U.S. Department of Homeland Security

United States Coast Guard

# COAST GUARD HEALTH PROMOTION MANUAL

**COMDTINST M6200.1A**
**July 2007**

U.S. Department of Homeland Security
United States Coast Guard

Commandant
United States Coast Guard

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COMMANDANT INSTRUCTION M6200.1A
Subj COAST GUARD HEALTH PROMOTION MANUAL

Ref: (a) Coast Guard Personnel Manual COMDTINST M1000.6 (series)
(b) Weight and Physical Fitness Standards for Coast Guard Military Personnel COMDTINST M1020.8 (series)
(c) Coast Guard Food Service Manual COMDTINST M4061.5 (series)
(d) Coast Guard Medical Manual COMDTINST M6000.1 (series)

1. PURPOSE. This is a revision to the Health Promotion Manual. It provides policy, guidance and direction for physical fitness, nutrition, stress management, weight management and substance abuse programs. It clarifies the roles and responsibilities for commands, Unit Health Promotion Coordinators, Regional Health Promotion Managers, Food Service and Health Service personnel with respect to the Health Promotion program core elements.

2. ACTION. Area, district and sector commanders, commanders of maintenance and logistics commands, commanding officers of integrated support commands, commanding officers of headquarters units, assistant commandants for directorates, Judge Advocate General and special staff elements at Headquarters shall ensure compliance with the provisions of this Manual. Internet release is authorized.

3. DIRECTIVES AFFECTED. Coast Guard Health Promotion Manual, COMDTINST M6200.1 is cancelled.

4. MAJOR CHANGES. Major changes to this Manual include:

   a. Addition of compliance requirements for Weight/Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

DISTRIBUTION – SDL No. 147

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NON-STANDARD DISTRIBUTION:

b. Establishment of a Coast Guard wide tobacco cessation program, the Mayo Clinic Tobacco Quitline.

c. Updating policies and procedures relating to prevention and treatment of substance abuse.

d. A new Stress Management chapter.

e. Terminology and name changes.

5. REQUESTS FOR CHANGES. Units and individuals may recommend changes in writing via the chain of command to Commandant (CG-111), U. S. Coast Guard Headquarters, 2100 Second St. S.W., Washington, D.C. 20593-0001.

6. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS. Environmental considerations were examined in the development of this Manual and have been determined to not be applicable.

7. FORMS/REPORTS. The forms called for in this Manual are available in USCG Electronic Forms on the Standard Workstation or on the Internet: http://www.uscg.mil/ccs/cit/cim/forms1/welcome.htm or Intranet: http://cgweb2.comdt.uscg.mil/CGFORMS/welcome.htm.

RADM MARK TEDESCO /s/
Director of Health and Safety

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## TABLE OF CONTENTS

## CHAPTER 1. HEALTH PROMOTION PROGRAM OVERVIEW.

A. Introduction. A healthy Coast Guard workforce is critical for optimal mission performance. An abundance of research shows that lifestyle factors such as dietary choices, exercise habits, stress management methods and alcohol/tobacco use practices are key determinants of health outcomes, risk of injury and work performance. In 1993, the Health Promotion Program was created within the Office of Work-Life to help the Coast Guard workforce and their families achieve desired health outcomes and improve quality of life. Implementation of this program helps participants stay physically fit for duty, maintain a healthy weight and reduce risks attributed to lifestyle imbalances. It also helps commands establish a work environment that supports healthy life practices. Collectively, program elements help ensure that the Coast Guard workforce is able to fulfill mission requirements and help our Coast Guard family live healthy, balanced and satisfying lives.

   The Health Promotion Division is an integrated component of the Health and Safety Directorate (CG-11). The Health Promotion Program supports priorities set by CG-11 as well as the Office of Health Services (CG-112) and other CG health-related policies, such as the Weight/Physical Fitness Standards for Military Personnel COMDTINST M1020.8 (series) and The Coast Guard Food Service Manual COMDTINST M4061.5.

B. Purpose. This Manual clarifies substance abuse and tobacco use policy for all Coast Guard military personnel. It provides practical information on weight management, physical fitness, nutrition, stress management, health risk assessments and unit Health Promotion Program requirements. It identifies responsibilities throughout the chain of command. Program initiatives are research-based and encourage the adoption of healthy behaviors that contribute to the prevention of disease and injury.

