OF CHANGES**

This new revision updates the OPR/certifying official, updates the address and office symbol of the AFMOA ADAPT/Drug Demand Reduction (DDR) Branch, implements the use of Alcohol Brief Counseling (ABC) in place of the 6-hour Substance Abuse Awareness Seminar (SAAS), provides new guidance that clarifies requirements for the assessment and treatment of civilian employees, provides a consent for release of patient information for civilian employees seen in ADAPT, updates guidance on the clinical practice of Certified Alcohol and Drug Abuse Counselors (ADC), deletes the out-of-date list of AD SA Recovery Centers, and implements the use of AF Form 469, *Duty Limiting Conditions Report*, for reporting duty limiting conditions as required by AFI 10-203, *Duty Limiting Conditions*.

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## Chapter 1

### RESPONSIBILITIES

#### *Section 1A—Office of the Surgeon General*

**1.1. Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR).** SAF/MR serves as an agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs, and budgets addressing drug and alcohol abuse prevention and treatment.

**1.2. Air Force Surgeon General (AF/SG).** AF/SG oversees policy and implementation of the ADAPT Program.

**1.3. Air Force Medical Operations Agency, (AFMOA) Mental Health Division (SGHW), ADAPT/DDR Branch.**

1.3.1. Develops, implements, and manages the ADAPT Program operations to support established policies.

1.3.2. Manages programming and execution of AF SA and DDR budgets.

1.3.3. Coordinates with Headquarters AF (HAF) and their Field Operating Agencies (FOAs) involved in ADAPT Programs.

1.3.4. Communicates with other AF, Department of Defense (DoD), and civilian agencies that have collateral ADAPT responsibilities and interests.

1.3.5. Prepares policy and operational guidance and clarification to Major Commands (MAJCOMs).

1.3.6. Convenes and attends conferences and other professional forums that address ADAPT-related issues and determines appropriate AF representation at these events.

1.3.7. Advises the MH Enlisted Career Field Manager with manpower and personnel issues regarding ADAPT Programs.

1.3.8. Responds to ADAPT-related complaints and suggestions, Congressional and high-level inquiries, and Freedom of Information Act requests.

1.3.9. Serves as Office of Primary Responsibility (OPR) for the DDR Programs.

1.3.10. Serves as Office of Collateral Responsibility (OCR) on deterrence, interdiction, anti-smuggling and intelligence activities.

1.3.11. Monitors the Alcohol and Drug Counselor Certification Program.

1.3.12. Develops procedures for managing and documenting ADAPT activities.

1.3.13. Develops and prepares ADAPT statistical data and reports for program management and policy development.

1.3.14. Collects data for the ADAPT Program and prepares reports as required by DoD and AF higher headquarters.

1.3.15. Reviews inspection reports and other assessments. Reports trends and recommends process improvements to the field.

***Section 1B—Headquarters, US Air Force***

**1.4. Judge Advocate General of the Air Force (AF/JA).** AF/JA provides legal opinions, instructions, guidance and assistance regarding ADAPT programs and policies.

**1.5. Air Force Director of Security Forces (AF/A7S).** Ensures that Security Forces provides Law Enforcement sensitive data to ADAPT Staff on SA incidents.

***Section 1C—Major Command (MAJCOM) SGs and Direct Reporting Units (DRUs)***

**1.6. MAJCOM SGs.**

1.6.1. Implements, coordinates, evaluates and reports AF ADAPT policies and programs at the MAJCOM/level.

1.6.2. Appoints a Behavioral Health Consultant, or an ADAPT Program Manager (PM), who:

1.6.2.1. Identifies problem areas through trend analysis and takes corrective actions for issues that cannot be solved at the installation level.

1.6.2.2. Ensures development of prevention programs that specifically target high-risk groups, encourages responsible behavior and enhance organizational wellness.

1.6.2.3. Ensures installation MH technicians working in ADAPT receive on-going, formal training and guidance, and certification processes are performed in accordance with (IAW) AF policy.

1.6.2.4. Determines the necessity for special assistance and training. This includes acting as liaison for continuing education quotas and all other training required or requested by installation offices.

1.6.2.5. Provides ADAPT guidance to geographically separated units (GSUs) on programs and policy.

1.6.2.6. Responds to SA related complaints, suggestions, and Congressional and higher level inquiries.

1.6.2.7. Provides assistance and guidance to base-level MH offices regarding ADAPT issues.

1.6.2.8. Develops MAJCOM unique ADAPT programs and procedures as appropriate.

**1.7. DRU.** DRUs that have an ADAPT function, such as the USAF Academy, will perform the same functions as above (see paragraphs 1.6.1. through 1.6.2.8.).

***Section 1D—Installation***

**1.8. Installation Commander.**

1.8.1. Ensures ADAPT Programs are developed and implemented.

1.8.2. Ensures allocation of adequate space for provision of SA classroom education and services.

1.8.3. Ensures ADAPT Program receives adequate funding to support counseling, treatment, prevention and outreach efforts. Since non-clinical prevention, education and aftercare are not funded through the Defense Health Program (DHP), resources will be provided by the Program Element (PE) 88723 funds (i.e., “line” funding) to support these programs.

1.8.4. Ensures available funding in PE 88723 (SA Program) for continuing education and training for certified SA counselors to meet requirements of International Certification and Reciprocity Consortium (IC&RC). The IC&RC requires that Certified SA Counselors attain a minimum of 60 continuing education hours every three (3) years in order to maintain their certification.

### **1.9. Medical Treatment Facility (MTF) Commander.**

1.9.1. Serves as the OPR for SA issues.

1.9.2. Appoints, in writing, a privileged MH provider (MHP) as ADAPT PM, who is knowledgeable in SA and addictions prevention, assessment, intervention, and treatment.

1.9.3. Ensures SA clinical services meet current quality assurance standards and complies with relevant accreditation standards for SA treatment facilities.

1.9.4. Ensures all medical personnel, working in direct patient care, or clinical supervisory roles receive annual training in SA and chemical dependency (see **Table 3.1.**). The training will include the identification of SA problems to enhance the skills of medical personnel to recognize cases of suspected or diagnosed SA and to refer those individuals to the ADAPT Program for assessment.

1.9.5. Ensures SA assessments are conducted on a priority basis IAW **Chapter 3** of this instruction.

1.9.6. Provides or arranges for medical assessment, detoxification, residential and non-residential treatment for substance abusers, including patient and family psychoeducational programs at SA treatment facilities.

1.9.7. Provides or arranges for aeromedical evacuation or civilian transportation of members in inpatient status for SA, and family members attending SA treatment programs when necessary.

### **1.10. ADAPT Program Manager (ADAPT PM).**

1.10.1. Manages local ADAPT Program IAW current policies and guidance.

1.10.2. Coordinates clinic resources to provide effective education, identification, assessment and treatment programs, as well as coordinates with the Resiliency Element (RE) to provide prevention programs. On-base services should include early intervention (Level 0.5) and outpatient programs (Level I) as defined in the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders. Limited Scope Medical Treatment Facilities with insufficient MH personnel or inadequate patient census to support the full range of ADAPT services will ensure individuals requiring these services are referred to an appropriate ADAPT Program or civilian treatment facility.

1.10.3. Coordinates funding requirements using PE 88723 through the wing budgeting cycle. A Responsible Center/Cost Center (RC/CC) should be established within the MTF to capture funds in PE 88723. This allows SA funds to be managed by the MTF resource advisor (RA) with assistance of the Wing RA.

1.10.3.1. DHP dollars may be used to support initial SA assessment and clinical treatment services. Clinical treatment includes services provided to clients receiving a medical diagnosis of SA or dependence such as outpatient treatment partial hospitalization or inpatient treatment programs.

1.10.3.2. Prevention, awareness education and non-clinical intervention (services provided to clients not receiving diagnosis of abuse or dependence) will be paid for out of PE 88723 (line) funds.

1.10.3.3. ADAPT PMs will ensure that SA workload reporting is completed using Medical Expenses Performance Report Services (MEPRS) codes AFBA (Inpatient SA Treatment) and BFFA (Ambulatory Care - SA Clinic). Since SA authorizations are funded through the line, SA personnel will account for Full Time Equivalent (FTE) Work Month, and workload, IAW DoD 6010.13M, *Medical Expense and Performance Reporting System For Fixed Military Medical and Dental Treatment Facilities Manual*.

1.10.4. Must be a privileged MHP.

1.10.5. Coordinates with off-base resources to effectively supplement the base ADAPT programs.

1.10.6. Ensures development and implementation of ADAPT education programs.

1.10.7. Assists commanders and supervisors to identify and refer individuals needing ADAPT services.

1.10.8. Ensures that all care and services provided by non-privileged personnel are supervised IAW AFI 44-119, *Medical Quality Operations*, and other applicable AF Policy.

1.10.9. Proposes written wing or installation guidance concerning alcohol and drug abuse prevention and treatment.

1.10.10. Ensures continuous quality improvements in the ADAPT Program by developing and tracking metrics related to alcohol and drug abuse prevention and treatment.

1.10.11. Provides leadership, managerial guidance and clinical supervision to the ADAPT staff.

1.10.11.1. Conducts required reviews of the patient's medical records and all documentation provided by the ADAPT Program staff on a priority basis.

1.10.11.2. Observes the patient's general physical and mental condition during the assessment. Refers for additional medical, psychiatric, or laboratory examinations as needed.

