

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

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Medical

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

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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 use disorders (SUDs) and describes AF policy regarding alcohol abuse, prescription drug misuse, 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 SUD 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 Department of Defense (DoD) medical services, Air Reserve Component (ARC) members will obtain, when needed, non- military SUD services at their own expense. This instruction requires collecting and maintaining information IAW the *United States Air Force Alcohol And Drug Abuse Prevention and Treatment (ADAPT) Program Guide*, and guidance for the detailed operation of the installation ADAPT Program.

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 and is available at <http://privacy.defense.gov/notices/usaf/>. 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 in the Air Force Records Information Management System (AFRIMS). The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force. Send comments and suggested improvements on AF Form 847, Recommendation for Change of Publication through channels to Department of the Air Force, AFMOA/SGHW, 2261 Hughes Ave, Suite 153, JBSA Lackland, TX 78236-1025. This publication may be supplemented at any level, but all direct Supplements must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

SUMMARY OF CHANGES

This new revision updates requirements issued in DoDI 1010.04 and changes in terminology with the publication of DSM-5.

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Chapter 1

ROLES AND RESPONSIBILITIES

1.1. Responsibilities.

1.1.1. **The 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.

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

1.1.3. Air Force Medical Operations Agency (AFMOA), Mental Health Division (SGHW), ADAPT Branch.

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

1.1.3.2. Manages programming and execution of AF ADAPT budget.

1.1.3.3. Develops and publishes detailed Standards to ensure standardization and compliance.

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

1.1.3.5. Communicates with other DoD, AF, and civilian agencies that have collateral ADAPT responsibilities and interests.

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

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

1.1.3.8. Advises the MH Enlisted Career Field Manager in manpower and personnel issues regarding ADAPT Programs.

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

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

1.1.3.11. Monitors the Certified Alcohol and Drug Counselor Program.

1.1.3.12. Develops procedures for managing and documenting ADAPT activities.

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

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

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

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

1.1.5. **Air Force Director of Security Forces (AF/A7S).** Ensures that Security Forces provides Law Enforcement sensitive data to ADAPT Staff on alcohol or other drug related misconduct incidents. (T-1)

1.1.6. **Major Command (MAJCOM) SGs and Direct Reporting Units (DRUs).**

1.1.6.1. Ensures that each installation in the command establishes and maintains ADAPT IAW DoD and this AFI.

1.1.6.2. Appoints a MAJCOM Behavioral Health Consultant and an enlisted MAJCOM Functional Manager.

1.1.7. MAJCOM Behavioral Health Consultant/MAJCOM Functional Manager.

1.1.7.1. Will refer ADAPT related issues to the AF Chief, ADAPT Branch.

1.1.7.2. 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. (T-0, DoDI 1010.6 and DoDI 1010.04)

1.1.7.3. Responds to applicable substance abuse and misuse related complaints, suggestions, and Congressional and higher level inquiries.

1.1.7.4. Provides assistance and guidance to base-level MH Flights regarding ADAPT-related issues.

1.1.8. DRU. DRUs that have an ADAPT function, such Guard Medical Units (GMUs) will perform the same function, as above, in 1.6.2.

1.1.8.1. DRUs that do not have an ADAPT function, such as GMUs, will only perform function, as above, in 1.6.2.

1.1.9. **Installation Commander. (CC).**

1.1.9.1. Responsible for the installation ADAPT Program. (T-0)

1.1.9.2. Designates the Medical Treatment Facility (MTF)/CC to administer and monitor the installation ADAPT Program. (T-1)

1.1.9.3. Will ensure allocation of adequate space for provision of substance abuse and misuse classroom education and services. (T-0)

1.1.9.4. Will ensure ADAPT Program receives adequate funding to support counseling, treatment, prevention and outreach efforts. (T-1) Although 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. (T-0)

1.1.9.5. Shall make available funding in PE 88723 (Substance Abuse Program) for continuing education and training for certified alcohol and drug counselors (CADCs) to meet requirements of International Certification and Reciprocity Consortium (IC&RC).

(T-0) The IC&RC requires that CADCs attain a minimum of 20 continuing education hours every year in order to maintain their certification. (T-0) (The Air Force Substance Abuse Counselor Certification Board (AFSACCB) requires counselors to recertify every three (3) years which amounts to sixty (60) continuing education hours for recertification. (T-0)

1.1.10. Medical Treatment Facility (MTF) Commander (CC).

1.1.10.1. Serves as the OPR for substance use disorder (SUD) issues. (T-1)

1.1.10.2. Will appoint, in writing, a privileged MH provider (MHP) as ADAPT Program Manager (PM), who is knowledgeable in substance abuse and misuse, and addictions prevention, assessment, intervention, and treatment. (T-0)

1.1.10.3. Shall ensure SUD clinical services meet current quality assurance standards and comply with relevant accreditation standards for SUD treatment facilities. (T-0)

1.1.10.4. Ensures substance use and misuse assessments are conducted IAW this AFI. (T-2)

1.1.10.5. Will ensure all medical personnel, working in direct patient care, or clinical supervisory roles receive annual training in SUDs and chemical dependency (see Table 3.1.). (T-0)

1.1.10.6. Shall provide or arrange for medical assessment, detoxification, residential and non-residential treatment for substance abusers, including patient and family psychoeducational programs at SUDs treatment facilities. (T-0)

1.1.10.7. If a psychiatrist is not on staff, will appoint a physician who is knowledgeable in treating SUDs as the ADAPT Medical Director. (T-1)

1.1.10.8. Provides or arranges for aeromedical evacuation or civilian transportation of members in inpatient status for SUD, and family members attending treatment programs when necessary. (T-2)

1.1.11. ADAPT Program Manager (ADAPT PM).

1.1.11.1. Manages the installation ADAPT Program IAW current guidance, including DoD and Health Affairs, and provides clinical supervision to the ADAPT Program staff. (T-1)

1.1.11.2. Will coordinate clinic resources to provide effective education, identification, assessment and treatment programs, as well as coordinates with other MH Flight and base assets to provide substance use-related prevention efforts. (T-0)

1.1.11.3. Will coordinate funding requirements using PE 88723 through the wing budgeting cycle. (T-1) A Responsible Center/Cost Center (RC/CC) should be established within the MTF to capture funds in PE 88723. This allows ADAPT funds to be managed by the MTF resource advisor (RA) with assistance of the Wing RA. (T-1)

1.1.11.4. Ensures SUDs workload reporting is completed using Medical Expenses Performance Report Services (MEPRS) code BFFA (Ambulatory Care and Partial Hospitalization Program - ADAPT). (T-1)

1.1.11.5. Must be a privileged MHP. (T-0)

- 1.1.11.6. Assists commanders and supervisors to identify and refer individuals needing ADAPT services. (T-0)
- 1.1.11.7. 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. (T-0)
- 1.1.11.8. Ensures continuous quality improvements in the ADAPT Program by developing and tracking metrics to alcohol and drug abuse prevention and treatment. (T-1)
- 1.1.11.9. Chairs Treatment Team (TT) Meetings. (T-1)
- 1.1.11.10. Ensures non-privileged ADAPT personnel receive continuous substance abuse training and are certified or actively participating in the certification process. (T-0)
- 1.1.11.10.1. 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 Alcohol and Drug Counselor Certification Handbook. (T-1)
- 1.1.11.11. 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 a SUD, has not had HIV testing within the past six months. See AFI 48-135 (T-1)
- 1.1.11.12. Personnel will undergo drug monitoring during the course of all levels of substance use disorder treatment in DoD facilities. (T-0) Medically-directed drug tests will be used to determine an individual's adherence to treatment goals. (T-0) Testing for alcohol use during treatment will be conducted when clinically indicated. (T-0) In order to determine if patients have been drinking, random labs should be ordered throughout the course of treatment. (T-0) The following labs should be considered: Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), Gamma-glutamyl Transpeptidase (GGT), Carbohydrate Deficient Transferrin (CDT), Hemoglobin A1c (HbA1c), and Blood Alcohol Level. (T-1) When a patient is diagnosed with another substance use disorder, they should have random labs ordered throughout treatment depending on the diagnosis. (T-1)
- 1.1.11.13. Coordinates with other MH Flight clinic staff to provide effective education, identification, assessment and treatment programs, as well as coordinates with other MH Flight staff to provide prevention services to the base community. (T-3)
- 1.1.11.14. Coordinates with off-base resources to effectively supplement installation ADAPT programs. (T-3)
- 1.1.11.15. Ensures development and implementation of ADAPT education and prevention programs. (T-3)
- 1.1.11.16. Proposes written wing or installation guidance concerning alcohol and drug abuse prevention and treatment. (T-3)
- 1.1.11.17. Conducts required reviews of the patient's medical records and all documentation provided by the ADAPT Program staff. (T-3)

1.1.11.18. Observes the patient's general physical and mental condition during the assessment. (T-3) Makes referrals for additional medical, psychiatric, or laboratory examinations as needed. (T-3)

1.1.11.19. Helps geographically separated units (GSUs) with ADAPT-related issues as outlined in the local host-tenant agreement or memoranda of understanding. (T-3)

1.1.11.20. Markets ADAPT Programs to installation leadership and base population. (T-3)

1.1.11.21. Coordinates with MH flight personnel and the Airman and Family Readiness Center (A&FRC) in the development of community referral guidelines in support of the Integrated Delivery System (IDS). (T-3)

