



# Department of Defense **INSTRUCTION**

**NUMBER** 1010.04

February 20, 2014

Incorporating Change 1, Effective May 6, 2020

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USD(P&R)

**SUBJECT:** Problematic Substance Use by DoD Personnel

**References:** See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)), this instruction:

a. Reissues DoDD 1010.4 (Reference (b)) as a DoD instruction (DoDI) and implements the requirements in section 596 of Public Law 111-84 (Reference (c)).

b. Establishes policies, assigns responsibilities, and prescribes procedures for problematic alcohol and drug use prevention, identification, diagnosis, and treatment for DoD military and civilian personnel.

c. Describes the relationship between the DoD and the Department of Veterans Affairs (VA) with regard to drug and alcohol use treatment.

d. Incorporates and cancels DoDI 1010.6 (Reference (d)) and Assistant Secretary of Defense for Health Affairs (ASD(HA)) Memorandum 97-029 (Reference (e)).

2. APPLICABILITY. This instruction applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this instruction as the "DoD Components").

3. POLICY

a. It is DoD policy to:

(1) Prevent and eliminate problematic substance use in the DoD. Such substance use is incompatible with readiness, the maintenance of high standards of performance, and military discipline.

(2) Return DoD personnel to full duty following substance use disorder (SUD) treatment whenever consistent with mission requirements.

(3) Ensure regular and systematic medical screening for at-risk substance use.

(4) Counsel and encourage employees who have substance use problems to seek treatment as necessary. Personnel actions for civilian employees must be taken in accordance with DoDI 1010.09 (Reference (f)) and chapter 75 of Title 5, United States Code (U.S.C.) (Reference (g)).

(5) Prohibit DoD personnel from unlawfully possessing, dispensing, selling, or using illicit drugs, prescription drugs, or other substances in a manner other than for their legally intended purpose in accordance with current laws, regulations, and DoD issuances.

(6) Prohibit DoD personnel from unlawfully possessing, selling, or using drug paraphernalia; prohibit the illegal possession or sale of drug paraphernalia at DoD resale outlets, including military exchanges, open messes, and commissaries, and by private organizations and concessions located on DoD installations and facilities under DoD control.

(7) Ensure DoD personnel will report to the cognizant security officer employees assigned to national security positions (i.e., eligibility for access to classified information or assignment to sensitive duties) who are involved in:

(a) Habitual or episodic use of intoxicants to excess; or

(b) Illegal or improper use, possession, transfer, sale or addiction to any controlled or psychoactive substance, narcotic, cannabis, or other dangerous drug in accordance with Executive Order 12968, DoD Manual 5200.02, and Under Secretary of Defense for Intelligence Memorandum (References (h), (i) and (j)).

(8) Ensure DoD Components make available evidence-based SUD services that adhere to the clinical practice guidelines, as published by a DoD/VA-sanctioned task force and accredited professional organizations specializing in the treatment of SUDs.

(9) Provide a comprehensive TRICARE SUD treatment benefit to all eligible beneficiaries.

(10) Promote technological approaches to evidence-based screening and interventions for substance use-related concerns.

b. Facilitates the adoption of minimum program outcome and process measures to compare programs and identify best practices and effective services through the guidance of the DoD

Addictive Substance Misuse Advisory Committee (ASMAC). The DoD ASMAC is comprised of DoD Component leaders and will act to coordinate substance use policy and resources across DoD as designated by its Charter (Reference (k)).

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. INFORMATION COLLECTION REQUIREMENTS. The DoD 2011 Health Related Behaviors Survey, referred to in paragraph 2b of Enclosure 2 of this instruction, has been assigned DD-HA(AR)2189 in accordance with the procedures in DoD Manual 8910.01 (Reference (l)).

7. RELEASABILITY. **Cleared for public release.** This instruction is available on the Directives Division Website at <https://www.esd.whs.mil/DD/>.

8. SUMMARY OF CHANGE 1. The change to this issuance updates references and removes expiration language in accordance with current Chief Management Officer of the Department of Defense direction.