1.10.11.3. Chairs Treatment Team (TT) Meetings.

1.10.12. Helps GSUs with ADAPT-related issues as outlined in the local host-tenant agreement or memoranda of understanding.

1.10.13. Ensures non-privileged ADAPT personnel are trained and certified or actively participating in the certification process.

1.10.13.1. Eligibility for certification. AF personnel who are currently performing duties related to ADAPT are eligible to apply for certification if they meet the standards outlined in the AF SA Counselor Certification Handbook.

1.10.13.2. Maintaining Certification. Individuals certified through the AF SA Counselor Certification Board will maintain their certification as long as they provide services in support of the ADAPT Program. Requirements for counselor recertification are outlined in the AF SA Counselor Certification Handbook.

1.10.14. Markets ADAPT Programs to senior leadership on the installation and to the base population.

1.10.15. Coordinates with RE to provide input to the Airmen and Family Readiness Center (A&FRC) in the development of community referral guidelines and the Integrated Delivery System (IDS).

1.10.16. Ensures that ADAPT staff will verify that human immunodeficiency virus (HIV) testing is current, and initiate the labs if the military member, who has been identified for illicit or illegal drug abuse or who has been diagnosed with Alcohol Abuse or Alcohol Dependence, has not had HIV testing within the past six months.

1.10.17. Ensures that the SGP, as chair of the Deployment Availability Working Group (DAWG), is provided with the treatment status of all ADAPT Program clients, including their profile status, on a monthly basis.

1.10.18. Ensures AFRC and ANG members who have been evaluated by the ADAPT Program staff but are not eligible for DoD medical services are given information on how to obtain follow-up care by a qualified non-military provider for SA treatment.

1.10.19. Collaborates and communicates with Reserves Medical Unit (RMU) personnel, and AFRC and ANG Commanders, when required by AF and DoD policy, regarding any AFRC or ANG member who presents to the ADAPT Program for services.

1.10.20. Shall provide fitness for duty or status recommendations to AFRC and ANG commanders for AFRC and ANG members who work in special duty assignments such as PRP, and who have been seen by non-military providers for SA evaluation and/or treatment.

1.10.20.1. When a fitness for duty or status recommendation must be made for a special duty assignment such as PRP, an AFRC or ANG member who has been referred to a non-military provider for treatment will coordinate with that non-military provider to ensure that treatment records are made available to the ADAPT Program staff in a timely manner. The member will ensure the records are available for review by the ADAPT provider for status recommendation at appropriate times as determined by the commander, in consultation with an ADAPT provider. The member must be on orders to be seen in ADAPT for any appointments associated with status recommendations.

1.10.21. The ADAPT PM will provide PRP status recommendations to the PRP Competent Medical Authority and return to duty recommendations to the flight surgeon as required by relevant governing instructions.

### 1.11. Alcohol and Drug Counselor (ADC).

1.11.1. Background. MH technicians serve in clinical roles as ADCs in the ADAPT Program (formerly referred to as Certified Alcohol and Drug Abuse Counselors, or CADACs). They provide services in the following 12 core functions outlined by the IC&RC: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, education, referral, report and record keeping, and consultation. **Note:** The AF SA Counselor Certification program issues the certification and has the authority to revoke certification for cause.

#### 1.11.2. Education and Certification Requirements:

1.11.2.1. Have a minimum of 270 hours didactic instruction and 6,000 hours within the 12 core functions of SA counseling, 300 of which must be accomplished via direct supervision by another fully qualified ADC or privileged MHP.

1.11.2.2. Have a signed agreement to practice under strict AF ethical guidelines. **Note:** Ethical guidelines are state/board specific.

1.11.2.3. Pass a recognized written examination administered by the AF.

1.11.2.4. Obtain nationally recognized certification from the IC&RC.

1.11.2.5. Recertify every three (3) years by obtaining a minimum of 60 hours of continuing professional education within the behavioral sciences, as outlined by the AF Alcohol and Drug Counselor Certification Handbook. See handbook for additional information regarding entire certification process. An electronic copy of the handbook can be obtained from the ADAPT Branch staff at AFMOA/SGHW.

1.11.3. Scope of Practice/Supervision. ADCs perform the 12 core functions independently as directed by the ADAPT PM. They provide treatment planning, crisis intervention and group treatment under the supervision of a privileged MHP. For initial assessment, development of or changing a treatment plan, and crisis intervention, privileged MHPs are responsible for “eyes on” supervision of ADCs. This is defined as direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation note made in the chart by the ADC before the patient departs the appointment. Supervising privileged MHPs must document supervision in the medical record following each episode supervised.

1.11.3.1. The ADAPT PM is responsible for the clinical practice of ADCs. To ensure ongoing training and competency assessment for ADCs, the ADAPT PM, or designee, must observe and assess the ADC while providing individual or group treatment, at least two times per month for a total of at least two hours monthly. Competency assessments will focus on direct client contact within the 12 core functions of SA counseling, and will be documented in the ADC’s training record (see [Attachment 2](#) for sample memorandum to track training). In fulfilling this requirement, the observer and counselor will abide by strict ethical standards. The ADAPT PM maintains training records of all ADCs working in SA.

1.11.3.2. Non-certified 3-level MH technicians who are in training may conduct the 12 core functions only when supervised by an ADC or privileged MHP and must have direct supervision during the entire patient contact. At the discretion of the ADAPT PM following a period of direct observation and evaluation, non-certified 5-level and 7-level

MH technicians may conduct the 12 core functions without direct supervision. A privileged MHP is responsible for eyes-on supervision before the patient departs the appointment. Eyes-on supervision is defined as direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation before the patient departs the appointment. The privileged MHP who performed this supervision must cosign the note in the patient record.

**1.12. Installation Defense Force Commander (DFC).** Provides the base ADAPT Program personnel Law Enforcement Sensitive information needed for SA incidents.

**1.13. Geographically Separated Unit (GSU) Commanders.** GSU commanders will refer individuals to the nearest ADAPT Program for assessment when substance use is suspected to be a contributing factor in an incident or when an individual is suspected of having a problem with alcohol or other drugs (also see paragraph 3.8., Commander's Identification and Associated Roles and Responsibilities).

1.13.1. Support for requested prevention services will be provided by the host installation ADAPT Program.

1.13.2. Treatment of SA problems for clients assigned to GSUs may include services through local (civilian) resources with on-going case-management provided through the ADAPT PM at the nearest MTF.

**1.14. AFRC and ANG Commanders.** (Refer to Para. 3.8.).

1.14.1. IAW AFI 48-123, *Medical Examinations and Standards*, and AFI 36-2254-v1, *Reserve Personnel Participation* (para. 1.6.), unit commanders are encouraged to place the member suspected of SA on orders to receive the initial assessment and treatment recommendation from the ADAPT Program. ARC members not already eligible for military treatment services (i.e., were placed on orders for the SA assessment only) will be managed IAW para. 1.10.18. of this instruction.

1.14.2. If the commander chooses not to place a member on orders, the commander will refer those ARC members [e.g., Traditional Reservists, Air Reserve Technicians (ARTs), Individual Mobilization Augmentees (IMAs), or Drill Status Guardsmen] who are suspected of SA to a non-military MH provider for a SA assessment and any recommended treatment. The non-military provider must be a licensed MH provider or a certified SA counselor.

## Chapter 2

### MENTAL HEALTH RECORDS FOR ADAPT PROGRAM PARTICIPANTS

**2.1. Objective.** Establish guidance on documentation.

**2.2. Managing Records.**

2.2.1. ADAPT Program treatment information will be maintained as part of a single, integrated MH record (Per AFI 44-172, *Mental Health*, Chapter 4). The ADAPT section of the MH record will thoroughly reflect findings during the initial assessment, intake and patient orientation, diagnosis, treatment plan, course of treatment, referrals, case management activities, progress reviews and status upon termination.

2.2.2. Providers shall document care in the patient's medical record IAW AFI 41-210, *Patient Administration Functions*.

2.2.3. Case notes will be documented in the standard Subjective, Objective, Assessment, Plan (SOAP) format.

2.2.4. Records Disposition

2.2.4.1. Maintain and dispose of all records created by processes prescribed in this publication IAW AF Records Disposition Schedule in the AF Records Information Management System (AFRIMS), especially Table 41-12 Rule 12.00, the records disposition schedule for Substance Abuse Records (Active Duty, Retired and Family Members).

2.2.5. When clients PCS and are still receiving ADAPT treatment or aftercare services, a copy of the patient's MH record will be forwarded within 30 calendar days to the gaining installation ADAPT Program office to ensure continuity of care is provided. See **Section 3E**, paragraphs 3.16. and 3.17. in this AFI for additional information about transfer of care issues.

## Chapter 3

### AF ADAPT PROGRAM

#### *Section 3A—General Information*

**3.1. Alcohol Abuse.** The AF policy recognizes that alcohol abuse negatively affects public behavior, duty performance, and/or physical and MH. The AF provides comprehensive clinical assistance to eligible beneficiaries seeking help for an alcohol problem.

**3.2. Illicit Drug Use.** The AF does not tolerate the illegal or improper use of drugs by AF personnel.

3.2.1. Such use:

3.2.1.1. Is a serious breach of discipline.

3.2.1.2. Is incompatible with service in the AF.

3.2.1.3. Automatically places the member's continued service in jeopardy.

3.2.1.4. Can lead to criminal prosecution resulting in a punitive discharge or administrative actions, including separation or discharge under other than honorable conditions.