C. Policy. The Coast Guard is committed to supporting the health of its workforce through health promotion policy, programs, education and direct services to ensure mission readiness. Members are strongly encouraged to adopt a healthy lifestyle including eating nutritious foods, engaging in regular physical activity, avoiding tobacco use, participating in preventative screening tests and learning how to effectively manage stress. By adhering to a healthy lifestyle, individuals can prevent or control the devastating effects of heart disease, diabetes, cancer and other chronic diseases. Command leadership is an integral part of any successful health promotion program. Commanding Officers and Officers-in-Charge are expected to champion the Health Promotion Program by creating a work environment that allows members to routinely engage in healthy lifestyle practices.

D. Applicability. Policy and programs within this Manual apply to all Coast Guard active duty personnel. Reservists, retirees, civilian employees, auxiliarists, and dependents are eligible for most of the Health Promotion Programs and services. Exceptions are clearly indicated.

E. Policies and Other Resources. Policies and instructions supported by this manual include:

   1. Weight/Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series);

2. Coast Guard Personnel Manual, COMDTINST M1000.6 (series), Chapter 20.A;

3. Coast Guard Food Service Manual, COMDTINST M4061.5 and Food Service Practical Handbook;

4. Coast Guard Medical Manual, COMDTINST M6000.1 (series);

5. Crew Endurance Management, COMDTINST 3500.2 (series);

6. Safety and Environmental Health Manual, COMDTINST M5100.47 (series);

7. Operating Procedures for Work-Life Staffs, COMDTINST 5400.A (series)

8. Critical Incident Stress Management, COMDTINST 1754.3 (series);

F. Discussion.

1. National Health Trends and Health Promotion Focus. Results from nationwide surveys reveal alarming increases in obesity and decreases in levels of physical activity for Americans. Cancer, stroke and heart disease are the top three causes of death and disability in the United States. These chronic diseases are directly linked to tobacco use, poor dietary choices, a sedentary lifestyle, poorly managed stress, and substance abuse. Individuals who make positive health behavior choices can reduce their risks of disease and maximize their quality of life.

2. Organizational Benefits. Research shows that organizations that implement health promotion policies and programs experience significantly lower health care costs, fewer disability claims, decreased absenteeism and increased productivity, morale and retention. The policies, programs and interventions developed by the Health Promotion Program are well researched and proven effective. They adhere to recommendations made by the Centers for Disease Control and Prevention, The Department of Health and Human Services, national health organizations and Department of Defense military partners.

G. Core Program Elements.

1. Substance Abuse Prevention. The goal of the Coast Guard substance abuse program is to eradicate negative consequences related to substance abuse. It encourages self responsibility and mandates a zero tolerance drug policy. Coast Guard members are encouraged to either abstain from or engage in responsible, moderate alcohol consumption. Personnel assigned to address substance abuse issues include Command Drug and Alcohol Representatives (CDARs), Substance Abuse Prevention Specialists (SAPSs), Regional Health Promotion Managers (HPMs) and Employee Assistance Program Coordinators (EAPCs). Substance abuse policy is found in **Chapter two**.

2. Tobacco Cessation and Avoidance. Tobacco use is the number one cause of preventable death in this country. It causes heart disease, cancer, oral disease and respiratory problems. According to a 2006 Surgeon General report, exposure to secondhand smoke at home or

work significantly increases the *non-smoking* person's risk of developing heart or lung disease. Second hand smoke exposure has also been linked to Sudden Infant Death Syndrome (SIDS), respiratory problems, ear infections and asthma attacks in infants and children. The Coast Guard discourages the use of all tobacco products. Persons dependent on nicotine find it difficult to quit and often require multiple attempts to overcome the addiction. The Coast Guard understands this and has implemented a variety of programs to help individuals gain life-long freedom from tobacco. All beneficiaries considering quitting tobacco use are encouraged to see their health care provider or Health Promotion Manager for support in developing an effective "quit" plan. In addition, beneficiaries are encouraged to use the *free* telephone counseling program, the Mayo Clinic Tobacco Quitline. By calling 1-888-642-5566, beneficiaries will be connected to a professional counselor who can help individuals end their tobacco use or assist individuals who are interested in learning more about the program but who are not yet ready to quit. Additional tobacco-related services provided by the Health Promotion Program include training on tobacco use, coordinating group tobacco cessation programs and providing educational resources. Tobacco policy is found in **Chapter three**.