9. EFFECTIVE DATE. This instruction is effective February 20, 2014.

  
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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
- (b) DoD Directive 1010.4, "Drug and Alcohol Abuse by DoD Personnel," September 3, 1997, as amended (hereby cancelled)
- (c) Section 596 of Public Law 111-84, "The National Defense Authorization Act for Fiscal Year 2010," October 28, 2009
- (d) DoD Instruction 1010.6, "Rehabilitation and Referral Services for Alcohol and Drug Abusers," March 13, 1985 (hereby cancelled)
- (e) Assistant Secretary of Defense for Health Affairs Memorandum, "Policy Memorandum on TRICARE Substance Abuse Treatment," February 13, 1997 (hereby cancelled)
- (f) DoD Instruction 1010.09, "DoD Civilian Employee Drug-Free Workplace Program," June 22, 2012, as amended
- (g) Chapter 75 of Title 5, United States Code
- (h) Executive Order 12968, "Access to Classified Information" August 4, 1995, as amended
- (i) DoD Manual 5200.02, "Procedures For The DoD Personnel Security Program (PSP)," April 3, 2017
- (j) Under Secretary of Defense for Intelligence Memorandum, "Implementation of Adjudicative Guidelines for Determining Eligibility for Access to Classified Information (December 29, 2005)," August 30, 2006
- (k) DoD Addictive Substance Misuse Advisory Committee, "Charter," February 14, 2011<sup>1</sup>
- (l) DoD Manual 8910.01, "DoD Information Collections Manual," June 30, 2014, as amended
- (m) Executive Order 12564, "Drug-Free Federal Workplace," September 15, 1986
- (n) Title 49, Code of Federal Regulations
- (o) DoD Instruction 5400.11, "DoD Privacy and Civil Liberties Programs," January 29, 2019
- (p) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
- (q) DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," August 17, 2011
- (r) DoD Instruction 1010.16, "Technical Procedures for the Military Personnel Drug Abuse Testing Program (MPDATP)," October 10, 2012, as amended
- (s) DoD Instruction 1010.01, "Military Personnel Drug Abuse Testing Program (MPDATP)," September 13, 2012, as amended
- (t) DoD Instruction 1332.14, "Enlisted Administration Separations," January 27, 2014, as amended
- (u) DoD Instruction 1332.30, "Enlisted Administrative Separations," January 27, 2014, as amended
- (v) American Psychiatric Association, "Diagnostic and Statistical Manual of Mental Disorders (DSM)," current edition

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<sup>1</sup> Addictive Substance Misuse Advisory Committee Charter can be obtained by contacting Defense Health Agency, Clinical Support Division, 7700 Arlington Boulevard, Suite 5101, Falls Church, VA 22402.

- (w) National Center for Health Statistics, “International Classification of Diseases, Clinical Modification,” current edition
- (x) Chapter 47 of Title 10, United States Code (also known as “The Uniform Code of Military Justice (UCMJ)”)
- (y) Public Law 98-24, “Alcohol and Drug Abuse Amendments of 1983,” April 26, 1983
- (z) Section 290dd-2 of Title 42, United States Code
- (aa) DoD Instruction 4515.13, “Air Transportation Eligibility,” January 22, 2016, as amended
- (ab) DoD Instruction 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS),” February 27, 2011, as amended
- (ac) DoD Manual 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS),” October 29, 2013
- (ad) Public Law 96-22, “Veterans Health Care Amendments of 1979,” June 13, 1979
- (ae) Public Law 97-174, “Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act,” May 4, 1982
- (af) Part 199.3 of Title 32, Code of Federal Regulations
- (ag) Title 21, United States Code

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R):

- a. Develops and distributes policies to prevent and detect problematic substance use by DoD military and civilian employees.
- b. Develops and distributes policies that encourage civilian employees who are problematic substance users to seek treatment and return to full duty.
- c. Monitors and coordinates all DoD activities that implement Executive Order 12564 (Reference (m)), and the drug abuse provisions of parts 40 and 382 of Title 49, Code of Federal Regulations (CFR) (Reference (n)).
- d. Establishes DoD substance use policies.
- e. Establishes policies on substance use prevention programs for DoD dependent schools.
- f. Coordinates strategic inter-agency efforts on behalf of DoD for the prevention and treatment of problematic substance use.

2. ASD(HA). Under the authority, direction, and control of the USD(P&R), the ASD(HA):

- a. Develops and distributes SUD treatment program guidance.
- b. Sponsors epidemiological studies to assess the extent of alcohol and drug use and related health behaviors among military personnel in both the Active and Reserve Components.
- c. Uses the DoD ASMAC to oversee DoD Component program measures to evaluate the extent to which prevention services meet organizational needs and program goals.
- d. Ensures that substance use services are provided to eligible beneficiaries in a manner that recognizes cultural and gender-specific issues.
- e. Makes available substance use prevention and treatment services necessary to meet the needs of Military Health System (MHS) beneficiaries.
- f. Reviews and revises TRICARE benefits to ensure entitlements are consistent with current science and practices in the treatment of SUDs.



g. In coordination with the Under Secretary for Health, VA and the Assistant Secretary of Defense for Reserve Affairs, implements programs to ensure coordinated SUD treatment for activated Reserve Component personnel who are demobilizing.

3. DoD COMPONENT HEADS. The DoD Component heads:

a. Establish and enforce policies by or under the authority of this instruction, and implement and regularly evaluate any programs established under this instruction.

b. Ensure that program and policy goals and guidelines specified in this instruction are reflected in DoD Component policies.

c. Educate DoD personnel about health and other risks to military readiness associated with problematic substance use and train healthcare personnel to prevent, diagnose, and treat SUDs.

d. Provide DoD personnel with information on departmental policies related to problematic substance use.

e. Ensure that commanders and healthcare personnel receive annual training on the identification, assessment, and referral of personnel displaying signs of problematic substance use and the services that are available for treatment.

f. Ensure that personnel protect beneficiaries' privacy and personally identifiable information provided pursuant to this instruction, DoDI 5400.11 (Reference (o)), and DoD 5400.11-R (Reference (p)).

g. Ensure that employees are notified of the impact of substance use on continued security eligibility. In accordance with Reference (j), supervisors must notify their security official of employees in national security positions who:

(1) Have habitually or episodically used intoxicants in excess; or

(2) Are involved in the illegal or improper use, possession, transfer, sale, or addiction to any controlled or psychoactive substance, narcotic, cannabis, or other dangerous drug.

h. Use empirically validated training and education programs to prevent problematic substance use on installations and facilities under DoD control.

i. Identify employees who are problematic substance users and provide assessment, intervention, and treatment, as appropriate.