1.1.11.22. Ensures that the SGP, as chair of the Deployment Availability Working Group (DAWG), is provided with the treatment status of all ADAPT Program patients, including their profile status, on a monthly basis. (T-3)

1.1.11.23. 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 SUD treatment. (T-1)

1.1.11.24. Collaborates and communicates with Reserves Medical Unit (RMU) and Guard Medical Unit (GMU) personnel, and Air Reserve Component (ARC) Commanders, when required by AF and DoD policy, regarding any AFRC or ANG member who presents to the ADAPT Program for services. (T-1)

1.1.11.25. Will provide fitness for duty or status recommendations to ARC Commanders for ARC members who have been referred by the ADAPT PM and seen by non-military providers for SUD evaluation and/or treatment. (T-1)

1.1.11.26. Will coordinate with non-military providers for ARC members who have been referred by the ADAPT Program staff to non-military providers for treatment to ensure treatment records are available to the ADAPT Program staff in a timely manner. (T-1) 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. (T-1) The member must be on orders to be seen in ADAPT for any appointments associated with status recommendations. (T-1)

1.1.11.27. ANG members who have not been entered into the ADAPT Program will ensure the civilian SUD records are available for review by the GMU. (T-1)

1.1.11.28. Will provide PRP status recommendations to the PRP Competent Medical Authority or MDG PRP monitor, and return to duty recommendations to the flight surgeon as required by relevant governing instructions. (T-1)

1.1.12. **Certified Alcohol and Drug Counselor (CADC).**

1.1.12.1. Background. MH technicians typically serve in clinical roles as CADCs in the ADAPT Program. Note: The IC&RC is the parent organization of the AF Substance Abuse Counselor Certification Board (AFSACCB). The AFSACCB issues the certification and has the authority to revoke, suspend, or put in abeyance any individual's

certification for cause. The guidance for the AF certification program is detailed in the AF Alcohol and Drug Counselor Certification Handbook. (T-1)

1.1.12.2. Education and Certification/Recertification Requirements:

1.1.12.2.1. Have a minimum of 270 hours didactic instruction and 6,000 hours within the 12 core functions of SUD counseling, 300 of which must be accomplished via direct supervision by another fully qualified CADC or privileged MHP. (T-0)

1.1.12.2.2. Have a signed agreement to practice under strict AF ethical guidelines. Note: Ethical guidelines are state/board specific. (T-0)

1.1.12.2.3. Pass a recognized written examination administered by the AF or another IC&RC sanctioned board. (T-1)

1.1.12.2.4. Obtain internationally recognized certification from the IC&RC. (T-0)

1.1.12.2.5. Ensure CADC credential information is entered into the Centralized Credentials Quality Assurance System (CCQAS) by the local credentialing office. (T-0)

1.1.12.2.6. 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. (T-0) See handbook for additional information regarding entire certification process. (T-2) An electronic copy of the handbook can be obtained from the ADAPT Branch staff at AFMOA/SGHW. (T-2)

1.1.12.2.7. Maintaining Certification. Individuals certified through the AF Substance Abuse Counselor Certification Board will maintain their certification as long as they provide services in support of the ADAPT Program. (T-0) Requirements for counselor recertification are outlined in the AF Alcohol and Drug Counselor Certification Handbook. (T-0)

1.1.12.2.7.1. Individuals initially certified by the AFSACCB who are in a special duty, cross-flowed or cross-trained into another career field, can be recertified if all requirements stated in 1.1.12.2.5. are met. (T-1) All continuing education for these individuals will be accrued at member's/unit's expense. (T-1)

1.1.12.3. Scope of Practice/Supervision. CADCs perform the 12 core functions independently as directed by the ADAPT PM. (T-0) They provide treatment planning, crisis intervention and group treatment under the supervision of a privileged MHP. (T-0) For initial assessment, development of or changing a treatment plan, and crisis intervention, privileged MHPs are responsible for "eyes on" supervision of CADCs. (T-0) Supervising privileged MHPs must document supervision in the medical record following each episode supervised. (T-0)

1.1.12.3.1. The ADAPT PM is responsible for the clinical practice of CADCs. (T-0) To ensure ongoing training and competency assessment for CADCs, the ADAPT PM, or designee, must observe and assess the CADC while providing individual or group treatment, at least two times per month for a total of at least two hours monthly. (T-0) Competency assessments will focus on direct patient contact within the 12 core

functions of SUD counseling, and will be documented in the CADC's AFTR (see Attachment 2 for sample memorandum to track training). (T-0)

1.1.12.3.2. Removal of CADCs from duties due to adverse actions. See AFI 44-119, Section 9.62 regarding removing unlicensed technicians from clinical practice.

1.1.12.3.3. Non-certified 3-level MH technicians who are in training may conduct the 12 core functions only when supervised by a CADC or privileged MHP and must have direct supervision during the entire patient contact. (T-0) 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, but must be observed at least two times per month for a total of at least two hours monthly. (T-0) A privileged MHP is responsible for eyes-on supervision before the patient departs the appointment. (T-0) The privileged MHP who performed this supervision must co-sign the note in the patient record. (T-0)

1.1.12.3.4. Non-CADC MH Technicians: Skills and education required for CADC are crucial for all MH technicians. All non-CADC technicians and their supervisors must have a written plan to develop these competencies IAW expectations for their current skill level. (T-0) Topics could include: American Society of Addiction Medicine (ASAM), 12 Core Functions, Motivational Interviewing, and Ethics. Per CFETP 4COX1, completion of 100 percent core task training is prerequisite to award of the 7-level. (T-0) Completion of Qualification Training Package (QTP) 1, the 12 Core Functions of SUD Counseling, is mandatory. (T-0) Craftsman will continue to obtain the necessary education and experience required to complete the case presentation, and written exam to meet the AF SUD Counselor Certification Board. (T-0)

1.1.12.3.4.1. Expired CADCs: Certified technicians that do not recertify before their credential expires will enter into "Inactive" status. (T-1) Once credential is Inactive, expired CADCs will function as Non-CADC MH Technicians until recertification is complete. (T-1)

1.1.12.3.4.1.1. Expired CADC counselors that have been Inactive for two (2) years will be ineligible for recertification. (T-1) Members will be required to meet initial certification requirements to obtain new CADC credential. (T-1) See handbook for additional information regarding entire recertification process.

1.1.13. Installation Defense Force Commander (DFC). Provides the base ADAPT Program personnel Law Enforcement Sensitive information (e.g. blotter entries) identifying alcohol related misconduct (ARM). (T-1)

1.1.14. Geographically Separated Unit (GSU) Commanders. GSU CCs will refer individuals to the nearest ADAPT Program for assessment when substance use or misuse is suspected to be a contributing factor in misconduct or when an individual is suspected of having a problem with alcohol or other drugs. (T-1)

1.1.14.1. Treatment of SUDs for patients assigned to GSUs may include services through local (civilian) resources with on-going case-management provided through the ADAPT PM at the nearest MTF. (T-1)

1.1.15. AFRC and ANG Commanders.

1.1.15.1. IAW AFI 48-123, Medical Examinations and Standards, and AFI 36-2254-v1, Reserve Personnel Participation (paragraph 1.6), unit CCs are encouraged to place the member suspected of having a SUD on orders to receive the initial assessment and treatment recommendation from the ADAPT Program (evaluation only). (T-1) ARC members not already eligible for military treatment services (i.e. were placed on orders for the SUD assessment only) will be managed IAW paragraph 1.11.13 of this instruction. (T-1)

1.1.15.2. If the CC chooses not to place a member on orders, the CC 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 having a SUD to a non-military MHP for a SUD assessment and any recommended treatment. (T-1) The non-military provider must be a licensed MHP or a CADC. (T-1) ANG members who have not been entered into the ADAPT Program will ensure the civilian SUD records are available for review by the GMU. (T-1) ANG members who have not been entered into the ADAPT Program will be encouraged to follow up with the DPH for case management services. (T-1)

Chapter 2

MENTAL HEALTH RECORDS FOR ADAPT PROGRAM PARTICIPANTS

2.1. Managing Records.

2.1.1. ADAPT Program treatment information will be maintained IAW AFI 44-172. (T-1)
The ADAPT 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. (T-2)

2.1.2. Providers will document care in the patient's medical record IAW AFI 44-172, and 41-210, *Patient Administration Functions*. (T-1)

2.1.3. Case notes will be documented in the standard Subjective, Objective, Assessment, Plan (SOAP) format. (T-2)

2.2. Records Disposition.

2.2.1. 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). (T-1)

Chapter 3

AF ADAPT PROGRAM

3.1. Alcohol Misuse.

3.1.1. The AF policy recognizes that alcohol misuse negatively affects public behavior, duty performance, and/or physical and mental health. The AF provides comprehensive clinical assistance to eligible beneficiaries seeking help for an alcohol problem. (T-1)

3.2. Illicit Drug Use.

3.2.1. The AF does not tolerate the illegal or improper use of drugs by AF personnel. (T-1)
Such use:

3.2.1.1. Is a serious breach of discipline. (T-1)

3.2.1.2. Is incompatible with service in the AF. (T-1)

3.2.1.3. Automatically places the member's continued service in jeopardy. (T-1)

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. (T-1)

3.3. ADAPT Program Overview.

3.3.1. 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. (T-1) These objectives are met through four levels of activities:

3.3.1.1. Universal (Primary) Prevention and Education: This includes population-based outreach, education, prevention programs, screening, and consultation. Community-based prevention and education efforts will be delivered by ADAPT staff through coordinated efforts with other community agencies. (T-3) Clinic-based services, screening and consultation will be delivered through the ADAPT Program. (T-2)

3.3.1.2. Selective (Targeted) Prevention: This involves global screenings for alcohol misuse, as well as initiatives to prevent future alcohol misuse, prescription drug misuse, or drug use with individuals who are identified as high risk or are suspected of substance misuse. Selective prevention includes screening, assessment, education, brief preventive counseling, and tailored feedback in specific individuals or groups identified as moderate to high risk.