3.2.2. Studies have shown that products made with hemp seed and hemp seed oil may contain varying levels of tetrahydrocannabinol (THC), an active ingredient of marijuana which is detectable under the AF Drug Testing Program. In order to ensure military readiness, the ingestion of products containing or products derived from hemp seed or hemp seed oil is prohibited. Failure by military personnel to comply with the prohibition on the ingestion of products containing or products derived from hemp seed or hemp seed oil is a violation of Article 92, Uniform Code of Military Justice (UCMJ).

3.2.3. In order to ensure military readiness; safeguard the health and wellness of the force; and maintain good order and discipline in the service, the knowing use of any intoxicating substance, other than the lawful use of alcohol or tobacco products, that is inhaled, injected, consumed, or introduced into the body in any manner to alter mood or function is prohibited. These substances include, but are not limited to, controlled substance analogues (e.g., designer drugs such as “spice” that are not otherwise controlled substances); inhalants, propellants, solvents, household chemicals, and other substances used for “huffing”; prescription or over-the-counter medications when used in a manner contrary to their intended medical purpose or in excess of the prescribed dosage; and naturally occurring intoxicating substances (e.g., *Salvia divinorum*). The possession of any intoxicating substance described in this paragraph, if done with the intent to use in a manner that would alter mood or function, is also prohibited. Failure by military personnel to comply with the prohibitions contained in this paragraph is a violation of Article 92, UCMJ.

**3.3. Program Objective.** The primary objectives of the ADAPT Program are to promote readiness, health, and wellness through the prevention and treatment of substance misuse and abuse; to minimize the negative consequences of substance misuse and abuse to the individual, family, and organization; to provide comprehensive education and treatment to individuals who

experience problems attributed to substance misuse or abuse; to restore function and return identified substance abusers to unrestricted duty status or to assist them in their transition to civilian life, as appropriate. These objectives are met through four tiers of activities:

3.3.1. Tier I--Primary Prevention and Education: This tier includes population-based outreach, education, prevention programs, screening, and consultation. Community-based prevention and education efforts will be delivered through the RE. Clinic based services, screening and consultation will be delivered through the ADAPT Element.

3.3.2. Tier II--Secondary/Targeted Prevention: This involves initiatives to prevent future alcohol misuse or drug use with individuals who are identified as high risk or are suspected of substance misuse. Tier II includes screening, assessment, education, brief preventive counseling, and tailored feedback in specific individuals or groups identified as moderate to high risk.

3.3.3. Tier III--Tertiary Care/Treatment: Provide evidence-based clinical treatment to individuals who are abusing or are dependent on alcohol or drugs. The primary aim should be restoring function, improving quality of life, and returning members to productive and unrestricted duty, or to assist them in their transition to civilian life, as appropriate.

3.3.4. Tier IV--Training: Includes timely and evidence-based education for obtaining and maintaining certification/licensure for ADAPT Program staff.

### **3.4. Scope and Limitations.**

3.4.1. ADAPT Program treatment information collected and maintained as a part of ADAPT treatment or aftercare services are maintained IAW 42 U.S.C. 290dd-2 and AFI 33-332. These records are protected from public disclosure, and are released only under the circumstances listed in 42 U.S.C. 290dd-2(b) and (c).

3.4.2. ADAPT Program treatment information may be disclosed or released to other offices or agencies within the Armed Forces. This information can be disclosed for use within the Armed Forces for treatment purposes. ADAPT Program treatment information may also be released or disclosed to components of the Department of Veterans' Affairs furnishing health care to veterans.

3.4.3. In the course of SA assessment, treatment or aftercare services in the ADAPT Program, information disclosed about child abuse or neglect, or spousal abuse may be disclosed to appropriate authorities, civilian or military, to the extent necessary to comply with military, state or local child abuse and child neglect reporting requirements.

3.4.4. AD members, dependents, and retirees are eligible for counseling and treatment, following TRICARE guidelines for access. Eligible beneficiaries shall receive SA services as authorized through their selected health care option: TRICARE Prime, TRICARE Extra, TRICARE Standard, or TRICARE Reserve Select.

### ***SECTION 3B—Tier I: Prevention and Education***

**3.5. SA Prevention Strategies.** SA prevention efforts are geared toward enhancing individual and unit resiliency, both of which can be compromised by hazardous alcohol use and substance use disorders. Prevention strategies must be comprehensively structured to educate and inform the overall population as well as specifically target higher risk populations. SA prevention

activities and outreach programs will be coordinated through the RE within the MH Flight (See AFI 44-172 for additional information on the RE).

3.5.1. SA prevention at the installation level is a collaborative effort shared among various agencies to include the RE,(e.g., representative from ADAPT Program), DDR, and Health Promotions.

3.5.1.1. The IDS will be the focal point for these agencies, in collaboration with other IDS member organizations, and will work to develop and implement programs geared towards increasing organizational and individual awareness of SA issues, trends, and threat to mission readiness.

3.5.1.2. Educational outreach will specifically target all health care providers, commanders, first sergeants, and supervisors to ensure they understand the impact of SA on the mission, how to identify the warning signs of SA, and the referral process.

3.5.2. DDR Program activities are limited to those directly related to illegal and illicit drug abuse prevention.

3.5.3. SA prevention and education programs will at a minimum meet the objectives listed in **Table 3.1** of this AFI, DoD Directive (DoDD) 1010.4, *Alcohol and Drug Abuse by DoD personnel*, DoDD 1010.6, *Rehabilitation and Referral Services for Alcohol and Drug Abusers*, and be tailored to meet the specific needs of the organization.

**Table 3.1. SA Education.**

<b>Table 3.1. SA Education.</b>		
	<b>If the Individual is...</b>	<b>then the required training...</b>
1	a military member (enlisted and officer) on his/her first permanent duty assignment	focuses on prevention of SA, standards, desire for peer acceptance, role models, responsible behavior, healthy alternatives, and legal/administrative consequences of SA.
2	a military member in the grade of E1 through E4 on a second or subsequent permanent change of station	will be conducted within 60 days after PCS and shall emphasize standards, healthy lifestyles, responsible behavior and consequences of SA to self and career.
3	a health care professional who provides direct patient care (to include providers, nurses and technicians)	emphasizes prevention, intervention, identification, diagnosis, and treatment of SA. Training will be provided annually as part of in-service training events.
4	an Airman Leadership School or NCO Academy Student	focuses on responsibilities of leaders in SA prevention, identification and referral of substance abusers, the education and counseling processes, SA treatment programs, intervention, and the impact of SA on the mission. Curriculum developed IAW AFH 36-2235, <i>Information for Designers of Instructional Systems</i> .

5	an Air University student attending PME Course; Senior NCO Academy (SNCOA); Squadron Officers School (SOS); Air Command and Staff College (ACSC); Air War College (AWC)	focuses on roles and responsibilities of senior leaders in the SA prevention program; effects of SA on mission, morale, readiness, and health and wellness; the education, counseling, referral, and follow-up process; influence of senior leaders attitudes on SA; and the benefits of the service's prevention and treatment programs. Curriculum developed IAW AFH 36-2235.
6	commander, senior enlisted advisor, first sergeant, and other senior personnel	emphasizes need for active support for SA prevention programs; early intervention of substance abusers; the referral and treatment process; fostering help-seeking behavior; and reducing the stigma associated with SA treatment. Training will be provided annually as part of in-service training events.

### ***SECTION 3C—Tiers II and III: Eligibility, Self Identification, and Referral***

#### **3.6. Eligibility.**

3.6.1. AF members, dependents, and retirees are eligible for counseling and treatment, following TRICARE guidelines for access.

3.6.2. To ensure maximum workplace productivity through an alcohol misuse and drug-free workforce; Government Service (GS) and non-appropriated funds (NAF) employees may be seen for an initial ADAPT evaluation if they screen positive for drugs or have work-related substance related misconduct. On a space available basis, this assessment and referral appointment can be completed at the ADAPT clinic, at no cost to the civilian employee. Although the AF will encourage treatment and rehabilitation, it is the responsibility of every employee to refrain from SA and take personal responsibility for rehabilitation when SA problems occur. See *Section H, Clinical Services for Civilian Employees*, for further details on referral and treatment for civilian employees.

**3.7. Self-Identification.** AF members with SA problems are encouraged to seek assistance from the unit commander, first sergeant, SA counselor, or a military medical professional. Following the assessment, the ADAPT PM will consult with the TT when indicated and determine an appropriate clinical course of action.

#### 3.7.1. Drugs.

3.7.1.1. An AF member may voluntarily disclose evidence of personal drug use or possession to the unit commander, first sergeant, SA evaluator, or a military medical professional.

3.7.1.2. Commanders will grant limited protection for AF members who reveal this information with the intention of entering drug treatment.

3.7.1.3. Commanders may not use voluntary disclosure against a member in an action under the UCMJ or when weighing characterization of service in a separation.

3.7.1.4. Disclosure is not voluntary if the AF member has previously been:

3.7.1.4.1. Apprehended for drug involvement.

3.7.1.4.2. Placed under investigation for drug abuse. The determination of “*placed under investigation*” status is made based on the circumstances of each individual case. A member is under investigation, for example, when an entry is made in the SF blotter, when the SF Investigator’s log shows an initial case entry, or when the AF Office of Special Investigations (AFOSI) opens a case file. A member is also considered under investigation when he or she has been questioned about drug use by investigative authorities or the member’s commander, or when an allegation of drug use has been made against the member.