4. SECRETARIES OF THE MILITARY DEPARTMENTS. In addition to the responsibilities listed in section 3 of this enclosure, the Secretaries of the Military Departments:

a. Dispel the stigma of seeking services for concerns related to problematic substance use by implementing notification practices that are consistent with DoDI 6490.08 (Reference (q)), including the limitations on the amount of information provided to command when command notification is appropriate.

b. Prohibit the recruitment and hiring of military personnel (or civilian employees) into the DoD who are actively impaired by an SUD. The policy on military applicants or new entrant testing and dependency evaluation is described in DoDI 1010.16 (Reference (r)) and DoDD 1010.01 (Reference (s)).

c. Analyze data to permit internal assessment and review of:

- (1) Prevalence and incidence of SUDs.
- (2) The number of personnel receiving treatment, set apart by diagnoses.
- (3) Active duty retention status (e.g., return to duty, separated) at time of discharge from treatment.
- (4) Program referral type (e.g., self, command, medical).
- (5) Annual adult screening with an empirically validated instrument for at-risk alcohol use.
- (6) Substance use trends, as determined by the ASMAC.

d. Develop and train personnel on DoD and Service substance use policies.

e. Assign Service medical departments the primary responsibility for the provision of SUD treatment within the direct care system.

f. Initiate administrative actions against Service members who do not meet retention standards established by the Military Services for SUDs.

(1) Separation of Service members who do not comply with the retention standards established by the Military Services must be in accordance with DoDI 1332.14 (Reference (t)) or DoDI 1332.30 (Reference (u)).

(2) Policies must distinguish between disciplinary actions resulting from violations of the law and treatment related administrative actions, such as compliance with treatment plans or adherence to retention standards.

(3) Administrative separation of active duty and Reserve Component Service members need not be delayed as a result of their participation in treatment. However, when determining the date of discharge, commanders should weigh the benefits of the Service member completing treatment prior to discharge against any disruption to the good order and discipline of the unit.

g. Ensure that Service members (or DoD civilian personnel) diagnosed with an SUD who do not adequately engage in treatment services as medically prescribed, or who persistently fail to attend appropriate follow-up or aftercare services and continue to be impaired by an SUD, are considered for separation from Service or termination of employment.

h. Coordinate treatment and referral services with other military programs serving populations at high risk for problematic substance use, such as programs for child and spouse maltreatment, exceptional family member programs, and hospitals' medical and surgical services.

i. Train all medical providers to recognize signs and symptoms of problematic substance use and the available services for providing treatment.

j. Maximize the coordination of care between SUD treatment and other forms of mental health care.

ENCLOSURE 3

PROCEDURES

1. SUBSTANCE USE EDUCATION AND AWARENESS

a. Overview. Substance use education and awareness activities provide information intended to prevent or reduce problematic substance use. Universal community approaches to education and awareness activities aim to reduce community substance use trends. Targeted education and awareness activities provide DoD personnel who have been identified as using substances problematically, but who do not meet the criteria for having an SUD, with information intended to reduce problematic substance use.

b. Community Prevention Program Goals

(1) Foster the recognition of problematic substance use and its harmful effects for Service members, their families, and communities.

(2) Encourage early identification of personnel engaged in problematic substance use through comprehensive prevention strategies and education.

(3) Ensure personnel who have used substances problematically, but do not meet the diagnostic criteria for having an SUD, receive education from local medical personnel.

c. Program

(1) Substance use awareness and education will be provided to all DoD personnel.

(2) Universal community education and awareness campaigns will address identified substance use trends.

(3) Selective prevention services address the needs of personnel who are at risk for problematic substance use and abuse, as identified by DoD-approved studies.

(4) Education and awareness services address the needs of personnel who have been identified as problematic substance users.

d. Program Guidelines

(1) DoD personnel who have been identified as engaging in problematic substance use will undergo a comprehensive assessment for an SUD by authorized medical personnel before receiving substance use education services.

(2) Substance use education services for problematic substance users provide information to Service members and DoD employees to encourage the modification of behaviors

and reinforce individual attitudes and behaviors that are consistent with healthy drinking limits. Training and education will at least consist of:

- (a) Strategies for responsible alcohol use and the proper use and management of prescription medications.
  - (b) Identification of major classifications and types of controlled substances and their social, physical, and psychological impact on the user.
  - (c) Information related to the progressive nature of the disease of SUDs.
  - (d) Identification of early warning signs of problematic substance use behaviors.
  - (e) Referral and resource information on education and treatment services.
- (3) Substance use awareness and education efforts will address current trends in problematic substance use.
- (4) Medical providers will receive annual education on current trends and practices in the identification, assessment, and referral of personnel at risk for substance use related problems, including the interpretation and use of the alcohol screening instrument Alcohol Use Disorders Identification Test, Alcohol Consumption Questions (AUDIT-C).
- (5) Commanders will receive annual training on the identification, management, and treatment of personnel with an SUD.
- (6) Command notification is not required for Service members who self-refer for substance use education services in accordance with Reference (q).