3.3.1.3. Indicated Prevention: This is indicated for those who are engaging in risky drinking but have not yet developed problems associated with their drinking. Individuals in this group can be identified through screening in primary care or other appropriate setting. The majority of these individuals are best served through motivational

interviewing and brief advice. This focuses on those who are already in the early stages of alcohol and substance use.

3.3.1.4. Treatment and Continuing Care (Aftercare): Provide evidence-based substance use disorder treatment for individuals who are abusing or are dependent on alcohol or drugs that follows the clinical practice guidelines. (T-3) 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. (T-3) All installations will provide Level 1.0 care, other higher level care can be provided by civilian or military facilities with a referral from the provider. (T-1)

3.3.2. Use of evidence-based services.

3.3.2.1. ADAPT Program will provide evidence-based substance use disorder services that adhere to this instruction, clinical practice guidelines (CPGs), as well as other DoD/Veterans Affairs (VA) sanctioned task force and/or accredited professional organizations specializing in the treatment of substance use disorders. (T-0)

3.3.3. The American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) will be utilized by every installation ADAPT Program to match personnel to the appropriate level of care. (T-1) The ASAM PPC describes treatment on a continuum of five basic levels of care. Every installation will have the following: (T-1)

3.3.3.1. Level 0.5: Alcohol Brief Counseling (ABC, Selective Prevention and Education). (T-1)

3.3.3.2. Level 1.0: Outpatient Services. (T-1)

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. (T-0) 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). (T-0)

3.4.2. ADAPT Program treatment information may be disclosed or released to other offices or agencies within the Armed Forces. (T-0) 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. (T-0)

3.4.3. In the course of the initial assessment, treatment or continuing care (aftercare) services in the ADAPT Program, information disclosed about child abuse or neglect, or spousal abuse will 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. (T-1)

3.5. Eligibility.

3.5.1. All beneficiaries are eligible for treatment, following TRICARE guidelines for access. Eligible beneficiaries shall receive SUD services as offered through their selected health care option: TRICARE Prime, TRICARE Extra, TRICARE Standard, or TRICARE Reserve

Select [Assistant Secretary of Defense (ASD) Health Affairs (HA) Policy Memorandum on TRICARE Substance Abuse Treatment, 13 Feb 97]. (T-0)

3.5.2. Civilians will be seen for a SUD assessment in accordance with AFI 44-107 (or 90-508 once AFI 44-107 has been replaced by 90-508), AF Civilian Drug Demand Reduction Program (See Chapter 2). (T-1)

3.6. Substance Misuse Prevention Strategies.

3.6.1. Substance misuse prevention efforts are geared toward enhancing individual and unit resiliency, both of which can be compromised by hazardous alcohol use and SUDs. Prevention strategies must be comprehensively structured to educate and inform the overall population as well as specifically target higher risk populations. (T-0)

3.6.1.1. In collaboration with other Integrated Delivery System (IDS) members, the ADAPT staff works to develop and implement prevention programs geared towards increasing organizational and individual awareness of SUD issues, including misuse and abuse of prescription medications, illegal and illicit drug abuse, trends, and threat to mission readiness. (T-0)

3.6.2. Substance abuse and misuse prevention and education programs will at a minimum meet the objectives listed in Table 3.1 of this AFI, DoD Directive (DoDD) 1010.4, Drug and Alcohol Abuse by DoD Personnel, DoDD 1010.6, Rehabilitation and Referral Services for Alcohol and Drug Abusers, DoDI 1010.04, Problematic Substance Use by DoD Personnel, and be tailored to meet the specific needs of the organization. (T-0)

3.6.3. Alcohol Use Screening and Evaluation in Primary Care: All AD personnel are screened at least annually for alcohol misuse in Primary Care. (T-0) All TRICARE beneficiaries are also screened for alcohol misuse during appointments in Primary Care. (T-0) Individuals are typically screened using the Alcohol Use Disorders Identification Test (AUDIT) or AUDIT-C. If an individual screens positive for alcohol misuse, the Primary Care provider may provide a brief intervention, refer the individual to a behavioral health optimization program (BHOP) provider, or refer to the ADAPT Program for an evaluation for specialty treatment depending on what the screening results indicate from the VA/DoD CPGs. See Module A of VA/DoD CPG. (T-0)

Table 3.1. Substance Abuse and Misuse Education (Tier 0).

	If the individual is...	then the required training...
1	a military member (enlisted or officer) on his/her first permanent duty assignment	will focus on prevention of substance abuse and misuse, standards, desire for peer acceptance, role models, responsible behavior, healthy alternatives, and legal/administrative consequences of substance abuse and misuse.

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 Permanent Change of Station (PCS) and shall emphasize standards, healthy lifestyles, responsible behavior and consequences of substance abuse and misuse to self and career.
3	a health care professional who provides direct patient care (to include providers, nurses and technicians)	will emphasize identification, assessment, and referral of personnel displaying signs of problematic substance use and misuse, and the services that are available for treatment. Training will be provided annually as part of in-service training events.
4	an Airmen Leadership School or NCO Academy student	will focus on responsibilities of leaders in substance abuse and misuse prevention, identification and referral of substance abusers, the education and counseling processes, SUD treatment programs, intervention, and the impact of SUD on the mission. Curriculum developed IAW AFH 36-2235, Information for Designers of Instructional Systems.
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)	will focus on roles and responsibilities of senior leaders in the substance abuse and misuse prevention program; effects of substance abuse and misuse on mission, morale, readiness, and health and wellness; the education, counseling, referral, and follow-up process; influence of senior leaders attitudes on substance use; 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	will emphasize the early identification of substance abusers, assessment, and referral of personnel displaying signs of problematic substance use and misuse, the services that are available for treatment. Training should also emphasize the need for active support for substance abuse and misuse prevention programs, fostering help-seeking behavior, and reducing the stigma associated with SUD treatment. Training will be provided annually as part of in-service training events.

3.7. Referrals Types: Self-Identification, Command Referrals, and Medical Referrals.

3.7.1. Self-Identification. AF members with substance abuse and misuse problems are encouraged to seek assistance from their unit CC, first sergeant, a military medical professional, or MHP. Following the assessment, the ADAPT PM will consult with the TT when indicated and determine an appropriate clinical course of action. (T-1)

3.7.1.1. Alcohol. CCs should provide sufficient incentive to encourage members to seek help for problems with alcohol without fear of negative consequences. (T-1)

3.7.1.1.1. Self-identification is reserved for members who are not currently under investigation or pending action as a result of an ARM. (T-1)

3.7.1.1.2. Self-identified members who enter the ADAPT assessment process will be held to the same standards as others entering substance abuse and misuse education, counseling and treatment programs. (T-0) However, if the member is not diagnosed with a SUD, the member's chain of command will not be notified. (T-0)

3.7.1.2. Drugs.

3.7.1.2.1. An AF member may voluntarily disclose evidence of personal drug use or possession to the unit commander, first sergeant, substance use/misuse evaluator, or a military medical professional. (T-1)

3.7.1.2.2. CCs will grant limited protection for members who reveal this information with the intention of entering drug treatment. (T-0)

3.7.1.2.3. CCs may not use voluntary disclosure against a member in an action under the UCMJ or when weighing characterization of service in a separation. (T-0)

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

3.7.1.2.4.1. Apprehended for drug involvement. (T-1)

3.7.1.2.4.2. Placed under investigation for drug abuse. (T-1) The determination of "placed under investigation" status is made on the circumstances of each individual case. (T-1) Consult with appropriate medical legal consultant, if one is available, or other legal and/or investigative authorities regarding any questions. (T-1)

3.7.1.2.4.3. 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. (T-1)

3.7.1.2.4.4. Advised of a recommendation for administrative separation for drug abuse. (T-1)

3.7.1.2.4.5. Entered treatment for drug abuse. (T-1)

3.7.1.2.5. The limited protection under this section for self-identification does not apply to: (T-1)

3.7.1.2.5.1. 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. (T-1)

3.7.1.2.5.2. 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. (T-1)

3.7.2. Command Referral: CC's Identification and Associated Roles and Responsibilities.

3.7.2.1. In accordance with this instruction and applicable DoDIs, a unit CC will refer all service members for assessment when substance use or misuse is suspected to be a contributing factor in any misconduct, e.g., driving under the influence (DUI)/driving while intoxicated (DWI), public intoxication, drunk and disorderly, spouse/child abuse and maltreatment, underage drinking, positive drug test, or when notified by medical personnel under paragraph 3.7.3 of this instruction. (T-0) CCs who fail to comply with this requirement place members at increased risk for developing severe substance problems and jeopardize the mission. (T-0)