3.7.1.4.3. Ordered to give a urine sample as part of the drug-testing program in which the results are still pending or have been returned as positive.

3.7.1.4.4. Advised of a recommendation for administrative separation for drug abuse.

3.7.1.4.5. Entered treatment for drug abuse.

3.7.1.5. The limited protection under this section for self-identification does not apply to:

3.7.1.5.1. The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse (or lack thereof) has been first introduced by the member.

3.7.1.5.2. Disciplinary or other action based on independently derived evidence (other than the results of commander-directed drug testing), including evidence of continued drug abuse after the member initially entered the treatment program.

3.7.2. Alcohol. Commanders must provide sufficient incentive to encourage members to seek help for problems with alcohol without fear of negative consequences.

3.7.2.1. Self-identification is reserved for members who are not currently under investigation or pending action as a result of an alcohol-related incident.

3.7.2.2. Self-identified members will enter the ADAPT assessment process and will be held to the same standards as others entering SA education, counseling and treatment programs.

### **3.8. Commander’s Identification and Associated Roles and Responsibilities.**

3.8.1. A unit commander shall refer all service members for assessment when substance use is suspected to be a contributing factor in any incident, e.g., driving under the influence (DUI)/ driving while intoxicated (DWI), public intoxication, drunk and disorderly, spouse/child abuse and maltreatment, under-aged drinking, positive drug test, or when notified by medical personnel under paragraphs 3.9.1. - 3.9.3. of this instruction. Commanders who fail to comply with this requirement place members at increased risk for developing severe SA problems and jeopardize the mission.

3.8.2. Commander or first sergeant closely examines all AF Form 3545, *Incident Report*, for evidence of substance use or abuse.

3.8.3. After coordination with the Staff Judge Advocate (SJA), unit commanders will direct drug testing within 24 hours of suspected alcohol-related misconduct (ARM) incidents,

episodes of aberrant or bizarre behavior, or where there is reasonable suspicion of drug use and the member refuses to provide consent for testing. Commanders are also encouraged to ensure that a Blood Alcohol Test (BAT) is taken as soon after the incident as possible to determine the level and intensity of alcohol involvement.

3.8.4. The unit commander contacts the installation's ADAPT staff within seven (7) calendar days of the incident to initiate the assessment process. In incidents of DUI/DWI, the commander will refer the individual to the ADAPT Program within 24 hours whenever possible, but no later than (NLT) the next duty day.

3.8.4.1. TDY (Non-Deployed Locations). If a member is involved in an ARM incident at a TDY location, the commander at that location (or home location if appropriate) determines if the member must return to the permanent duty station, or if the individual is able to complete the TDY. If MH staff are available at the TDY location, then the MH staff at that location can conduct a preliminary evaluation to advise command on appropriate action. A referral to the ADAPT Program for a full SA assessment is required upon return to permanent duty location.

3.8.4.2. Deployed Location. If the member is involved in an ARM incident at a deployed location, the commander at that location determines if the member must return to the permanent duty station, or if the individual is able to complete the deployment. If MH staff are available at the deployed location, then the MH staff at that location can conduct a preliminary evaluation to advise command on appropriate action. A referral to the ADAPT Program for a full SA assessment is required upon return to permanent duty location.

3.8.4.2.1. If the member completes the deployment tasking (versus the member returning early), the member will be required to report to the ADAPT Program for the full SA assessment within seven (7) calendar days following completion of rest and recuperation (R&R) time and upon return to the member's permanent duty location.

3.8.4.3. Upon return to permanent duty station from a TDY or deployed location, the member's commander will contact the installation's ADAPT staff within seven (7) calendar days of the member's return to initiate the assessment process.

3.8.4.3.1. All AFRC members returned home early from a TDY or deployed location due to an ARM incident will receive a SA assessment by the nearest ADAPT Program upon return to their home of record.

3.8.4.4. Given limited resources in theater, every effort should be made to evaluate members suspected of drug/alcohol misuse prior to deployment.

3.8.5. Commander refers individuals under investigation for drug abuse for assessment after the commander prefers charges (that is, signs DD Form 458, *Charge Sheet*), or after consulting with the base legal office. Commanders who elect not to prefer charges but suspect the individual of drug abuse must refer members for a SA assessment as soon as possible.

3.8.6. The commander provides information to the ADAPT staff to assist in the assessment (e.g., BAT results), including comments on observed performance and behavior to the SA staff before the assessment appointment.

3.8.7. The commander directs the member's immediate supervisor to contact the ADAPT staff before the assessment to provide pertinent information on the patient's duty performance, on and off duty behavior, or other incidents.

3.8.8. The commander tells the member the following:

3.8.8.1. The reason for the assessment.

3.8.8.2. That the assessment is not punitive in nature.

3.8.8.3. That the member must report in uniform for the SA assessment appointment at the appointed date and time.

3.8.9. The commander ensures the assessment and treatment of personnel is not delayed by ordinary leave or TDYs.

3.8.10. The commander is responsible for all personnel/administrative actions pertaining to clients involved in the ADAPT Program, to include assignment availability, promotion eligibility, reenlistment eligibility, PRP, security clearance, etc. Application of administrative restrictions should be based on the establishment of a UIF or control roster resulting from the member's unacceptable behavior and not solely based on their involvement in the ADAPT Program.

3.8.11. The commander, and/or first sergeant will actively participate on the TT by providing input to treatment decisions. Command involvement is critical to a comprehensive SA treatment program, particularly in the prevention and early intervention stages, as well as during aftercare and follow-up activities. The commander shall also provide command authority to implement the treatment plan when the member does not voluntarily comply with the TT's decisions.

### **3.9. Medical Care Referrals.**

3.9.1. Medical personnel must notify the unit commander and the ADAPT PM when an AF member:

3.9.1.1. Is observed, identified, or suspected to be under the influence of drugs or alcohol.

3.9.1.2. Receives treatment for an injury or illness that may be the result of substance use.

3.9.1.3. Is suspected of abusing substances.

3.9.1.4. Is admitted as a patient for alcohol or drug detoxification.

3.9.2. All beneficiaries are eligible for treatment, following TRICARE guidelines for access. Eligible beneficiaries shall receive SA services as offered through their selected health care option: TRICARE Prime, TRICARE Extra, TRICARE Standard, or TRICARE Reserve [Assistant Secretary of Defense (ASD) Health Affairs (HA) *Policy Memorandum on TRICARE Substance Abuse Treatment*, 13 Feb 97].

3.9.3. Civilians will be seen for a SA assessment in accordance with AFI 44-107, *AF Civilian Drug Demand Reduction Program* (See [Chapter 2](#)).

### **SECTION 3D—Tier II: Targeted/Secondary Prevention and Education**

**3.10. Overview.** Secondary prevention strategies focus on individuals who have been identified or are suspected of high risk use of substances but do not indicate a pattern of diagnosis substance abuse or dependence. The goal of clinical prevention and education activities should be reducing further alcohol misuse or drug use by increasing awareness and understanding of consequences, as well as, developing a plan for positive change. All individuals referred to the ADAPT Program who have had an ARM incident will be required to receive targeted prevention education. AF members who self-identify for a SA problem will also receive ABC. Civilians will be seen for a SA assessment, ABC, and other services in accordance with AFI 44-107, *Air Force Civilian Drug Demand Reduction Program* (See [Chapter 2](#); Also noted in 3.9.3., *Medical Care Referrals* above).

3.10.1. Conduct Substance Use Assessment Tool (SUAT) Intake/Assessment.

**3.11. Alcohol Brief Counseling (ABC).** Refer to the *ADAPT ABC Counselor's Manual* for additional information. An electronic copy of the manual can be obtained from the ADAPT Branch staff at AFMOA/SGHW. The ABC process requires eliciting client response to identified risks and concerns, as well as identifying possible areas for behavior change.

3.11.1. ABC Component 1: Brief Consultation and Feedback Session. This will follow the intake assessment and should be scheduled for a minimum of 30 minutes. It can be completed on the same day as the assessment and coded as an additional intervention or at an additional appointment. The process includes review and discussion of the SUAT Patient Feedback, and other pertinent assessment results. The next step is the development of the personalized change plan, which is for patients who do not meet diagnostic criteria for Alcohol Abuse or Alcohol Dependence. Clinics can decide if this should be initiated on the same day as the assessment or use a separate visit. The completion of the ABC and change plan should occur no later than 14 calendar days after the initial assessment.

3.11.1.1. A treatment plan is developed for those patients with a substance use disorder who will be entering the Tier III level of treatment reviewed in Sections 3E and 3F.

3.11.1.2. Alcohol Education Model (AEM). AEM provides an overview of the AF and DoD policy, as well as civilian laws regarding to proper use of alcohol, and will be completed within two weeks (10 duty days) of assessment. AEM also reinforces the AF and DoD policy that any use of illicit drugs is incompatible with AF and DoD standards and will automatically place an AF member's career in jeopardy. Other modules, such as Values Clarification, Anxiety Management, Anger Management, Assertive Communication, Changing Self-Talk, Sleep Enhancement, Key Ingredients for Relaxation, can be added based on the individual's needs. All individuals seen in the ADAPT Program will receive the AEM, including those who have gone directly into inpatient treatment following an ARM incident or detoxification.

3.11.1.2.1. For clients who misuse substances other than alcohol, the required AEM can be modified or replaced as appropriate.