## 2. ALCOHOL USE SCREENING

a. Overview. Annual adult screening for at-risk alcohol use for beneficiaries enrolled in military treatment facility (MTF) primary care medical settings is an essential component of educating and identifying personnel who may be at risk for developing problems related to their alcohol use.

### b. Primary Care Medical Setting Goals

- (1) Promote health and readiness through the early identification of risky alcohol use.
- (2) Provide early opportunities for MTF healthcare providers to intervene with enrolled beneficiaries who are at-risk for an alcohol use disorder, as clinically indicated.

c. Program

(1) Screening and intervention for at-risk alcohol use in adults will adhere to the clinical practice guidelines, as published by a DoD and VA-sanctioned task force or accredited professional organizations specializing in the treatment of SUDs, and will be performed at least annually in primary care medical settings.

(2) Healthcare providers, including behavioral health personnel assigned to primary care settings, will receive training on:

(a) Using the AUDIT-C as a screening tool for at-risk alcohol use.

(b) Providing intervention strategies that are consistent with the level of risk identified by the AUDIT-C or other assessments.

(3) The AUDIT-C will be incorporated into the annual Periodic Health Assessment for all active duty and Reserve Component personnel.

d. Program Guidelines

(1) Military Services will ensure that adult beneficiaries who are admitted to an MTF for care are screened annually for problematic substance use using the AUDIT-C screening tool.

(2) Medical providers must inquire further about any suspect screening results and take appropriate actions, as clinically indicated. Actions may include patient education about hazardous substance use, health risks, recommended alcohol consumption limits, brief intervention, and referral to mental health or SUD treatment personnel for further assessment, as indicated by VA/DoD clinical practice guidelines.

(3) Medical encounters that include the screening and, when necessary, brief interventions (as described in this section) are to be coded using the appropriate Healthcare Common Procedure Coding System representing such clinical services.

3. EVALUATION FOR TREATMENT SERVICES

a. Overview. Matching personnel to the most appropriate level of care requires a thorough biopsychosocial diagnostic assessment using criteria for SUDs defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (Reference (v)) or the International Classifications of Diseases (Reference (w)).

b. Evaluation. A biopsychosocial evaluation of personnel being considered for treatment is essential to prescribing the appropriate level of care. The evaluation must include collateral information, as appropriate, and involve a command consultation, as permitted by DoD or Military Service policy (for Service members) in order to assess the patient's treatment and support needs. Additionally, the evaluation will assess:

- (1) Level of acute intoxication and withdrawal potential.
- (2) Medical conditions and complications, including a history of past and current medical conditions that may complicate treatment or contribute to the patient's condition.
- (3) Additional medical or psychological conditions that are either diagnosable or sub-clinical that complicate treatment or require separate medical treatment.
- (4) Readiness to change, including resistance to treatment and willingness to accept the current diagnosis and treatment strategy.
- (5) Risk of harm to self or others, including additional risks associated with delayed treatment.
- (6) The nature of the recovery environment, such as family members, significant others, and living situations, that poses a threat to the patient's safety, the safety of others, or their treatment.

#### 4. TREATMENT ENTRY CRITERIA

- a. Overview. Criteria for the placement of personnel in a particular level of care provide a framework to guide clinical decision making.
- b. Goal. Treatment entry criteria are intended to improve the matching of personnel with an SUD to the least restrictive and most clinically appropriate level of care.
- c. Inpatient Treatment. Personnel recommended for inpatient (hospital-based) treatment should at a minimum meet the American Society of Addiction Medicine (ASAM) patient placement criteria (PPC) for Level III.7 treatment and at least two of the following criteria:
  - (1) Have an established diagnosis of an SUD (using References (v) or (w)).
  - (2) Suffered from a drug overdose and cannot be safely treated in an outpatient setting or safely discharged from an emergency department setting.
  - (3) In withdrawal and are at risk for a severe or complicated withdrawal syndrome.
  - (4) Have acute or chronic medical conditions that make detoxification in a residential or less intensive setting unsafe.
  - (5) Has marked psychiatric comorbidity and is in acute danger of harming themselves or others.

(6) Manifests substance use or other behaviors that are acutely dangerous to themselves or others by virtue of their substance use.

(7) Has a documented history of not engaging in or benefiting from treatment in a less intensive setting and whose SUD poses an ongoing threat to their physical and mental health.

d. Residential Treatment. Personnel recommended for residential treatment should meet the ASAM PPC for Level III treatment or meet at least two of the following criteria:

(1) Have an established diagnosis of an SUD (using References (v) or (w)).

(2) Require monitoring for withdrawal, but not inpatient medical care.

(3) Assessed with a moderate level of understanding of environmental factors that contribute to their behavior, but lacks the coping skills necessary to abstain from problematic substance use.

(4) Reside in an environment that hinders their ability to recover from problematic substance use, requiring a structured environment that is consistent with treatment and a return to full recovery.

e. Partial Hospitalization. Personnel recommended for partial hospitalization should meet the ASAM PPC for Level II treatment and meet at least two of the following criteria:

(1) Have an established diagnosis of an SUD (using References (v) or (w)).

(2) Possess a co-morbid or SUD condition that is stable enough to permit ambulatory treatment for conditions that do not place the patient or others at risk for danger or harm.