3.7.2.2. CC or first sergeant closely examines all AF Forms 3545 and Incident Reports, for evidence of ARM, or substance abuse or misuse. (T-1)

3.7.2.3. After coordination with the Staff Judge Advocate (SJA), unit CCs will direct drug testing within 24 hours of suspected ARM, episodes of aberrant or bizarre behavior, or where there is reasonable suspicion of drug use and the member refuses to provide consent for testing. (T-0) CCs are also encouraged to ensure that blood alcohol content (BAC) is taken as soon after the incident as possible to determine the level and intensity of alcohol involvement. (T-0)

3.7.2.4. The unit CC contacts the installation's ADAPT staff within seven (7) calendar days of the misconduct to initiate the assessment process. (T-1) 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. (T-1)

3.7.2.4.1. Referrals for Service Members in Deployed Locations or during TDY (Non-Deployed Locations) will be managed IAW this instruction. (T-1) Given limited resources in theater, every effort should be made to evaluate members suspected of substance abuse or misuse prior to deployment. (T-1)

3.7.2.5. CC 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. (T-1) CCs who elect not to prefer charges but suspect the individual of drug abuse must refer members for a SUD assessment as soon as possible. (T-1)

3.7.2.6. The CC provides information to the ADAPT staff to assist in the assessment (e.g. BAC results), including comments on observed performance and behavior to the ADAPT staff before the assessment appointment. (T-1)

3.7.2.7. The CC 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 misconduct. (T-1)

3.7.2.8. The CC tells the member the following: (T-1)

3.7.2.8.1. The reason for the assessment. (T-1)

3.7.2.8.2. That the assessment is not punitive in nature. (T-1)

3.7.2.8.3. That the member must report in uniform for the initial assessment at the appointed date and time. (T-1)

3.7.2.9. The CC ensures the assessment and treatment of personnel is not delayed by ordinary leave or TDYs. (T-1)

3.7.2.10. The commander is responsible for all personnel/administrative actions pertaining to patients involved in the ADAPT Program, to include assignment availability, promotion eligibility, reenlistment eligibility, PRP, security clearance, etc. (T-2) 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. (T-3)

3.7.2.11. The CC, and/or first sergeant will actively participate on the TT by providing input to treatment decisions. (T-0) Command involvement is critical to a comprehensive treatment program, as well as during aftercare and follow-up services. The CC shall also provide command authority to implement the treatment plan when the member does not voluntarily comply with the TT's decisions. (T-0)

3.7.3. Medical Care Referrals.

3.7.3.1. Medical personnel must notify the member's unit commander and the ADAPT PM when a member of the armed forces: (T-1)

3.7.3.1.1. Is observed, identified, or suspected to be under the influence of drugs or alcohol. (T-1)

3.7.3.1.2. Receives treatment for an injury or illness that may be the result of substance use. (T-1)

3.7.3.1.3. Is suspected of abusing substances. (T-1)

3.7.3.1.4. Is admitted as a patient for alcohol or drug detoxification. (T-1)

3.8. Documentation (Prevention, Treatment, and Aftercare).

3.8.1. ADAPT staff will document reason for referral and conduct the substance-related assessment within seven (7) calendar days of all referrals. (T-1) This includes, but is not limited to, self, medical, command, and other referrals. (T-1)

3.8.2. If the patient 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 and document in the record any delays of the assessment. (T-1)

3.8.3. Documentation for selective prevention, treatment, and aftercare will be placed in the record IAW AFI 44-172. (T-1)

3.9. Patient Assessment and Diagnostic Responsibilities.

3.9.1. Treatment or prevention counseling for all patients should be based on thorough assessment (e.g. Substance Use Assessment Tool (SUAT), clinical interview, and collection of collateral data as appropriate), determination of risk, and should be tailored for the individual. (T-0)

3.9.2. Evaluation for specialty treatment requires a thorough biopsychosocial assessment that adheres to evidence based clinical practice guidelines from VA/DoD. (T-0) The initial assessment in ADAPT is the SUAT Intake/Assessment. (T-3) Information from the SUAT intake is utilized to make treatment recommendations. (T-3)

3.9.2.1. When treating ADAPT patients, providers and technicians must do a complete review of the individual's medical history, including a thorough medication reconciliation. (T-1) This can help providers uncover potential poly-substance abuse disorders, identify drug-seeking behaviors, and target therapy appropriately. Throughout treatment, providers should periodically monitor any changes in the patient's medical diagnoses or medication regimen in order to identify unrecognized prescription medication abuse. (T-1)

3.9.3. Information gathered during the assessment will form the basis for patient diagnosis, treatment planning, and delivery of SUDs-related services. (T-0)

3.9.4. 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 SUD (or lack thereof). Consult with appropriate medical legal consultant, if one is available, or other legal and/or investigative authorities regarding any questions. (T-3)

3.9.5. Before adjudication, the privileged MHP will provide assessment results on individuals who are charged with DUI/DWI to the patient's commander. (T-0)

3.9.6. Credentialed MH providers are responsible for diagnostic decisions, treatment/change plan, and disposition of the case. (T-1)

3.9.6.1. Other prevention and treatment activities can be performed by the appropriate counselor (credentialed MHP, CADC, or supervised MH technician) as determined by patient 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. (T-0)

3.10. Disclosure.

3.10.1. Before eliciting information from the patient, ADAPT staff will brief the patient about: (T-0)

3.10.1.1. Stipulations of self-identification, if applicable. (T-0)

3.10.1.2. Limits of confidentiality. (T-0)

3.10.1.3. Privacy Act and Health Insurance Portability and Accountability Act (HIPAA) provisions. (T-0)

3.10.1.4. Overview of ADAPT Program, to include patient rights and responsibilities. (T-0)

3.10.1.5. The responsibilities of the respective members of the ADAPT Program staff engaged in assessment, education, brief preventive counseling, or treatment. (T-0)

3.10.1.6. The purpose, access, and disposition of MH records. (T-0)

3.10.1.7. The potential consequences of refusing assessment, preventive counseling, and/or treatment. (T-0)

3.10.2. If the referral is from the command or the result of an ARM, the ADAPT staff must explain the following to the patient prior to assessment: (T-1)

3.10.2.1. The requirement that the supervisor provide information on the patient's duty performance and on- and off-duty behavior. (T-1)

3.10.2.2. The expected time requirements for the member to complete the assessment. (T-1) Time requirements for secondary prevention and treatment services should be explained after the assessment, when recommended level of care has been determined. (T-1)

3.10.2.3. Limits of confidentiality. (T-0)

3.10.2.4. The counselor's responsibilities. (T-1)

3.10.3. 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 SUD treatment with the Veterans Administration (VA). (T-0) Services will continue to be provided, according to member needs, until separation occurs. (T-0)

3.11. Level 0. 5: Requirements for Alcohol Brief Counseling (ABC; Selective Prevention and Education).

3.11.1. Overview. Selective 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 other 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 that do not receive a SUD diagnosis and have had an ARM, or self-identify for a substance abuse and misuse problem will receive ABC. (T-1) ABC is not mandated for individuals who receive Level 2.1 or higher. Civilians will be seen for an initial assessment, ABC, and other services IAW AFI 44-107 (90-508 once 44-107 has been replaced). (T-1)

3.11.2. For members who are not diagnosed with a SUD, the intensity of preventative counseling services should be based on evaluation of risk. (T-0)

3.11.3. Early Intervention: ABC. Refer to the ADAPT ABC Counselor's Training 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 patient response to identified risks and concerns, as well as identifying possible areas for behavior change. (T-1)

3.11.3.1. Session 1: Motivational-focused discussion on patient concerns. Patients assigned Alcohol Education and Value Exploration Modules (AEM and VEM). (T-3) For patients who misuse substances other than alcohol, the required AEM can be modified or replaced as appropriate.

3.11.3.2. Session 2: Discuss patient concerns. Follow-up on AEM and VEM, and develop change plan. (T-3)

3.11.3.2.1. Alcohol Education Model (AEM). 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. 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 (14 calendar days) of assessment. (T-3)

3.11.3.2.2. Value Exploration Module (VEM). VEM provides an opportunity for the patient to share what he or she feels is important, and allows for identification of specific goals. The goals that are developed during VEM are essential for helping patients see the discrepancy between his or her current behavior and the patient's goals.