3.11.2. ABC Component 2: Follow-up(s). There should be at least one Motivational Interviewing (MI)-based follow-up appointment of a minimum of 30 minutes duration to reassess risk, assess progress with the change plan and, as appropriate, conduct a follow-up review of the educational components. If the individual is assessed to be at moderate or greater risk, there should be at least two 30-minute follow-ups with progress updates on the

change plan. The focus of these appointments is not treatment; they are designed to be targeted (secondary) prevention, education and reassessment.

3.11.3. ABC Component 3: Final Follow-up/Case Closure. This should occur no later than 14 calendar days after the initial assessment, but the specific time frame will be determined based on individual risk and need for continued monitoring. Case closure can be performed in conjunction with the follow-up visit or at the last follow-up visit if the individual has more than one visit as determined using the guidance above.

### ***SECTION 3E—Clinical Care in Tier III: Treatment and Aftercare***

#### **3.12. Overview.**

3.12.1. Clients who receive a SA or dependence diagnosis should receive feedback discussion following the SUAT assessment, as detailed in Tier II above, to include educational component (assessment, initial feedback, and education). The key difference for clients receiving Tier III services, versus Tier II services, is the Treatment Team process: implementation of a treatment plan (instead of a change plan), treatment execution, and aftercare.

3.12.2. The treatment plan must be developed IAW ASAM criteria. ASAM criteria reflect the philosophy of placing clients in the least intensive/restrictive treatment environment, appropriate to their therapeutic needs. Variable lengths of stay/duration of treatment shall be provided within a variety of treatment settings.

3.12.3. The treatment program will reflect a multi-disciplinary approach to assist the patient to achieve full recovery, free of the negative effects of the SA.

3.12.4. It is important to note that command involvement is critical to a comprehensive SA treatment program, particularly in the prevention and early intervention stages, as well as during aftercare.

3.12.5. Individuals being processed for separation will be provided appropriate medical care prior to separation. Separation action will not be postponed because of a members participation in the ADAPT Program.

#### **3.13. Treatment Team (TT).**

3.13.1. TT Composition, Roles, and Function. The primary objective of the TT is to guide the clinical course of treatment of the client after examining all the facts.

3.13.1.1. The TT Meeting (TTM) will be held within 14 calendar days of the initial assessment appointment.

3.13.1.2. Membership of TT includes:

3.13.1.2.1. Commander and/or First Sergeant.

3.13.1.2.2. Client's immediate supervisor.

3.13.1.2.3. ADAPT PM, or a privileged MHP with administrative oversight responsibility for the ADAPT Program. The ADAPT PM, or privileged MHP, chairs the TTM and determines the clinical course of treatment for clients in the ADAPT Program.

- 3.13.1.2.4. ADCs, MH technicians, or other privileged MH providers involved in the case.
- 3.13.1.2.5. Medical providers as needed (e.g., primary care managers). If the client is on flight status, a flight surgeon will be included in the TTM. Refer to AFI 48-123, Volume 3, *Medical Examinations and Standards*, for further guidance.
- 3.13.1.2.6. Other individuals as deemed necessary.
- 3.13.1.2.7. The client, unless deemed clinically inappropriate. In this case, the client will be briefed on the treatment decisions of the TT.
- 3.13.1.3. Commander (or First Sergeant) and supervisor involvement in the TT at key points in the client's treatment and recovery is important. The commander (or First Sergeant) and supervisor must be involved at program entry, termination, and any time there are significant treatment difficulties with the client. ADAPT staff must brief commanders (or first sergeant) on client progress at least quarterly [e.g., recommend every three (3) months] – telephonically, individually, or within the TT.
- 3.13.1.3.1. Commanders are responsible for the administrative determination about the service member and can concur or non-concur with the medical determination, and then take the action they deem appropriate.
- 3.13.1.4. TTMs must be mindful of protecting client privacy to the greatest extent possible while still allowing for meaningful review. Only information pertinent to treatment decisions should be shared with the treatment team. The client's biopsychosocial history and sensitive information should be protected unless absolutely critical to treatment decisions. Further, the client should be informed about the purpose of the TT and the nature of the information that will be shared. ADAPT will brief the Commander/First Sergeant/Supervisor about privacy of client's information and document a verbal non-disclosure agreement.
- 3.13.1.5. Treatment Planning. The primary purpose of the treatment plan is to establish the frame work for the patient's treatment and recovery.
- 3.13.1.5.1. The treatment plan documents the level and intensity of care, incorporates issues, problem areas, life skill deficits, and goals identified during the biopsychosocial assessment, and identifies appropriate treatment resources to be utilized during the client's course of treatment.
- 3.13.1.5.2. The treatment plan will be comprehensive, individual-specific, and stated in behavioral terms.
- 3.13.1.5.3. Treatment plans will be reviewed on a regular basis, every three (3) months, to ensure that the plan reflects status of the patient's progress toward effective SA recovery and stabilization of other identified clinical issues.
- 3.13.1.6. The ADAPT PM, in consultation with the TT, makes a treatment decision within 14 calendar days of the client's assessment in the ADAPT Program. Reasons for delays must be documented in the outpatient MH record on SF 600 and conveyed to the commander.

3.13.1.7. Documenting the TT. TT activity will be documented completely in the MH record, and a brief overview of the TT activity will be placed in the outpatient medical record on SF 600.

### **3.14. Detoxification Prior to Treatment.**

3.14.1. Clients being referred for inpatient treatment will be assessed to determine the level of detoxification services required. When medically indicated, patient detoxification will be managed on an outpatient basis prior to inpatient treatment.

3.14.2. Clients assessed as requiring medically managed detoxification (inpatient) will be entered into an appropriate medical facility.

3.14.3. All clients utilizing aeromedical evacuation services must have 72 hours of monitored abstinence (inpatient or outpatient) prior to departure.

### **3.15. Treatment.**

3.15.1. Individuals diagnosed with alcohol abuse or alcohol dependence will refrain from the use of alcohol during treatment. During aftercare, abstinence may be an important treatment goal. However, responsible drinking goals can also be considered for aftercare. A return to drinking during treatment or aftercare is not uncommon and should not, in itself, be considered unsatisfactory progress.

3.15.2. Involvement in self-help recovery groups (e.g., 12-step, Rational Recovery) is encouraged as an adjunct to treatment. The frequency of attendance is determined by the TT with the patient. The TT will encourage the patient to attend smoke-free recovery groups.

3.15.3. Clients will adhere to the treatment plan developed by the TT.

3.15.4. ADAPT Program staff will work with inpatient treatment facility staff to ensure continuity of care before, during and after inpatient treatment. ADAPT staff members will communicate with inpatient providers upon admission and discharge and at appropriate intervals (e.g., recommend weekly contact) throughout the duration of the inpatient treatment program.

3.15.5. Local clients referred to a partial (day treatment) or inpatient SA service may begin treatment immediately, if the history, physical examination, and other documentation indicate that the patient can safely begin treatment. If, however, the patient experiences symptoms of apparent withdrawal, he or she will be re-assessed and a detoxification protocol initiated.

3.15.6. Clients returning from an inpatient treatment facility will have a TT meeting convened within 14 calendar days of return to assess the patient's progress during inpatient treatment and design a treatment plan for aftercare.

3.15.7. Use of pharmacological treatments, such as Disulfiram (Antabuse), Naltraxone, etc., will be strictly monitored by the physician or psychiatrist who has prescribed the medication, and/or the physician or psychiatrist assigned to monitor patients within the ADAPT Program. The ADAPT staff will communicate with all providers to ensure continuity of treatment.

3.15.8. Outcome Measurements. The local ADAPT Program will develop procedures to evaluate the effectiveness of its program.

3.15.8.1. Procedures should include determining accuracy of patient assessments, appropriateness of treatment plans, proportion of clients successfully completing the treatment program, unforeseen complications in treatment process, and access time to assessment and treatment.

3.15.8.2. Procedures should also include assessment of drinking behavior and duty performance at the 3, 6, and 12 months from the ADAPT outpatient treatment program and post-discharge from intensive outpatient, partial hospitalization, variable length of stay or inpatient treatment programs. Also include monitoring of reoccurrence of ARMs following ABC. ADAPT Program staff should utilize data gained to make improvements to ADAPT treatment program as well as to SA prevention efforts.

3.15.8.2.1. Follow-up assessments at 3, 6, and 12 months for those former ADAPT patients who have been administratively or medically discharged from service may be difficult or impossible to contact for outcome measures. Attempts to contact any former ADAPT patients should be documented appropriately in their MH record.

3.15.8.3. Prevention services should assess the proportion of the target population provided SA preventive education, range of preventive education offered, attendee satisfaction with the program, and appropriate performance/outcome measures.

**3.16. Continuity of Care Following Intensive Outpatient, Partial or Inpatient Treatment Completion.** Clients will be seen for a face-to-face visit the same day whenever possible, but NLT the next duty day after discharge from inpatient, partial hospitalization or intensive outpatient treatment programs. This includes discharges from DoD or civilian facilities. At minimum, a relapse prevention plan will be created (or reviewed if created prior to discharge) and agreed upon. Suicide risk will also be assessed at this visit. A follow-up visit will be scheduled. Clients discharged from inpatient or partial hospitalization will be categorized as High Interest and monitored over a sufficient period of time until clinical stability is well established. If a face-to-face visit cannot be accomplished on the same day of discharge, the ADAPT Program staff must document the reason(s) why the evaluation did not occur (e.g., discharged on Saturday or holiday weekend, transferred to general medical unit afterwards, etc.).