(3) Require a structured environment and services that are typically not provided in outpatient treatment.

(4) Assessed with co-occurring disorders that complicate treatment and require frequent coordination with other treatment services.

(5) Require a further treatment that can be safely managed at a lower level of care from residential treatment, but is at high risk for relapse because they:

(a) Have problems with motivation, frequent cravings or urges to use a substance, or poor social support; or

(b) Require extended monitoring of co-occurring conditions.



f. Intensive Outpatient Treatment. Personnel recommended for intensive outpatient treatment should meet the ASAM PPC for Level II treatment and meet at least two of the following criteria:

- (1) Have an established diagnosis of an SUD using References (v) or (w).
- (2) Be able to be safely managed through intensive outpatient treatment services consisting of a minimum of 9 hours per week.
- (3) Possess co-occurring disorders that require specialty consultation and coordination, but do not require the close monitoring and proximity of such services typically provided through a partial hospitalization program.
- (4) Be at risk for relapse due to problems with motivation, cravings or urges to use a substance, or poor social support.
- (5) Require a change in the level of care from other treatments and are at high risk for relapse because they:
  - (a) Have problems with motivation, frequent cravings or urges to use a substance, or poor social support; or
  - (b) Require extended monitoring of co-occurring conditions.

g. Outpatient (Nonresidential) Treatment. Personnel recommended for outpatient treatment should meet the ASAM PPC for Level I treatment. Patients must ordinarily be treated in a non-residential program if they meet one or more of the following criteria:

- (1) Have an established diagnosis of an SUD using References (v) or (w).
- (2) Do not meet the criteria for intensive outpatient treatment, partial hospitalization, or residential treatment.
- (3) Have completed a higher level of care and have relapsed necessitating further treatment.

h. Aftercare. Aftercare treatment provides support and ongoing treatment for the maintenance of recovery and addresses lingering general medical or psychiatric conditions. It is appropriate for all patients who have completed a higher level of substance use care.

## 5. TREATMENT SERVICES

a. Overview. SUD treatment services consist of inpatient and outpatient treatment modalities that vary in their intensity, duration, philosophy driving primary interventions (medical model, 12-step, peer support), and level of personal freedom allowed (locked versus open services).

### b. Treatment Setting Choice

(1) Personnel should be treated in the least restrictive environment that is likely to be safe and effective.

(2) Selection of the level of care should consider an individual's:

- (a) Ability to cooperate with treatment.
- (b) Ability for self-care.
- (c) Social environment (supportive or high risk).
- (d) Need for structure, support, and supervision to remain safe and abstinent.
- (e) Need for specific treatment of co-occurring general medical or psychiatric services.
- (f) The patient's preference for treatment.

### c. Treatment Program Guidelines

- (1) Treatment should be uninterrupted whenever possible.
- (2) Programs must ensure that the treatment of co-occurring disorders is an integrated component of SUD care.
- (3) Personnel will undergo drug monitoring during the course of all levels of SUD treatment in DoD facilities. Medically directed drug tests will be used to determine an individual's adherence to treatment goals.
- (4) Testing for alcohol use during treatment will be routinely conducted.
- (5) Personnel undergoing treatment will abstain from drug and alcohol use with the exception of medications prescribed by healthcare personnel. Expectations related to substance use should be specified in the treatment plan.

(6) An individualized treatment plan must be developed for each patient based on the biopsychosocial assessment and treatment progress must be evaluated against the goals specified in this plan.

(7) Discharge from a level of care occurs when a patient has met their individual treatment goals, reached maximal benefit from services at the current level of care, or transitions to another level of care.

(8) Commanders will ensure that active duty personnel with a drug use history undergo monthly random drug monitoring (testing) for 1 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.

(9) Changes in responsibility or duty station do not eliminate the requirement for continued follow-up and require communication between losing and gaining treatment staff.

(10) Slips are manifestations of the recovery process and do not, in and of themselves, constitute a failure to benefit from treatment. When these events are presented to the clinician or brought into the therapeutic milieu, they may in fact be therapeutic. Following a slip, a reassessment must be conducted to assess the need for more intensive treatment.

(11) Every effort must be made to involve the patient's immediate commander and supervisor in the development of the treatment plan. For personnel not subject to chapter 47 of Title 10, U.S.C., also known and referred to in this instruction as the "Uniform Code of Military Justice (UCMJ)" (Reference (x)), written consent from the patient must be obtained in order to allow for a supervisor's participation in accordance with Public Law 98-24 (Reference (y)) and section 290dd-2 of Title 42, U.S.C. (Reference (z)).

d. Treatment Program Goals

(1) Restore all personnel completing a treatment program to maximal physical, social, psychological, familial, and employment health, free from the harmful effects of an SUD.

(2) Maintain force health and readiness of the Military Services.

(3) Provide evidence-based SUD services that adhere to the clinical practice guidelines, as published by a DoD and VA-sanctioned task force or accredited professional organizations specializing in the treatment of SUDs.

e. Inpatient Treatment

(1) Overview. Services consist of hospital-based services that are medically monitored and involve daily medical care. Hospital-based programs typically include emergency detoxification and stabilization during withdrawal; assessment and treatment of co-occurring general medical and psychiatric conditions, group, individual, and family therapies; pharmacotherapies; psychoeducation; and motivational counseling.