3.11.3.3. Session 3: Discuss patient concerns and follow-up on change plan. Following session three, the patient may be assigned additional modules and sessions, may be referred to treatment, or the patient's case may be closed out and patient will be provided resources. (T-3)

3.12. Treatment Program Guidelines.

3.12.1. Overview. After being diagnosed with a SUD, patients will be placed in the appropriate level of care IAW ASAM PPC. (T-0) To make the appropriate placement, ADAPT staff will utilize the ASAM Criteria Assessment Dimensions. (T-0)

3.12.2. At every level of care, the treatment program will reflect a multi-disciplinary approach to assist the patient to achieve full recovery, free of the negative effects of the SUD. (T-0)

3.12.3. It is important to note that command involvement is critical to a comprehensive SUD treatment program, prevention and early intervention stages, as well as during continuing care (aftercare). (T-0)

3.12.4. The treatment plan must be developed IAW ASAM PPC. (T-0) ASAM PPC reflects the philosophy of placing patients 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. (T-0)

3.12.5. When patients are diagnosed with a SUD 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 check code 31(for most ADAPT patients), and enter a release date on the AF Form 469 in ASIMS. (T-1) Only specific limitations will be entered. (T-1) Diagnoses will not be recorded on the comment or limitation section of this form. (T-1) After electronic signature, the form will be automatically forwarded to the Medical Standards Management Element (MSME), and to the Profile Officer. (T-1) The Profile Officer will validate by electronic signature, and the form will be automatically returned to MSME. (T-1) It is then forwarded electronically to the member's unit commander for concurrence/non-concurrence. (T-1) The commander or designated representative will issue the profile to the member. (T-1) Complete profile IAW AFI 48-123 & AFI 10-203. (T-1)

3.12.6. Individuals diagnosed with an alcohol use disorder will refrain from the use of alcohol during treatment. (T-0) During continuing care (aftercare), abstinence may be an important treatment goal. However, responsible drinking goals can also be considered for continuing care (aftercare). A return to drinking during treatment or continuing care

(aftercare) is not uncommon and should not, in itself, be considered unsatisfactory progress or treatment failure. (T-0)

3.12.7. Ensure that primary care manager (PCM) is notified of TT outcome if appropriate for continuity of care. (T-2)

3.12.8. 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. (T-3)

3.12.9. Involvement in self-help recovery groups (e.g. 12-step, Rational Recovery, etc.) is encouraged as an adjunct to treatment. The frequency of attendance is determined by the TT with the patient. (T-3)

3.12.10. Commander (or First Sergeant) and supervisor involvement in the TT at key points in the patient's treatment and recovery is important.

3.12.11. Determinations about a patient's availability for PCS or TDYs will be coordinated through the TT during the patient's course of treatment. (T-3) Generally, patients diagnosed with substance use disorders are restricted from worldwide duty for their first six months of treatment. (T-3)

3.12.12. When patients PCS, (while in continuing care) the ADAPT staff will forward one copy of the AD patient's outpatient MH record (if a hard copy record exists) to the gaining base's outpatient MH clinic to ensure continuity of care is maintained. (T-2) See AFI 44-172 for additional information.

3.13. Referrals made by ADAPT Program staff.

3.13.1. Referral to MH. When indicated, ADAPT Program staff will refer patients to outpatient MH for treatment of co-morbid concerns. (T-1)

3.13.2. Referral to Medical. ADAPT Program staff will coordinate any referrals to Primary Care or Flight Medicine (for members on flight status) for medical conditions or coordinate with a medical provider when a psychiatrist is not on staff for the use of clinical pharmacological treatments in conjunction with ADAPT treatment and continuing care (aftercare). (T-1)

3.13.3. Referral to Family Advocacy Program (FAP). If information is revealed that indicates child abuse or neglect, or spousal abuse, then ADAPT Program staff will make the appropriate referral to the FAP and other appropriate authorities. (T-0)

3.14. Treatment Team (TT). TT Composition, Roles, and Function.

3.14.1. The primary objective of the TT is to guide the clinical course of treatment of the patient after examining all the facts. The TT Meeting (TTM) will be held within 14 calendar days of the initial assessment appointment. (T-1)

3.14.1.1. The ADAPT PM, in consultation with the TT, makes a treatment decision(s) within 14 calendar days of the patient's assessment in the ADAPT Program. Reasons for delays must be documented in the MH record and conveyed to the commander. (T-1)

3.14.2. Membership of TT includes: (T-1)

3.14.2.1. Commander and/or First Sergeant. (T-1)

3.14.2.2. Patient's immediate supervisor. (T-1)

3.14.2.3. ADAPT PM, or a privileged MHP with administrative oversight responsibility for the ADAPT Program. (T-1) The ADAPT PM, or privileged MHP, chairs the TTM and determines the clinical course of treatment for patients in the ADAPT Program. (T-1)

3.14.2.4. CADCs, MH technicians, or privileged MH providers involved in the case. (T-1)

3.14.2.5. Medical providers as needed (e.g. primary care managers). If the patient is on flight status, a flight surgeon will be included in the TTM. Refer to AFI 48-123, *Medical Examinations and Standards*, for further guidance. (T-1)

3.14.2.6. Other individuals as deemed necessary. (T-1)

3.14.2.7. The patient, unless deemed clinically inappropriate. In this case, the patient will be briefed on the treatment decisions of the TT. (T-1)

3.14.3. CC (or First Sergeant) and supervisor must be involved at program entry, termination, and any time there are significant treatment difficulties with the patient. (T-0) ADAPT staff must brief CCs (or first sergeant) on patient progress at least quarterly either – telephonically, individually, or within the TT. (T-0) Per DoD guidance, the CC must be involved in the patient's treatment (and continuing care (aftercare)) program (T-0)

3.14.4. TTMs must be mindful of protecting patient privacy to the greatest extent possible while still allowing for meaningful review. (T-0) Only information pertinent to treatment decisions should be shared with the TT. (T-0) The patient should be informed about the purpose of the TT and the nature of the information that will be shared. (T-0) ADAPT staff will brief the CC/First Sergeant/supervisor about privacy of patient's information and document a verbal non-disclosure agreement. (T-0)

3.14.5. Treatment Planning. The primary purpose of the treatment plan is to establish the frame work for the patient's treatment and recovery. 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 patient's course of treatment. (T-0)

3.14.5.1. The treatment plan will be comprehensive, individual-specific, and stated in behavioral terms. (T-0)

3.14.5.2. Treatment plans will be reviewed at each individual session to ensure that the plan reflects status of the patient's progress toward effective SUD recovery and stabilization of other identified clinical issues. (T-1)

3.14.5.3. Patients will adhere to the treatment plan developed by the TT. (T-1)

3.15. Detoxification.

3.15.1. Patients being referred for inpatient treatment will be assessed to determine the level of detoxification services required (e.g. Level 1-WM – Level 4-WM). (T-0) When medically indicated, patient detoxification will be managed on an outpatient basis prior to inpatient or residential treatment. (T-0)

3.15.2. Patients assessed as requiring medically managed detoxification (inpatient) will be entered into an appropriate medical facility. (T-0)

3.15.3. All patients utilizing aeromedical evacuation services must have 72 hours of monitored abstinence (inpatient or outpatient) prior to departure. (T-1)

3.16. Continuity of Care in Treatment.

3.16.1. ADAPT Program staff will communicate with the non-AF Intensive Outpatient (IOP), Partial Hospitalization Program (PHP), residential, or inpatient treatment facility to ensure continuity of care before, during and after any treatment received and document interaction in the ADAPT patient record. (T-1)

3.16.2. Local patients referred to a PHP, residential, or inpatient program 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. (T-0)

3.16.3. Considerations following IOP, PHP, Residential or Inpatient Treatment Completion.

3.16.3.1. Patients will be seen for a face-to-face visit the same day whenever possible, but NLT the next duty day after discharge from inpatient, residential, PHP or IOP treatment programs. This includes discharges from DoD or civilian facilities. (T-1) At a minimum, a relapse prevention plan will be created (or reviewed if created prior to discharge) and agreed upon. (T-1) Suicide risk will also be assessed at this visit and a follow-up visit will be scheduled. (T-1) Patients discharged from inpatient, residential or PHP will be placed on High Interest and monitored over a sufficient period of time and removed from High Interest IAW AFI 44-172. (T-1) 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.). (T-1)

3.16.3.2. Patients returning from an IOP, PHP, residential or inpatient treatment facility will have a TT meeting convened within 14 calendar days of return to assess the patient's progress during inpatient or residential treatment and design a continuing care (aftercare) plan. (T-1) Decisions regarding continuing care (aftercare) services will be based on a current assessment of status and will include establishment of a continuing care treatment plan identifying specific goals, interventions, and means to assess interventions. (T-0)

3.16.3.3. The ADAPT staff will request a summary from the treatment facility and include it in the record IAW 44-172 and advise the command of all relevant treatment outcomes. (T-1)

3.16.4. Use of pharmacological treatments, such as Naltraxone, Disulfiram, Acamprosate, etc., will be strictly monitored by the psychiatrist or other physician who has prescribed the medication, and/or the physician assigned to monitor patients within the ADAPT Program. (T-1) The ADAPT Program staff will communicate with all providers to ensure continuity of treatment. (T-1)

3.16.5. Long-Term Inpatient/Residential Substance Use Treatment. Whenever possible and appropriate, military inpatient or residential substance use treatment facilities will be used for

service members for long-term treatment. (T-0) National Defense Authorization Act for Fiscal Year 2010, Section 596 prohibited services from using contract facilities for long-term inpatient or residential substance use treatment of AD members for periods exceeding 30 days. (T-0)

3.17. Continuing Care (Aftercare) Program.

3.17.1. Upon completion of the treatment section of the ADAPT Program (e.g. Outpatient, IOP, PHP, etc.), the member will begin a period of continuing care (aftercare). (T-0) A TTM will convene to create a continuing care (aftercare) plan. (T-0) All patients who completed treatment will participate in continuing care (aftercare) as part of the ADAPT Program. (T-0)