3.16.1. The TT will meet within 14 calendar days of a patient's completion of an intensive outpatient, partial day treatment, or inpatient treatment program to review progress and recommend a course of treatment for aftercare. Decisions regarding aftercare services will be based on a current assessment of status and will include establishment of an aftercare treatment plan identifying specific goals, interventions, and means to assess interventions.

3.16.2. Clients' progress will be monitored by the ADAPT staff at least monthly while the patient is in aftercare.

3.16.3. Determinations about a patient's availability for PCS or TDYs will be coordinated through the TT during the patient's course of treatment. Generally, clients diagnosed with alcohol abuse or alcohol dependence are restricted from worldwide duty for their first six months of treatment.

3.16.4. Clients on mobility status who are in aftercare should be carefully assessed by the TT. When appropriate, the TT should recommend in writing that the individual be temporarily removed from the mobility position during the period of aftercare.

3.16.4.1. Clients making minimal or unsatisfactory progress in recovery should not be allowed to proceed on TDYs or a PCS, except for mandatory PCS moves. The TT will recommend to the commander that the individual not be released. At times, exceptional circumstances may warrant other approaches.

3.16.4.2. When clients PCS, the ADAPT staff will forward one copy of the patient's outpatient MH record to the gaining base's outpatient MH clinic to ensure continuity of care is maintained. See paragraphs 2.2.5. and 3.17. of this instruction for additional information.

3.16.5. Following intensive outpatient, partial or inpatient treatment, the treatment facility staff will provide a treatment summary, to include aftercare recommendations, to the ADAPT staff. The ADAPT staff will ensure that the treatment summary is obtained and included in the ADAPT section of the client's MH record, and that the command is advised of all relevant treatment outcomes.

3.16.6. Decisions regarding access to classified material, security clearances, PRP, flying status, or other special duty status will be determined by governing instructions for each program.

**3.17. Transferring ADAPT Treatment Information and Coordination of Care at the Time of Permanent Change of Station (PCS).** The ADAPT Program will follow the guidelines for the transfer of MH records and coordination of care established IAW AFI 44-172 (see paragraph 5.4.). When clients PCS, the ADAPT staff will forward one copy of the client's outpatient MH record to the gaining base's outpatient MH clinic within 30 calendar days to ensure continuity of care is maintained.

**3.18. The Use Of The Preventive Individual Medical Readiness (PIMR) System To Monitor Clients in Treatment.**

3.18.1. When diagnosed with SA or dependence and entered into the ADAPT Program, the ADAPT PM will enter the demographic data, annotate that the member is not qualified for World Wide Duty, check the Mobility Restriction box, and enter a release date on the AF Form 469 in PIMR. Only specific limitations will be entered. Diagnoses will not be recorded on the comment or limitation section of this form. After electronic signature, the form will be automatically forwarded to Force Health Management (FHM) which will assess the form, determine if the condition will require a Code 31, 37, or 81 (ADAPT clients will normally be code 31), annotate it appropriately, and forward it to the Profile Officer. The Profile Officer will validate by electronic signature, and the form will be automatically returned to FHM. It is then forwarded electronically to the member's unit commander for concurrence/non-concurrence. The commander or designated representative will issue the profile to the member.

3.18.2. The ADAPT PM or ADC will monitor patient status and progress in treatment to determine the appropriateness for continuation or termination of the Duty Limiting Condition (DLC) at each visit and document. At least monthly, the ADAPT PM will review status with the DAWG. Guidance concerning the use of DLC can be found in AFI 10-203, *Duty Limiting Conditions*, and AFI 48-123, *Medical Examinations and Standards*.

3.18.3. The ADAPT PM, or another privileged MHP, will review all clients identified as having a substance use related DLC and ensures that the SGP, as chair of the DAWG, is provided with that information on a monthly basis.

***SECTION 3F—Clinical Care in Tiers II and III: Documentation, Assessment, & Program Completion***

**3.19. Scope.** Substance-related assessments provide a multi-method and evidence-based biopsychosocial evaluation of the individual. All evaluations will include a thorough review of substance-related and other emotional or psychosocial problems. ADAPT screenings and full evaluations will include assessment for risk factors that could require immediate action, to include detoxification and risk for self-harm/suicide. Based on this evaluation, input from collateral sources, and clinical judgment, the counselor must make a recommendation about the appropriate level of services that will best meet the needs of the individual and prevent or eliminate duty impairment.

**3.20. Documentation and Disclosure.**

3.20.1. ADAPT staff will document reason for referral and conduct the substance-related assessment within seven (7) calendar days of all referrals. This includes, but is not limited to, self, medical, command, and other referrals.

3.20.2. If the client is on TDY or leave status, the TDY location ADAPT staff will contact the member's home base and inform command of the substance-related event and the status of the assessment process.

3.20.3. If the referral is from the command or a substance-related misconduct incident, the ADAPT staff must explain the following to the client prior to assessment:

3.20.3.1. The requirement that the supervisor provide information on the client's duty performance and on-and-off-duty behavior.

3.20.3.2. The expected time requirements for the member to complete the assessment. Time requirements for Tier II or III services should be explained after the assessment, when recommended level of care has been determined.

3.20.3.3. Limits of confidentiality.

3.20.3.4. The counselor's responsibilities.

3.20.4. Before eliciting information from the client, brief the client about:

3.20.4.1. Stipulations of self-ID, if applicable.

3.20.4.2. Limits of confidentiality.

3.20.4.3. Privacy Act and Health Information Portability and Accountability Act (HIPAA) provisions.

3.20.4.4. Overview of ADAPT Program, to include client rights and responsibilities.

3.20.4.5. The responsibilities of the respective members of the ADAPT Program staff engaged in assessment, education, brief preventive counseling, or treatment.

3.20.4.6. The purpose, access, and disposition of MH records.

3.20.4.7. The potential consequences of refusing assessment, preventive counseling, and/or treatment.

3.20.5. When a member of the ADAPT staff becomes aware that a member is being considered or processed for separation, they must brief the member about the member's entitlement to SA treatment with the Veterans Administration (VA). Services will continue to be provided, according to member needs, until separation occurs.

### **3.21. Assessment and Diagnostic Responsibilities.**

3.21.1. Treatment or prevention counseling for all clients should be based on thorough assessment (e.g., SUAT, clinical interview, and collection of collateral data as appropriate), determination of risk, and should be tailored for the individual.

3.21.2. Credentialed MH providers are responsible for diagnostic decisions, treatment/change plan, and disposition of the case.

3.21.2.1. Other prevention and treatment activities can be performed by the appropriate counselor (credentialed MHP, ADC, or supervised MH technician) as determined by client needs and counselor education and skill. MH technicians should work in a provider-extender role to include collecting assessment information, preventive counseling, education, and implementing portions of treatment or change plan.

3.21.3. For members who do not qualify for a SA or Dependence diagnosis, intensity of preventative counseling services should be based on evaluation of risk as detailed in [Section 3D](#) above.

### **3.22. Using Assessment Results.**

3.22.1. Information gathered during the assessment will form the basis for patient diagnosis, treatment planning, and delivery of SA services.

3.22.2. Except in cases of self-identification, information the patient provides in response to assessment questions may be used in a court-martial and to characterize service at the time of discharge. Such evidence may be introduced for other administrative purposes or for impeachment or rebuttal purposes in any proceeding in which the patient introduced evidence of SA (or lack thereof).

3.22.3. Before adjudication, the privileged MHP will provide assessment results on individuals who are charged with intoxicated driving to the patient's commander.

### **3.23. Completing the Program.**

3.23.1. Successful Completion. Clients will not be considered to have successfully completed treatment until they meet the DSM criteria for early full remission. The TT determines, based on DSM criteria, patient progress towards agreed upon goals and/or issues as stated in the treatment plan, when the patient is effectively in recovery and no longer requires program resources.

3.23.2. Failing the Program. The TT determines a patient to have failed the program based on a demonstrated pattern of unacceptable behavior, inability or unwillingness to comply with their treatment plan, or involvement in alcohol and/or drug related incidents after receiving initial treatment. The determination that a patient has failed treatment is based on the patient's repeated failure to meet and maintain AF standards (behavior), rather than solely

on the use of alcohol. Individuals who have been determined as failing the ADAPT Program shall be considered for administrative separation by their commander IAW AFI 36-3207, *Separating Commissioned Officers*, or AFI 36-3208, *Administrative Separation of Airmen*.

### **SECTION 3G—Tier IV: Training**

**3.24. Training Mission.** ADAPT's mission includes oversight and management of substance misuse-related education for MH staff who are currently working in ADAPT or MH technicians who are expected to rotate to ADAPT.

#### **3.25. Alcohol Drug Addiction Prevention and Treatment Program Managers (ADAPT-PMs).**

3.25.1. PMs are responsible for ensuring they are competent for their duties. This means they must obtain the appropriate education and supervision needed to develop and maintain competency in substance misuse assessment, prevention, and treatment. Competency will be defined by the provider's experience, consultation with supervisors, and their own ethical and licensure requirements.

3.25.2. Lack of clinical experience or course work in substance misuse does not preclude a provider from working in the ADAPT Program. In this situation, the provider and their supervisor will be responsible for establishing a training plan to develop competency and ensure appropriate oversight until competency is attained.