(2) Treatment Goals

- (a) Provide safe emergency detoxification and stabilization during withdrawal.
- (b) Safely treat individuals with drug overdoses who cannot be safely treated in less intensive and less restrictive care settings.
- (c) Safely and successfully manage individuals in withdrawal who are at risk for a severe or complicated withdrawal syndrome or cannot receive necessary medical assessment, monitoring, and treatment in less intensive settings.
- (d) Safely and successfully manage acute or chronic general medical conditions that make detoxification in a residential or outpatient setting unsafe.
- (e) Stabilize and initiate treatment of individuals with a documented history of not engaging in, or benefiting from, treatment in a less intensive setting.
- (f) Provide a safe environment in order to address individuals with marked psychiatric comorbidity, who are in acute danger to themselves or others.
- (g) Successfully treat individuals who have not responded to less intensive treatment and whose SUD poses ongoing threat to their physical and mental health.

f. Residential Treatment

(1) Overview. Residential services provide psychosocial, occupation, and family assessment; pharmacotherapies; psychoeducation; and introduction to self-help groups, typically within the context of individual and group counseling. The services are medically managed and occur within a live-in 24-hour structured program in which lengths of stay vary based on an individualized treatment plan and patient goals.

(2) Treatment Goals

- (a) Provide safe detoxification and stabilization.
- (b) Foster the development of social support systems that do not focus predominantly on substance use.
- (c) Learn individual and group skills for preventing relapse.
- (d) Promote the individual's acceptance of the SUD diagnosis and readiness to change.
- (e) Provide sufficient stabilization of co-occurring general medical or psychiatric disorders so that the individual is considered suitable for outpatient aftercare.

(3) Use of Regional Long-Term SUD Treatment Programs. In accordance with Reference (c):

(a) The MHS relies on a regional system of MTF-based SUD treatment programs for residential inpatient treatment where SUD is the primary diagnosis and the expected duration exceeds 30 days. The availability of MTF-based programs meeting this need may be supplemented by programs provided by the VA.

(b) MTFs will not refer Service members to SUD treatment programs in the non-federal purchased care network for residential inpatient treatment where SUD is the primary diagnosis and the expected duration exceeds 30 days. This does not prohibit maintaining continuity of care if circumstances unexpectedly require an extension of treatment beyond 30 days.

g. Partial Hospitalization

(1) Overview. Provides intensive, structured hospital or clinic-based services for individuals with SUDs who require more services than those typically available in traditional outpatient settings, such as ancillary medical and psychiatric services. This level of care consists of psychosocial and pharmacologic treatments and often acts as a step-up or step-down level of care providing intensive ambulatory treatment and monitoring of relapse potential and co-occurring disorders.

(2) Treatment Goals

(a) Stabilize and initiate treatment with individuals who require intensive care, but who have a reasonable probability of refraining from substance use outside of a more restrictive environment.

(b) Stabilize individuals following inpatient or residential treatment by retaining them in treatment and providing extended intensive outpatient monitoring of relapse potential and co-occurring disorders.

(c) Provide step-down care for individuals leaving hospital or residential setting who are at risk of relapsing because of problems with motivation, cravings or urges to use a substance, poor social supports, immediate environmental cues for relapse and the availability of substances, and co-occurring medical and psychiatric disorders.

(d) Provide step-up care for individuals who have had a relapse, but who do not require inpatient detoxification or who have entered into a high-risk period for relapse because of life circumstances or recurrence of co-occurring medical and psychiatric symptoms.

h. Intensive Outpatient Treatment

(1) Overview. Intensive outpatient treatment provides intensive, structured services consisting of psychosocial and pharmacologic treatment typically provided for a minimum of 3 hours per day, 3 days a week. It is designed for individuals needing multidisciplinary services that cannot efficiently or effectively be met in a less intensive outpatient setting. Individual psychiatric and medical services are addressed through consultation and referral to appropriate specialties.

(2) Treatment Goals

(a) Provides an initial level of treatment for individuals with an SUD that requires the monitoring and further stabilization of an identified co-occurring disorder, but who do not require inpatient detoxification.

(b) Provide step-up or step-down level of care from less or more intensive treatment and further community integration and support.

(c) Provide increased structure, monitoring, and intensity of services to individuals who are not progressing well in less intensive outpatient treatment.

(d) Stabilize individuals with an SUD who have had a period of sobriety and relapsed, but who do not require intensive coordination of medical specialty care or inpatient detoxification.

i. Outpatient (Nonresidential) Treatment

(1) Overview. Services consist of a broad range of evidence-based outpatient approaches that include pharmacotherapy, self-help support groups, and relapse prevention and monitoring. Commonly consists of office visits, in which treatment and recovery services are provided.

(2) Treatment Goals

(a) Monitor clinical conditions or environmental and social circumstances that are at risk to deteriorate.

(b) Assess, treat, and stabilize any co-occurring medical or psychiatric disorders.

(c) Foster a social environment that is consistent with abstinence from substance use.

(d) Enhance an individual's acceptance of their condition and willingness to change.

j. Pharmacotherapies

(1) In addition to the psychosocial treatments provided in SUD treatment, all personnel should be evaluated for appropriate adjunctive pharmacotherapy as part of a comprehensive treatment plan.