3.17.2. Movement of patients into continuing care (aftercare) is not determined simply by completing the outpatient, IOP, PHP, inpatient or residential treatment. Continuing care (aftercare) does not begin until all goals of the treatment plan are met. (T-1) Once these goals are met, the patient is moved into continuing care (aftercare). (T-1)

3.17.3. Continuing Care (Aftercare) requirements.

3.17.3.1. Patient's progress will be monitored by the ADAPT staff at least every 30 days while the patient is in continuing care (aftercare). (T-0)

3.17.3.2. The goal of continuing care is to ensure any new goals are addressed, the patient does not need to be returned to treatment, and a relapse prevention plan is implemented and proceeding smoothly. (T-1)

3.17.4. CCs will ensure that AD personnel with a drug history undergo monthly random drug testing for one year following their most recent discharge from a treatment program. Those with special duty requirements may have additional drug monitoring standards imposed by professional boards or DoD policy. (T-0)

3.18. Program Completion and Program Failure.

3.18.1. Program Completion. Patients will not be considered to have successfully completed the ADAPT Program until the patient has completed treatment and continuing care (aftercare). (T-0) The TT determines, based on VA/DoD Clinical Practice Guidelines for Management of Substance Use Disorders, current DSM criteria and ASAM PPC, patient's progress towards agreed upon goals and/or issues as stated in the treatment and continuing care (aftercare) plans, when the patient no longer requires program resources. (T-0)

3.18.1.1. ANG members who are referred by the ADAPT PM to a non-military provider/agency for substance use disorder treatment will not be considered to have successfully completed the ADAPT Program until the member has completed treatment and continuing care (aftercare). (T-0) The TT determines, in coordination with GMU personnel, based on VA/DoD Clinical Practice Guidelines for Management of Substance Use Disorders, current DSM criteria and ASAM PPC, patient's progress towards agreed upon goals and/or issues as stated in the treatment and continuing care (aftercare) plans, when the patient no longer requires program resources. (T-0)

3.18.1.2. ANG members who have not been entered into the ADAPT Program will be referred to the DPH for case management services. (T-1)

3.18.2. Program Failure. The TT determines a patient to have failed the program based on a demonstrated pattern of unacceptable behavior, unwillingness to engage with the ADAPT Program after having an ARM, inability or unwillingness to comply with their treatment plan, or involvement in ARMs after receiving initial treatment. (T-0) 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. (T-0) Individuals who have been determined as failing the ADAPT Program shall be considered for administrative separation by their CC. (T-0)

3.18.2.1. If a patient is failed from the ADAPT Program and is awaiting discharge from the AF, the patient should be offered services until s/he is discharged. (T-1) If the patient refuses this continued support, the command should be notified so leadership can ensure safety of the individual. (T-1) This would provide the patient with transition services that are required. (T-0) These visits would be used to support patients in their transition to the civilian world and help ensure safety of the patient during a stressful time.

3.18.2.2. A member that has previously failed the ADAPT Program and has a subsequent ARM is not mandated to enter the program again. Entering the program will be at the discretion of the TT, with the ultimate decision made by the Program Manager. (T-1) At a minimum, a safety assessment should be conducted and if needed, further services should be provided in regards to patient safety. (T-1)

3.18.2.3. Individuals being processed for separation will be provided appropriate medical care prior to separation. (T-0) Separation action will not be postponed because of a members participation in the ADAPT Program. (T-0)

3.18.2.3.1. ANG members who are eligible for military treatment services will be provided appropriate medical care prior to separation. (T-0) Separation action will not be postponed because of a member's participation in the ADAPT Program. (T-0)

3.18.2.4. For ANG, the TT will be convened telephonically with the ANG Behavioral Health Consultant to determine if a patient has failed the program based on a demonstrated pattern of unacceptable behavior, unwillingness to engage with the GMU or ADAPT Program after having an ARM, inability or unwillingness to comply with their treatment plan, or involvement in ARMs after receiving initial treatment. (T-1) The ADAPT PM will coordinate with non-military providers for ANG members who have been referred for treatment to determine program outcome. (T-1) ANG members who have been determined as failing the ADAPT Program shall be considered for administrative separation by their CC. (T-1)

3.19. Additional Treatment and Continuing Care (Aftercare) Considerations.

3.19.1. Airmen who are in treatment and continuing care (aftercare) should be carefully assessed by the TT for mobility restrictions. (T-1) When appropriate, the PM, with input from the TT, should complete a mobility restricting profile during the period of treatment and continuing care (aftercare). (T-1) Any patient with a SUD diagnosis should be placed on a mobility restricting profile during treatment. (T-1) If a patient needs continuing care (aftercare), s/he should not be allowed to deploy. (T-1) If the TT determines, after a stable period of time in continuing care (aftercare), the patient could deploy with no follow-up

services, then the patient could be deployed. (T-1) The final recommendation on mobility status is made by the ADAPT PM. (T-1)

3.19.1.1. Duty limitations (which can include restrictions for military occupation, mobility, and/or fitness) are entered on the AF Form 469 IAW AFI 10-203. (T-1) Any DLC which restricts mobility or may be unfitting for continued military service must undergo an Initial RILO at HQ AFPC Medical Retention Standards Branch (DPANM), or the appropriate ARC Chief of Aerospace Medicine (SGP), after 365 cumulative days of restrictions documented on an AF Form 469 related to that condition IAW AFIs 48-123 and 41-210. (T-1) Airmen with an Assignment Availability Code (AAC) 31 (mobility restriction greater than 30 days) that exceeds, or is reasonably expected to exceed, 365 days (cumulative for same or related condition) require review by the installation Deployment Availability Working Group (DAWG) with referral, if indicated, to DPANM or Air Reserve Component (ARC) SGP for Initial RILO, unless discussed with DPANM or ARC SGP. (T-1)

3.19.1.2. Aeromedical Services Information Management System (ASIMS) will be used to monitor Clients' Profiles in Treatment. (T-1) The ADAPT PM will ensure that any mobility restrictions are noted and that profiles recommendations are completed IAW AFI 10-203 & AFI 48-123. (T-1)

3.19.1.3. The ADAPT PM or CADC 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. (T-1) Guidance concerning the use of DLC can be found in AFI 10-203, Duty Limiting Conditions, and AFI 48-123, Medical Examinations and Standards. (T-1)

3.19.2. PCS. Patients making minimal or unsatisfactory progress in recovery should not be allowed to proceed on TDYs or a PCS, except for mandatory PCS moves. (T-1) The TT will recommend to the commander that the individual not be released. (T-1) At times, exceptional circumstances may warrant other approaches. (T-1)

3.19.3. 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. (T-1)

3.20. Special Duty Assignments or Designations\Members on Flight Status\Providers.

3.20.1. Special Duty Assignments or Designations. Decisions regarding access to classified material, security clearances, PRP, PSP, or other special duty (other than flying) will be determined by governing instructions for each program (e.g. DoDDs, DoDIs, AFIs, etc.). (T-0)

3.20.2. Flight Status. When a flight surgeon suspects a member on flying status of having a substance use problem, he or she is required to inform the member's commander and to refer him/her to ADAPT for an evaluation. (T-1) If the member is diagnosed with a SUD, there are specific guidelines that must be followed including completion of treatment and continuing care (aftercare) program meeting timeframe requirements. (T-1) See AFI 48-123 and AF Waiver Guide for additional information and guidance. (T-1)

3.20.3. Impaired Privileged/Non-Privileged Providers. A provider may seek assistance for issues involving the abuse or misuse of substances voluntarily or involuntarily. Impaired providers typically require a specialized treatment program given the unique requirements of being a healthcare provider receiving treatment for a SUD. (T-1) If there is an ARM and the provider is seen in ADAPT or if the provider is diagnosed with a SUD, there are specific guidelines regarding AF credentialing that must be followed, as well as state licensing issues that must be considered. (T-1) See AFI 44-119 for additional information and guidance. (T-1) In order to ensure a provider who has completed the ADAPT program has continued to abstain from alcohol or prescription drugs, the provider will be randomly tested at the request of the commander for up to three years from completion of treatment, as a condition of privileging, and for non-privileged providers their continuation to provide patient care. (T-3)

3.21. Program Evaluation.

3.21.1. Each ADAPT Program will implement a comprehensive evaluation of their clinical services that includes data collection from ADAPT clients receiving services on substance use and misuse, as well as the operation of SUD services. (T-0) ADAPT Program staff will utilize the data collected to make improvements to all aspects of the ADAPT Program including the prevention efforts. (T-0) This critical part of the ADAPT Program is essential for improving care for all ADAPT patients and recipients of prevention services. (T-0)

3.21.2. Evaluation of the ABC Program (Level 0.5): In an effort to assess alcohol misuse and the impact of the ABC intervention, personnel participating in the ABC Program will complete assessments pre- and post- intervention. (T-0) As part of the SUAT, patients will complete the AUDIT. (T-0) In addition to the AUDIT, patients will be asked to complete a questionnaire standardized at AFMOA at 3 months that assesses the patient's substance use and misuse, as well as learning objectives from the program, their perceptions of the content of intervention, and the satisfaction with the intervention and the staff. (T-0)