3.25.3. If additional education is required, the written training plan may include, but is not limited to, review of the research, peer consultation, supervision, computer-based learning, and continuing education opportunities.

3.25.4. ADAPT PM may develop written training and education plans to assist ADAPT technicians in meeting educational requirements as designated in the 4C Career Field Education and Training Plan (CFETP) and the AF ADC Certification Handbook. The ADAPT PM may develop written training and education plans to maintain education currency of existing ADAPT technicians and to promote substance-related skill development in new provider and technician staff.

3.25.4.1. Education plans and goals will be tailored to individual needs.

3.25.4.2. Content will focus on evidence-based assessment, prevention and treatment approaches to reduce alcohol and drug misuse.

#### **3.26. Alcohol and Drug Counselors (ADCs).**

3.26.1. ADCs are responsible for ensuring they maintain their competencies and continuing education requirements to maintain their certification.

3.26.2. Responsibilities include oversight and supervision of non-ADC MH technicians to help them develop the skills and competencies required for certification.

#### **3.27. Non-ADC MH Technicians.**

3.27.1. Skills and education required for ADC certification are crucial for all MH technicians. All non-ADC technicians and their supervisors must have a written plan to develop these competencies IAW expectations for their current skill level. Topics could include: ASAM, 12 Core Functions, Motivational Interviewing, and Ethics. Per CFETP

4C0X1, completion of 100 percent core task training is prerequisite to award of the 7-level. Completion of Qualification Training Package (QTP) 1, the 12 Core Functions of SA Counseling, is mandatory. Craftsman will continue to obtain the necessary education and experience required to complete the case presentation, oral and written exam to meet the AF SA Counselor Certification Board (AFSACCB).

### *Section 3H—Clinical Services for Civilian Employees*

#### **3.28. Clinical Services.**

3.28.1. To ensure maximum workplace productivity through an alcohol misuse and drug-free workforce, General Schedule (GS), and non-appropriated funds (NAF) employees may be seen for an initial ADAPT evaluation if they screen positive for drugs, or have on base or on duty substance-related misconduct or incident.

3.28.2. Early intervention is essential to the effective operation of this program and the successful rehabilitation of civilian employees. Therefore, supervisors must be alert to behaviors that could indicate a SA problem [prior to the occurrence of ARM or a Medical Review Officer (MRO)-verified drug test positive] and advise civilian employees they may voluntarily seek assessment and treatment referral services.

#### 3.28.3. Referral Process.

3.28.3.1. Supervisors will advise civilian employees on the availability of services when there is any reason to believe that there may be a SA problem. This advice does not require an employee to admit to any problem, but merely offers appropriate assessment and referral to counseling and rehabilitation services.

3.28.3.1.1. The DDR Program Manager and/or ADAPT Program staff provides appropriate guidance to supervisors on referral for the evaluation. Supervisors must direct civilian employees to report for initial assessment and referral for treatment any time drug use is verified by the MRO or there is ARM and follow-up with civilian employees to ensure completion. Supervisors will notify the commander when an employee refuses to comply with a mandatory referral for counseling.

3.28.3.1.2. Mandatory notification requirements also exist for civilians in positions designated by the USAF as a testing designated position (TDP) under the USAF Civilian Drug Testing Program (see AFI 44-107). For the purpose of this program, TDP are those positions sufficiently critical to the USAF mission or to the protection of public safety to warrant screening of the incumbent employee to detect the presence of drugs as a job-related requirement. Illicit drug use by employees in sensitive positions presents a clear threat to the mission of the USAF, national security, or public safety.

3.28.3.2. When requested by an employee, a rehabilitation team will convene to provide advice and assistance to supervisors and/or employees to facilitate counseling and/or rehabilitation efforts. During the course of counseling/rehabilitation, underlying issues may be identified, e.g., financial or family conflicts as well as problems in the work setting. Although the employee is ultimately responsible for his/her rehabilitation, the team may review the facts and make recommendations to the supervisor and/or employee. Such recommendations may include additional referrals, e.g., financial or

family counseling, job training, work scheduling, reassignment and/or retirement options. When the employee has consented, in writing, to the release of confidential treatment information, the supervisor may request the team advice on the appropriateness of a treatment plan as well as whether the employee is making reasonable progress.

3.28.3.3. Regardless of the referral and/or treatment options chosen, the employee remains solely responsible for his or her behavior. Assertions that the counselor failed to consider one or more of the above factors in making a referral will not constitute either an excuse for continuing to abuse alcohol or a defense against disciplinary action if the employee is identified for subsequent SA.

#### 3.28.4. Counselor Responsibilities.

3.28.4.1. The ADAPT or contract counselor counsels the employee on the scope of services available for counseling, assessment and referral.

3.28.4.1.1. For the mandatory initial assessment appointment, the employee will be advised by way of documented initial informed consent that their supervisor will be notified that the employee attended the interview and the reporting and departing time of the employee.

3.28.4.1.2. The employee is advised of what information will be disclosed to the supervisor at the beginning of the initial interview. At that time, the counselor also tells the employee that strict rules govern the disclosure of SA counseling information and how those rules apply to the position the employee holds.

3.28.4.1.2.1. The employee will be provided a copy of a letter, Consent for Release of Patient Information During or After Treatment or Rehabilitation (see [Attachment 3](#) for a template letter). The counselor will explain that the employee is not required to sign the release, but doing so will allow for the treatment provider to communicate progress back to the supervisor and the Civilian Rehabilitation Team (see AFI 44-107, paragraph 1.4.7.9.). The information may then be considered in deciding on the appropriateness of various actions including discipline and continued assignments to testing designated or other sensitive positions. Release of this information also furthers the rehabilitation process by ensuring that the supervisor is involved in the process and serves to justify the use of sick leave for treatment and counseling.

3.28.4.2. ADAPT personnel will advise civilian employees that if they choose to use ADAPT services, a MH record and a medical record will be established to ensure professional accountability and to facilitate on-going assessment of the quality, appropriateness and progress of rehabilitation.

3.28.4.3. Regardless of options selected, civilian employees will be encouraged to authorize the release of information to appropriate management officials to assist in evaluation of their treatment. Civilian employees will be advised that release of such information is not mandatory.

### **3.29. Adopted Forms.** SF600, *Medical Record – Chronological Record of Medical Care*

AF Form 3545, *Incident Report*

AF Form 469, *Duty Limiting Conditions Report*

AF Form 847, *Recommendation for Change of Publication*  
DD Form 458, *Charge Sheet*

CHARLES B. GREEN  
Lieutenant General, USAF, MC, CFS  
Surgeon General

**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

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### ***Abbreviations and Acronyms***

**AA**—Alcoholic Anonymous

**ABC**—Alcohol Brief Counseling

**ADAPT**—Alcohol and Drug Abuse Prevention & Treatment

**ADAPT PM**—Alcohol and Drug Abuse Prevention and Treatment Program Manager

**ADC**—Alcohol and Drug Counselor

**AEM**—Alcohol Education Model

**AFPD**—Air Force Policy Directive

**A&FRC**—Airmen and Family Readiness Center  
**AFRC**—Air Force Reserve Command  
**AFRIMS**—Air Force Records Information Management System  
**AFOSI**—Air Force Office of Special Investigations  
**AGR**—Active Guard/Reserve  
**ANG**—Air National Guard  
**ARC**—Air Reserve Component  
**ARM**—Alcohol-Related Misconduct  
**ART**—Air Reserve Technician  
**ASAM**—American Society of Addiction Medicine  
**BAT**—Blood Alcohol Test  
**CADAC**—Certified Alcohol Drug Abuse Counselor  
**CAIB**—Community Action Information Board  
**CFETP**—Career Field Education and Training Plan  
**DAWG**—Deployment Availability Working Group  
**DDR**—Drug Demand Reduction  
**DDRPM**—Drug Demand Reduction Program Manager  
**DoDD**—Department of Defense Directive  
**DoDI**—Department of Defense Instruction  
**DRU**—Direct Reporting Unit  
**DSM**—Diagnostic Statistical Manual  
**DUI**—Driving Under the Influence  
**DWI**—Driving While Intoxicated  
**EAD**—Extended Active Duty  
**FOA**—Field Operating Agency  
**FOIA**—Freedom of Information Act  
**GSU**—Geographically Separated Unit  
**HIPAA**—Health Insurance Portability and Accountability Act  
**IAW**—In accordance with  
**IDS**—Integrated Delivery System  
**IMA**—Individual Mobilization Augmentee  
**JA**—Judge Advocate

**HQ USAF or HAF**—Headquarters Air Force, includes the Secretariat and the Air Staff

**MAJCOM**—Major Command

**MH**—Mental Health

**MHP**—Mental Health Provider

**MRO**—Medical Review Officer

**NAF**—Non-Appropriated Funds

**NCO**—Noncommissioned Officer

**NGB**—National Guard Bureau

**NPRC**—National Personnel Records Center

**PCS**—Permanent Change of Station

**PRP**—Personnel Reliability Program

**QTP**—Qualification Training Package

**RC/CC**—Responsible Center/Cost Center

**RE**—Resilience Element

**RMU**—Reserves Medical Unit

**R&R**—Rest and Recuperation

**SA**—Substance Abuse

**SFS**—Security Forces Squadron

**SG**—Surgeon General

**SJA**—Staff Judge Advocate

**SOAP**—Subjective, Objective, Assessment, Plan (case note format)

**SUAT**—Substance Use Assessment Tool

**TT**—Treatment Team

**TTM**—Treatment Team Meeting

**TDY**—Temporary Duty Assignment

**VA**—Veterans Administration

### *Terms*

**Abstinence**—The practice of refraining from the consumption or use of alcohol and other intoxicating substances.

**Active Guard/Reserve (AGR)**—National Guard or Reserve Members who are on voluntary AD providing full-time support to National Guard, Reserve, and Active Component organizations for the purpose of organizing, administering, recruiting, instructing, or training the Reserve Components. Although they continue to be members of the Reserve Components, they are in a different federal status than traditional part-time Army Reserve Component or Air Reserve

Component members (including full-time Army Reserve Technician and Air Reserve Technician Program members) called to AD for training, special work, operational support to the Active Component, or mobilized for contingency operations. AGR personnel also receive the same benefits and entitlements as Army and AF Active Component military personnel. See AFH 41-114, *Military Health Services System (MHSS) Matrix*, paragraph 5., for additional information.