(2) Long-term drug replacement therapies may be made available. Service members requiring long-term drug replacement therapies (greater than 6 months) must have their adherence to Service retention standards assessed by authorized medical personnel.

6. COMMAND, SUPERVISOR, AND FAMILY INVOLVEMENT IN CARE

a. Command or Supervisor Involvement. The commanding officer for Service members or civilian supervisor for DoD civilian employees, in conjunction with the treatment staff, should be involved in the individual's treatment program and engaged in their recovery support whenever necessary in accordance with DoDI 6490.08.

(1) Supervisor participation can be beneficial for DoD civilian employees who are treated in DoD facilities; however, written consent is required before supervisors are contacted.

(2) Commanders and supervisors must be informed in writing that residential or inpatient admission is only the initial stage of treatment to be followed by an aftercare treatment program.

(3) Commanders who refer personnel for evaluation will be informed of the results of the assessment, as permitted by regulation. For those not covered by the UCMJ, a consent form must be obtained.

b. Family Involvement. Initial patient assessment must include family data. An initial plan for family involvement in treatment and recovery support must be included. Family involvement should be encouraged and authorization from the patient complete when appropriate. An emphasis on this portion of the program must be made known to the patient before entry into treatment. Lack of participation by family members will not preclude treatment for personnel suffering with an SUD.

(1) Family member will have a high priority in receiving treatment when identified as having an SUD.

(2) Within the limitations of existing regulations, the family member will receive administrative support and assistance when being air transported for treatment, consistent with DoDI 4515.13 (Reference (aa)).

(3) Within the limitations of available resources, the local command or hospital must arrange for appropriate accommodations for the family member spouse.

(4) When necessary, the family member spouse should be assisted in making arrangements with his or her employer to attend treatment.

## 7. TREATMENT PROGRAM STAFFING

a. The Military Services must use a data-driven, risk-adjusted model to set staffing levels for trained professionals, treatment personnel, and support staff required to ensure program effectiveness.

b. Staff members must be under the direct supervision of personnel qualified to evaluate their clinical performance.

c. All unlicensed, non-privileged civilian or military personnel with clinical responsibilities for SUD treatment services must be certified, meeting the standards set by the International Certification and Reciprocity Consortium (IC&RC) for Alcohol and Drug Counselors (ADC) or approved State equivalent SUD certification with the exception of intern counselors, as specified in paragraph 5c(3) of this enclosure.

(1) A licensed, privileged mental health provider must be responsible for all care provided by the ADC and, in addition to the required “eyes on” supervision, the provider must provide sufficient additional supervision and direction of care to ensure the quality of services.

(2) Certified ADC’s practice within the scope of the 12 core functions, as specified by the IC&RC and as directed by a privileged healthcare provider.

(a) The initial assessment, any changes to the treatment plan, or crisis intervention requires “eyes on” supervision of the ADC by a licensed and privileged healthcare provider. In treatment situations, “eyes on” supervision must be provided by some observation of direct patient contact and review of the patient’s medical and other appropriate treatment records. All supervision must be documented in the medical record.

(b) An SUD diagnosis can only be made by a licensed and privileged healthcare provider.

(3) Intern ADCs are personnel who have completed a minimum of 270 hours of IC&RC ADC or approved State equivalent SUD education, and are working toward the experience and supervision requirement to meet certification standards.

(a) Intern ADC’s practice within the scope of the 12 core functions, as specified by the IC&RC or State equivalent SUD treatment standards, and under the direct supervision of a certified ADC or a privileged provider.

(b) All care provided by an ADC intern requires “eyes on” level of supervision by a certified ADC or privileged provider and must be documented in the medical and other appropriate treatment records.



(c) Staff members must be afforded the opportunity to continue their professional growth and development.

## 8. QUALITY ASSURANCE

a. DoD SUD treatment services must adhere to the MHS medical quality assurance standards related to the credentialing and privileging of providers, risk management, reporting of adverse medical events, and performance measurement and improvement in accordance with DoDI 6025.13 (Reference (ab)) and DoD Manual 6025.13 (Reference (ac)).

b. MTF services must maintain accreditation by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, or other authority approved by the ASD(HA).

c. MTF substance use services must satisfy the requirements of DoD and Service-specific clinical quality oversight activities. Program performance improvement activities must be linked to MHS strategic goals and SUD treatment evidenced-based best practices and clinical outcomes.

d. Case evaluations and reviews must be in compliance with the confidentiality requirements set forth in Reference (z).