3.21.3. AFMOA will track the following information, on at least a quarterly basis: (T-0)

3.21.3.1. Prevalence and incidence of SUD (e.g. alcohol use disorder mild, moderate or severe, etc.) at each base. (T-0)

3.21.3.2. The number of personnel receiving treatment, set apart by severity of specific diagnoses (must be able to track diagnosis and severity by month, by quarter, by year). (T-0)

3.21.3.3. Active duty retention status (e.g. return to duty, separated) at time of discharge from treatment. (T-0)

3.21.3.4. Program referral type (e.g. self, command, medical). (T-0)

3.21.3.5. Number of patients who successfully completed the ABC Program. (T-0)

3.21.3.6. Number of patients who were treated in outpatient, IOP, PHP, rehabilitation, and inpatient programs. (T-0)

3.21.3.7. Number of patients who successfully completed the treatment and aftercare programs. (T-0)

3.21.4. During continuing care (aftercare), a standardized measure provided by AFMOA will be utilized at 3, 6, and 12 months post-treatment to assess patients' substance use and misuse,

as well as current work performance, ability to cope, their perceptions of the content of interventions, and the satisfaction with treatment, aftercare and the staff. (T-1) Follow-up assessments at 3, 6, and 12 months are to be completed using the survey monkey assessments developed by AFMOA. (T-3)

3.21.4.1. 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. (T-3)

3.21.5. AFMOA will track referrals by type and will also monitor for a reoccurrence of ARM following ABC, as well as following continuing care (aftercare) (T-0)

3.22. Training.

3.22.1. Training Mission. The ADAPT Program'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. (T-1)

3.22.2. Alcohol and Drug Abuse Prevention and Treatment Program Managers (ADAPT PMs).

3.22.2.1. ADAPT PMs are responsible for ensuring they are competent for their duties. (T-0) This means they must obtain the appropriate education and supervision needed to develop and maintain competency in substance misuse assessment, prevention, and treatment. (T-0) Competency will be defined by the provider's experience, consultation with supervisors, training and their own ethical and licensure requirements. (T-0)

3.22.2.2. Lack of clinical experience or course work in substance misuse does not preclude a provider from working in the ADAPT Program. (T-2) 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. (T-1)

3.22.2.3. If additional ADAPT PM 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.

3.22.2.4. 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 Alcohol and Drug Counselor Certification Handbook. (T-0) The ADAPT PM will 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. (T-0)

3.22.2.4.1. Education plans and goals will be tailored to individual needs. (T-0)

3.22.2.4.2. Content will focus on evidence-based assessment, prevention and treatment approaches to reduce alcohol and drug misuse. (T-0)

3.23. Certified Alcohol and Drug Counselors (CADCs).

3.23.1. CADCs are responsible for ensuring they maintain their competencies and continuing education requirements to maintain their certification. (T-0)

3.23.2. Responsibilities include oversight and supervision of non-CADC MH technicians to help them develop the skills and competencies required for certification. (T-0)

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General

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

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- 10 U.S.C. 1090, Identifying and treating drug and alcohol dependence
- 42 U.S.C. 290dd-2, Confidentiality of records
- AF Alcohol and Drug Abuse Prevention and Treatment Tier II: Alcohol Brief Counseling, Counselor's Manual
- AF Alcohol and Drug Counselor Certification Handbook, September 2010
- AFI 36-2235, *Information for Designers of Instructional Systems*, 2 September 2002
- AFI 10-203, *Duty Limiting Conditions*, 15 Jan 2013
- AFI 31-501, *Personnel Security Program Management*, 27 January 2005
- AFI 33-332, *Privacy Program*, 4 June 2012
- AFI 33-360, *Publications and Forms Management*, 25 Sept 2013
- AFI 36-2254, *Volume 1, Reserve Personnel Participation*, 26 May 2010
- AFI 36-2254, *Volume 2, Reserve Personnel Training*, 9 June 2010
- AFI 41-210, *Tricare Operations and Patient Administrative Functions*, 6 Jun 2012
- AFI 44-107, *Air Force Civilian Drug Demand Reduction Program*, 7 April 2010
- AFI 44-119, *Medical Quality Operations*, 16 Aug 2011
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- AFI 48-123, *Medical Examinations and Standards*, 5 Nov 2013
- AFI 90-501, *Community Action Information Board and the Integrated Delivery System*, 15 Aug 2013
- AFPD 44-1, *Medical Operations*, 1 September 1999
- AF Records Disposition Schedule in AF Records Information Management System (AFRIMS), T 41-12 R 12.00, records disposition schedule for Substance Abuse Records (Active Duty, Retired and Family Members), 22 June 2010
- Air Force Waiver Guide, 4 April 2013
- ASD (HA) Policy OSD (HA) Memorandum On TRICARE Substance Abuse Treatment, 13 Feb 1997
- Assistant Surgeon General Health Care Operations Memorandum, *Long-Term Inpatient/Residential Substance Use Treatment*, September 27, 2012
- DoD Directive 1010.4, *Alcohol and Drug Abuse by DoD Personnel*, Sept 3, 1997

DoD Directive 1010.6, *Rehabilitation and Referral Services for Alcohol and Drug Abusers*, March 13, 1985

DoD Directive 1010.9, *DoD Civilian Employees Drug Abuse Testing Program*, January 20, 1992

DoD Directive 5210.42-R_AFMAN 10-3902_AFGM1, *Nuclear Weapons Personnel Reliability Program (PRP) Regulation*, July 16, 2010

DoD Directive 5400.07, *DoD Freedom of Information Act (FOIA) Program*, January 2, 2008

DoD Instruction 1010.04, *Problematic Substance Use by DoD Personnel*, 20 Feb 2014

DoD Instruction 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service members*, Aug 17, 2011

DoD 6010.13-M, *Medical Expense and Performance Reporting System For Fixed Military Medical and Dental Treatment Facilities Manual*, April 9, 2008

Diagnostic and Statistical Manual of Mental Disorders (4th Edition) – Text Revision (DSM-IV-TR), 2000

Diagnostic and Statistical Manual of Mental Disorders (5th Edition) – Text Revision (DSM-5), 2013

Executive Order 9397, *Numbering System for Federal Accounts Relating to Individual Persons* 22 Nov, 1943

Executive Order 11478, *Equal employment opportunity in the Federal Government*, August 8, 1969

National Defense Authorization Act for Fiscal Year 2010 (NDAA 2010), Section 596

Surgeon General NOTAM 10-014, *Recognition & Treatment of Impairment in Medical Professionals*, November 2010

The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition, 2013

United States Air Force Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program Guide

VA/DoD Clinical Practice Guideline: *Management of Substance Use Disorders* (2009)

VA/DoD Substance Use Disorder Pocket Guide (2011)

Prescribed Forms

None.

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*

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

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

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

ASIMS—Aeromedical Services Information Management System

BAT—Blood Alcohol Test

CADC—Certified Alcohol and Drug Counselor

CAIB—Community Action Information Board

CBC—Complete Blood Count

CC—Commander

CCQAS—Centralized Credentials Quality Assurance System

CDT—Carbohydrate Deficient Transferrin

CMP—Comprehensive Metabolic Panel

CFETP—Career Field Education and Training Plan

DAWG—Deployment Availability Working Group

DDR—Drug Demand Reduction

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

FOA—Field Operating Agency

FOIA—Freedom of Information Act
GGT—Gamma-glutamyl transpeptidase
GMU—Guard Medial Unit
GSU—Geographically Separated Unit
HbA1c—Hemoglobin A1c
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
NCO—Noncommissioned Officer
NGB—National Guard Bureau
PCS—Permanent Change of Station
PPC—Patient Placement Criteria
PRP—Personnel Reliability Program
QTP—Qualification Training Package
RC/CC—Responsible Center/Cost Center
RMU—Reserves Medical Unit
SG—Surgeon General
SJA—Staff Judge Advocate
SOAP—Subjective, Objective, Assessment, Plan (case note format)
SUAT—Substance Use Assessment Tool
SUD—Substance Use Disorder
TT—Treatment Team
TTM—Treatment Team Meeting
TDY—Temporary Duty Assignment

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.

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—See DSM-IV-TR for diagnostic criteria.

Alcohol Dependence—See DSM-IV-TR for diagnostic criteria.

Alcohol—Related Misconduct (ARM)—This type of conduct includes driving while intoxicated, public incidents of intoxication and misconduct, underage 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.

Centralized Credentials Quality Assurance System (CCQAS)—A web based software application for credentials, privileging, adverse action and risk management database utilized within DoD. The CCQAS software assists the credentials and risk managers with the control of credentials, managing the credentialing/privileging process, adverse actions, medical malpractice claim process, report generation, letter generation, MTF to MTF transfer of the electronic PCF, and inter-facility transfer briefs. MTF credentials and risk managers use CCQAS information for generating DoD and congressional reports, personnel management, quality assurance, and for performance improvement activities.

Certified Alcohol and Drug Counselor (CADC)—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). CADCs can also be officers. 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. See the AF Alcohol and Drug Counselor Certification Handbook for additional requirements to become a CADC.

Clinical Treatment—Services designed for the treatment of patients diagnosed with alcohol abuse or alcohol dependence. These services include a wide range of programs including IOP, PHP, residential and inpatient programs.

Detoxification—A planned management of alcohol and drug withdrawal. Patients usually undergo medical detoxification on inpatient. 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.

Eyes-on supervision—Direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation before the patient departs the appointment.