**Air Reserve Components (ARC)**—All units, organizations, and members of the Air National Guard (ANG) of the US and the USAF Reserve (USAFR).

**Air Reserve Technician (ART)**—ARTs are the core managers and trainers conducting day-to-day ARC unit operations. They serve as full-time civil service employees of the USAF and serve as Traditional Reservists in the same unit.

**Alcohol Abuse**—(From DSM-IV-TR)—The essential feature of alcohol abuse is a maladaptive pattern of alcohol abuse manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an Abuse criterion to be met, the alcohol-related problem must have occurred repeatedly during the same 12-month period or been persistent. A diagnosis of alcohol abuse requires that the client not meet the criteria for alcohol dependence and meet one (1) more of the following criteria occurring at any time in the same 12-month period: 1) Failure to fulfill major role obligations at work, school, or home because of recurrent drinking; 2) Recurrent drinking in hazardous situations; 3) Recurrent legal problems related to alcohol; 4) Continued use despite recurrent interpersonal or social problems. See DSM-IV-TR for additional information.

**Alcohol and Drug Counselor (ADC)**—In the USAF, they are typically MH technicians who serve in clinical roles in the ADAPT Program (formerly referred to as Certified Alcohol and Drug Abuse Counselors, or CADACs). They provide services in the following 12 core functions outlined by the IC&RC: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, education, referral, report and record keeping, and consultation. The USAF SA Counselor Certification program issues the certification and has the authority to revoke certification for cause. They are required to have a minimum of 270 hours didactic instruction and 6,000 hours within the 12 core functions of SA counseling, 300 of which must be accomplished via direct supervision by another fully qualified ADC or privileged MHP. See the *AF Alcohol and Drug Counselor Certification Handbook* for additional requirements to become a certified ADC.

**Alcohol Dependence**—(From DSM-IV-TR)—The essential feature of alcohol dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the alcohol despite significant alcohol-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive alcohol-consumption behavior. Dependence is defined as a cluster of three (3) or more of the symptoms listed below occurring at any time in the same 12-month period: 1) Tolerance; 2) Withdrawal syndrome or drinking to relieve withdrawal; 3) Drinking more or longer than intended; 4) Impaired control; 5) Time spent related to drinking or recovering; 6) Neglect of activities; 7) Continued use despite recurrent psychological or physical problems. See DSM-IV-TR for additional information.

**Alcohol—Related Misconduct (ARM)**—This type of conduct includes driving while intoxicated, public incidents of intoxication and misconduct, under-aged drinking, or similar offenses and is a breach of discipline.

**Alcoholics Anonymous**—(AA)—A fellowship of men and women who share with each other their experience, strength, and hope that they may solve their common problem and help others to recover from alcoholism.

**Civilian Rehabilitation Team**—Chaired by the ADAPT PM, this team establishes the treatment framework and monitors progress of individuals identified with a SA problem.

**Clinical Treatment**—Services designed for the treatment of clients diagnosed with alcohol abuse or alcohol dependence. These services include a wide range of programs including intensive outpatient treatment, partial hospitalization, variable length of stay programs, and inpatient hospitalization.

**Demand Reduction Program Manager**—Person responsible for oversight of civilian and military drug testing programs.

**Detoxification**—A planned management of alcohol and drug withdrawal. Clients usually undergo medical detoxification of inpatients. Detoxification includes keeping alcohol and other drugs of abuse away from the individual and providing indicated medical and psychological support.

**Drill Status Guardsmen**— ANG members who are committed to serving one weekend a month and two weeks a year. These members hold civilian jobs (typically) outside of the military.

**Drug**—Any controlled substance included in Schedules I, II, III, IV, and V in 21 U.S.C. 812, including anabolic or androgenic steroids, or any intoxicating substance other than alcohol, that is inhaled, injected, consumed, or introduced into the body in any manner to alter mood or function.

**Drug Abuse**—The illegal, wrongful, or improper use, possession, sale, transfer, or introduction onto a military installation of any drug defined in this instruction.

**Individual Mobilization Augmentee (IMA)**—They are Reservists who are assigned to AD units to do jobs that are essential in wartime, but do not require full-time manning during peace time. IMAs report for duty a minimum of one day a month and 12 additional days a year.

**Intervention**—The process of helping the member recognize at the earliest possible moment that he or she needs treatment for self-destructive drinking or drug abuse. This professionally structured event includes significant others in the member's life.

**Intoxication**—Maladaptive behavior, such as aggressiveness, impaired judgment, and manifestation of impaired social or occupational functioning, because of recent ingestion, inhalation, or injection of any substance into the body. Characteristic physiological and psychological signs include flushed face, slurred speech, unsteady gait, Nystagmus, lack of coordination, impaired attention, irritability, euphoria, or depression.

**Privileged MH Provider**—Military (Active or Reserve component) and civilian personnel (civil service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimes within the scope of his or her license, certification, or registration.

**Privileges**—Permission to provide medical and other patient care services in the granting institution within defined limits based on the individual's education, professional license, experience, competence, ability, health, and judgment.

**Relapse**—A return to drinking or drug use after a period of abstinence

**Responsible Center/Cost Center (RC/CC):**—Identifies a specific base organization responsible for the management of financial resources.

**Substance**—Alcohol and other mind or mood altering drugs, including illicit drugs, prescribed medications, and over-the-counter medications.

**Substance Abuse (SA)**—(From DSM-IV-TR Criteria)—The essential feature of substance abuse is a maladaptive pattern of substance abuse manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an Abuse criterion to be met, the substance-related problem must have occurred repeatedly during the same 12-month period or been persistent. A diagnosis of substance abuse requires that the client not meet the criteria for substance dependence and meet one (1) more of the following criteria occurring at any time in the same 12-month period: 1) Failure to fulfill major role obligations at work, school, or home because of recurrent drinking; 2) Recurrent drinking in hazardous situations; 3) Recurrent legal problems related to alcohol; 4) Continued use despite recurrent interpersonal or social problems. See DSM-IV-TR for additional information.

**Substance Misuse**—The use of any illicit drug or the misuse of any prescribed medication or the abuse of alcohol.

**SA Assessment Process**—The assessment and decision-making process to determine the nature and extent of a member's SA involvement and the appropriate intervention.

Attachment 2

FIGURE A2.1 SAMPLE MEMORANDUM FOR TRAINING

MEMORANDUM FOR TRAINING (Competency Assessment for ADC)

FROM: Squadron/Flt

SUBJECT: ADC Observation

1. I \_\_\_\_\_ observed \_\_\_\_\_ conduct  
 (Provider/ADAPT PM) (ADC Name)  
 \_\_\_\_\_ on \_\_\_\_\_ and \_\_\_\_\_ on \_\_\_\_\_ .  
 (12 Core Function) (Date) (12 Core Function) (Date)

2. Requirements were/were not met IAW AFI 44-119.

3. Time Spent Observing: \_\_\_\_\_

4. Strengths: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Areas for Improvement: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(ADC Signature)

(Provider/ADAPT PM Signature)

Attachment 3

FIGURE A3.1 TEMPLATE CONSENT FOR RELEASE

CONSENT FOR RELEASE OF PATIENT INFORMATION DURING OR AFTER TREATMENT OR REHABILITATION

I, \_\_\_\_\_, hereby consent to the disclosure of information

(Employee/Patient Name)

concerning my progress in terminating illicit drug use. I authorize the

\_\_\_\_\_

(Treatment/Rehabilitation Program)

to disclose that information to the following individuals: The Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program Manager or the Employee Assistance Program Counselor, (Name and location: \_\_\_\_\_); My supervisor (Name : \_\_\_\_\_); and the Human Resources Representative (Name: \_\_\_\_\_) for monitoring under Executive Order (EO) 12564, which sets forth the objective of achieving a drug-free Federal workplace. I understand that this consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, and that it will expire without express revocation upon \_\_\_\_\_.

(Date, Event, and/or Condition)

This consent to disclose the above described treatment records for the purpose set out above was voluntary and not subject to coercion.

\_\_\_\_\_

(Signature of Employee/Patient)

\_\_\_\_\_

(Date)

**CLAUSE FOR USE IF EMPLOYEE IS A MINOR OR LEGALLY INCOMPETENT**

I, \_\_\_\_\_, the (parent/legal guardian or personal legal

(Name)

representative) of the above named employee/patient, hereby consent to the aforementioned release of information on his/her behalf.

\_\_\_\_\_  
(Signature of parent/legal guardian or personal legal representative)

\_\_\_\_\_  
(Date)