9. VA. The DoD, in concert with the VA, must share resources in accordance with Public Law 96-22 (Reference (ad)) and Public Law 97-174 (Reference (ae)) when beneficial and feasible.

a. Residential VA Treatment. When mutually agreeable and authorized by law, the DoD Components may choose to use VA residential programs for DoD members using the criteria described in section 5 of this enclosure.

b. Outpatient (Nonresidential) VA Treatment. Criteria for entry are described in section 5 of this enclosure.

c. Treatment for DoD Members Who Are Being Discharged. Personnel who are to be discharged for an SUD may be referred for treatment to a VA facility when mutually agreed upon by the referring agency and the VA facility. In accordance with References (o) and (p) regarding patient confidentiality and release of information, the VA facility will be provided appropriate records, such as a copy of the Service member's Military Service record, and the nature of the Service member's discharge. The Service member must be informed of this opportunity for treatment. Service members who are evaluated as not having potential for further military service, if discharged, are to be evaluated by a physician, provided with appropriate care, and referred to a VA facility for further services in accordance with the provisions of part 199.3 of Title 32, CFR (Reference (af)).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

|          |  |
|----------|--|
| ADC      | alcohol and drug counselor   |
| ASAM     | American Society of Addiction Medicine                                   |
| ASD(HA)  | Assistant Secretary of Defense for Health Affairs                        |
| ASMAC    | Addictive Substance Misuse Advisory Committee                            |
| AUDIT-C  | Alcohol Use Disorders Identification Test, Alcohol Consumption Questions |
| CFR      | Code of Federal Regulations  |
| DoDD     | DoD directive  |
| DoDI     | DoD instruction  |
| IC&RC    | International Certification and Reciprocity Consortium                   |
| MHS      | Military Health System   |
| MTF      | military treatment facility  |
| PPC      | patient placement criteria   |
| SUD      | substance use disorder   |
| UCMJ     | Uniform Code of Military Justice   |
| U.S.C.   | United States Code   |
| USD(P&R) | Under Secretary of Defense for Personnel and Readiness                   |
| VA       | Department of Veterans Affairs   |

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purposes of this instruction.

ASMAC. The Committee will serve as a central point for information analysis and integration, program coordination, identification of policy needs and problem solving on Military Service issues involving policies and programs with regard to legal and illegal addictive substance use and SUDs in those served by the MHS.

at-risk or hazardous alcohol use. The consumption of alcohol in daily or weekly amounts greater than those defined as safe by the U.S. Preventive Task Force. Drinking at levels above the recommended amounts places an individual at greater risk for illness, injury, or social or legal problems.

beneficiary. An individual who has been determined to be eligible for TRICARE benefits, as defined in Reference (af).

comorbidity. Appearance of multiple illnesses: the simultaneous appearance of two or more psychiatric or physical illnesses.

detoxification. Planned management of the alcohol and drug withdrawal processes. Medical detoxification generally is accomplished on an inpatient basis, and includes withdrawing alcohol and other drugs of abuse from the individual, and providing medical and psychological support.

DoD civilian employee. A permanent employee of the DoD who is a U.S. citizen and who is paid from appropriated or nonappropriated funds.

DoD personnel. Members of the Military Services and civilian employees under the authority of the Department of Defense.

drug. Any substance, other than food, that a person inhales, injects, consumes, or introduces into their body in any manner, to alter mood or function.

drug paraphernalia. All equipment, products, and materials of any kind that are used, intended for use, or designed for use, in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of section 801 *et seq.* of Title 21, U.S.C. (Reference (ag)).

eyes on supervision. Direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation.

illegal drug use. The use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act. Such a term does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of Federal law.

illicit drug. A drug or other substance that is prohibited by law or DoD policy.

medically managed. Treatment that is delivered in an acute care inpatient setting in which the full resources of a general or psychiatric hospital are available. Services that involve daily medical care, where diagnostic and treatment services are directly provided and managed by an appropriately trained and licensed physician.

medically monitored. Services provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, and other health and technical personnel under the direction of a licensed physician. Medical monitoring is provided through appropriate mix of direct patient contact, review of records, treatment team meetings, 24-hour coverage by a physician, and a quality assurance program.

pharmacotherapy. The treatment of disease with prescribed medication.

prescription drug abuse. The use of a medication without a prescription, in a way other than as prescribed, or for the experience or feelings elicited.

prevention programs. Activities designed to influence participants to avoid problematic substance use or to encourage individuals to seek early assistance.

problematic substance use. The use of any substance in a manner that puts the user at risk of failing in their responsibilities to mission or family, or that is considered unlawful by regulation, policy, or law. This includes substance use that results in negative consequences to the health and/or well-being of the user or others; or meets the criteria for an SUD.

psychoeducation. The use of information or training that is intended to increase awareness or improve skills of persons with a psychological disturbance.

recovery support. Social support services, linkages to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life.

rehabilitation. The process of restoring a person who is impaired by the use of alcohol or other drugs to an effective functioning level.

relapse. The resumption of a pattern of substance use in an individual seeking abstinence that was previously identified as problematic.

step-down care. A level of care that is considered lower than the comparison level of care, as measured by intensity, duration, or both.

step-up care. A level of care that is considered higher than the comparison level of care, as measured by intensity, duration, or both.

substance or drug misuse. The use of any substance with or without a prescription with the primary goal to alter one's mental state (i.e., to alter mood, emotion, or state of consciousness) outside of its medically prescribed purpose. May include medications, illicit drugs, or use of a commercial product outside its intended purpose (such as inhalants or synthetic cannabinoids).

SUD. Defined in Reference (v).

slip. A temporary or isolated resumption of substance use in an individual seeking abstinence from that substance.

support staff. Members of an SUD treatment or referral program whose primary work activities involve clerical, housekeeping, security, laboratory, record-keeping, or other non-managerial functions necessary for the overall clinical and administrative operation of the program.

treatment personnel. Trained members of the SUD treatment program staff qualified to provide consultative, treatment, or referral services.