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.

Patient placement criteria (PPC)—Standards of, or guidelines for, alcohol or other drug abuse treatment that describe specific conditions under which patients should be admitted to a particular level of care (admission criteria), under which they should continue to remain in that level of care (continued stay criteria), and under which they should be discharged or transferred to another level (discharge/transfer criteria). PPC generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on alcohol or other drug diagnosis and other specific areas of patient assessment.

Privileged Mental Health 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 regimens 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.

Selective prevention (from IOM)—For those who may have a higher likelihood of developing unhealthy drinking habits as a result of particular risk factors.

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

Substance Abuse—See DSM-IV-TR for diagnostic criteria.

Substance Dependence—See DSM-IV-TR for diagnostic criteria.

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

Attachment 2

SAMPLE MEMORANDUM FOR TRAINING

MEMORANDUM FOR TRAINING (Competency Assessment for CADC)

FROM: [Squadron/Flight]

SUBJECT: CADC Observation

1. I _____ observed _____ conduct
 (Provider/ADAPT PM) (CADC 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:

(CADC Signature)

(Provider/ADAPT PM Signature)

Attachment 3

ADAPT CLINIC MONTHLY PEER REVIEW

TABLE A3.1. ADAPT CLINIC MONTHLY PEER REVIEW.

ADAPT CLINIC MONTHLY PEER REVIEW								
Provider Reviewed:				MONTH/YEAR OF REVIEW				
Reviewer								
Type of Review (Check One)		Routine		Other				
(Y) Standard Met	(N) Standard Not Met		(N/A) Not Applicable					
<u>For any (N) standard not met, an MFR documenting legitimate and clinically sound reasons for the deviation will constitute a (Y) standard met</u>				Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN
<u>ADMINISTRATIVE REVIEW</u>								
1. All AHLTA encounters have matching ADAPT note (clinic note, t-con)								
2. All documentation is in the correct section of the file								
3. Privacy Act/ADAPT Patient Info Sheet/Informed Consent completed and signed								
4. Time duration of appointment documented on each note								
5. Was the PHQ-9 administered and scores documented at each visit								
6. 469 initiated and current copy filed in record								
7. Patient was seen at least monthly								
8. HIL/PRP/PSP/LPSP Cover Sheet completed and on top of notes								
9. SF 600 documentation of weekly reviews of High Interest status in record								
10. Referral form is in file								
11. 3-6-12 month outcome measures were given and on time								
12. CC/CCF and referral source were provided feedback on assessment results								
13. Supervisor comments noted								
14. Initial labwork was completed, printed, and reviewed by psychiatry or PCM, f/u if needed								
15. Additional labwork was documented and reviewed by psychiatry or PCM, f/u if needed								
16. Timelines: Assessment was completed within 7 calendar days of referral								

ADAPT CLINIC MONTHLY PEER REVIEW								
Provider Reviewed:				MONTH/YEAR OF REVIEW				
Reviewer								
Type of Review (Check One)		Routine		Other				
(Y) Standard Met	(N) Standard Not Met		(N/A) Not Applicable					
<u>For any (N) standard not met, an MFR documenting legitimate and clinically sound reasons for the deviation will constitute a (Y) standard met</u>				Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN
17.	Initial TTM was conducted within 14 calendar days of initial Assessment							
18.	TTM from Level I/II/III was within 14 calendar days of discharge							
19.	New tx Plans are created within 14 calendar days of Level I/II/III							
20.	AEM was conducted within 10 duty days of assessment							
21.	ABC & Change Plan was completed within 14 calendar days after initial assessment							
Technician Signature:								
<u>PROVIDER REVIEW</u>								
<i>INTAKE</i>								
1.	SUAT was used							
2.	SUAT intake report includes enough details to justify diagnosis							
3.	SUAT intake report includes enough details to justify treatment recommendations							
4.	Suicidal/homicidal risk is assessed appropriately and documented							
5.	Profile/WWQ/Deployment status are documented							
6.	Thorough bio-psycho-social assessment is documented							
7.	If relevant, management of risk is appropriate, to include assessment for withdrawal							
8.	MSE is documented							
9.	Follow-up plan is consistent with assessment and appropriate							
10.	Use of consultation /referral services is appropriate							
<i>HIGH INTEREST/INPATIENT TREATMENT</i>								
1.	Patients who attend Level II or higher or are							

ADAPT CLINIC MONTHLY PEER REVIEW								
Provider Reviewed:				MONTH/YEAR OF REVIEW				
Reviewer								
Type of Review (Check One)		Routine		Other				
(Y) Standard Met	(N) Standard Not Met		(N/A) Not Applicable					
<u>For any (N) standard not met, an MFR documenting legitimate and clinically sound reasons for the deviation will constitute a (Y) standard met</u>				Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN
entered to the HIL for the duration of their treatment and a minimum of 4 weeks following tx unless clinically indicated and agreed upon by the team in the MCCC.								
2. First sentence of subjective elements will state in capital letters "HIGH INTEREST" and/or "LPSP"								
3. High Interest staffing notes are completed weekly								
4. There is documentation of weekly contact with the treatment facility throughout the treatment phase								
5. The patient was seen weekly by MH or ADAPT while on HIL								
6. The patient was seen no later than the next duty day after discharge from Level II or higher								
7. High Interest Log/hospitalization Checklist was used								

<i>FOLLOW UP</i>					
1. SOAP note format is utilized. Notes are clear, legible, signed/stamped					
2. AFMOA approved f/u note template used					
3. AHLTA note includes brief description of treatment, progress, diagnosis, and enough information for continuity					
4. Current treatment/follow up is appropriate to diagnosis/goals/presenting concerns					
5. On-going risk of suicide/homicide is assessed appropriately and documented					
- If relevant, management of risk is appropriate					
6. Profile/WWQ/Deployment status are documented					
7. No shows/missed appointments are documented with reason and follow up with patient (and unit if unexcused)					
8. Use of consultation/referral services is appropriate					
9. Warning signs, risk & protective factors listed on all notes					
10. Risk assessment was completed (as clinically indicated) on all notes					
11. Risk level documented and justified by documentation on all notes					
<i>TREATMENT PLANS</i>					
1. Tx plans were developed for all patients seen on an ongoing basis					
2. Tx goals are individualized and clearly defined					
3. Tx plan has been agreed upon by patient and provider					
4. Tx plan was reviewed quarterly					
<i>TTMs</i>					
1. TTMs document CC/CCF/Flt Surgeon participation and addressed mobility/TDY/deployment/PCS					
2. Initial TTM documented program goals, expectations, grounds for failure and consequences of program failure					
3. Evidence in chart that members PCM were notified of TTM out-comes (ex: AHLTA notes co-signed, e-mail with read receipt, etc.)					
Discrepancies discussed? Y / N / NA					
Referred to Clinic Chief for resolution? Y / N / NA					

Attachment 4

HIGH INTEREST LOG/HOSPITALIZATION CHECKLIST

TABLE A4.1. HIGH INTEREST LOG/HOSPITALIZATION CHECKLIST.

Patient Name (last 4):	SSN:	Squadron:
CC:	CCF:	PCM:
CC Phone:	CCF Phone:	PCM Phone:
Primary MH Provider:		
Patient was placed on High Interest for the following reason(s): <input type="checkbox"/> Suicidal ideation / attempt / behavior <input type="checkbox"/> Homicidal ideation / intent <input type="checkbox"/> Psychiatric hospitalization <input type="checkbox"/> Risk for Psychological Decompensation <input type="checkbox"/> Inpatient Alcohol or Drug program <input type="checkbox"/> Intensive Outpatient Treatment <input type="checkbox"/> Other: _____		
HOSPITALIZATION (if not applicable, leave blank)	Date	Provider Initials
Notify CC/CCF (if AD)		
Completed Involuntary Hospitalization Procedures – (if AD Emergency CDE)		
Add patient to “HIGH INTEREST Log”		
Inform MTF commanders of admission (MDG/CC, SGH)		
Follow up at least weekly w/hospital for updates		
Provider received and reviewed the discharge summary from the hospital		
Patient was seen within one duty day after hospitalization discharge		
ADDING/MANAGING PATIENT TO/ON HIL	Date	Provider Initials
Patient notified he/she is entered on HIL		
Completed Crisis Response Plan		
Modify/Complete Treatment Plan to address safety		
HIL Notifications:		
Commander (AD only)		
PCM/ED/PRP/Flight Med, MH providers, MH Technicians		
DLC/Profile created in ASIMS. DLC expiration date (at least 90 days):		
AHLTA BH1/BH2 High Interest List Flag Created		
If suicide attempt: Met with SGH to review case, treatment plan, potential administrative actions (disqualifying diagnosis/MEB/CDE)		
Completed DoDSER (if applicable) within 30 days		
Conducted Treatment Team Meeting with CC/CCF/Patient		
Added patient into LPSP (if applicable)		

REMOVING PATIENT FROM HIL	Date	Provider Initials
Patient has had at least 4 consecutive weeks of documented risk stability		
Clinical justification for removal, discussed with peers and documented		
Date patient was removed from the HIL		
Patient notified he/she is removed from HIL		
Command notified patient removed from HIL		
PCM notified patient removed from HIL		
AHLTA BH1/BH2 High Interest List Flag Removed		