3. Physical Fitness/Activity. Engaging in regular physical activity is an effective way to reduce stress, manage weight, decrease risk of disease and injury, improve physical appearance and have fun. Years of research show that exercise leads to improved physical function, decreased risk of chronic disease and decreased disability. In spite of this evidence, 50% of American adults do not get enough physical activity to gain health benefits. Just thirty minutes of brisk walking or other moderate physical activity daily provides significant health protection. To support the physical readiness of Coast Guard military personnel, per Weight and Physical Fitness Standards for Military Personnel, COMDINST M1020.8 (series), all military personnel are required to develop an annual basic fitness plan (form CG-6049). Commanding officers are to provide all military personnel on active duty, including reservists performing active duty training, a minimum of one hour three times per week for voluntary participation in fitness enhancing activities. To ensure a fit, ready for duty workforce, Regional Health Promotion Managers are available to help individuals develop a fitness program and assist commands to develop a unit-based fitness program. Additional health promotion fitness program services include individual fitness assessments, providing educational lectures, providing fitness incentive challenges and exercise demonstrations. More information on physical fitness can be found in **Chapter four**.

4. Weight Management. Achieving and maintaining a healthy weight is a continuous struggle for many individuals. Numerous factors such as diet, exercise, stress and genetics influence one's ability to successfully maintain a healthy weight. Coast Guard policy requires that all active duty and reserve military personnel comply with weight standards (Weight and Physical Fitness Standards for Military Personnel, COMDINST M1020.8 (series)). Failing to comply can lead to separation from the service. The weight management program provides the support, resources and education needed to help active duty members *safely* achieve compliance with their maximum allowable weight. All Coast Guard beneficiaries are encouraged to use these free services. There are many products and diets advertised that promise quick weight loss. These products and programs are often unsafe, ineffective, and

should be avoided. Effective, sustainable weight management requires a balance between calories taken in and calories expended, a commitment to regular fitness and effective stress management. There are no shortcuts. Health promotion personnel can assist members with a lifestyle plan that will free them from the diet roller coaster. Additional services provided through the Health Promotion Program include educational seminars on effective weight management strategies, body composition analysis, lifestyle coaching and resources such as the Coast Guard Weight Management Self-Help Guide. See **Chapter four** and **Chapter six** for more information on weight management.

5. Health Risk Appraisal (HRA). The HRA is a personal health assessment tool that identifies health risks, offers lifestyle improvement suggestions and tracks health status changes over time. Participants complete a questionnaire about their lifestyle habits, health history and are provided free preventive clinical screening tests and physical fitness assessments. Confidential reports containing individual HRA results are sent to each participant. Unit reports containing non-identifiable aggregate data are available to commands upon request and can be used to guide their health promotion priority initiatives. The HRA currently used by the Coast Guard is provided by WELLSOURCE and is administered by regional Health Promotion Managers. More information on the Coast Guard's HRA can be found in **Chapter five**.

6. Nutrition. To perform well and stay healthy, our bodies require a full range of nutrients which come from eating a broad variety of foods on a regular basis. However, this is often easier said than done. Food consumers are bombarded by information about magical foods and diets which makes sorting fact from fiction a difficult, time-consuming task. Research demonstrates that individual eating patterns impact health outcomes. What we eat contributes to a variety of health issues such as osteoporosis, heart disease, cancer, diabetes, low energy levels and inability to concentrate or sleep. The nutrition component of the Health Promotion Program provides beneficiaries with research-based information and guidance to help them make informed eating choices that contribute to a healthy life. Specific nutrition program services include providing guidelines for healthy eating, information needed to make informed food choices, nutrition seminars at units, dietary analysis, resources on national nutrition initiatives, training on healthy cooking ideas, and healthy meal planning. Food Service Specialists can receive training from regional Health Promotion Managers on healthy cooking techniques and menu planning. Additional information on nutrition and weight management can be found in **Chapter six**.

7. Stress Management. Stress is our body's response to change. It has physical and emotional effects and can build us up or break us down. The goal of the stress management program is to help individuals become aware of personal stressors, be tuned into one's typical response to these stressors and develop skills to better respond to negative or challenging situations. Stress Management services include unit stress management training, unit and individual stress management assessment inventories, Crew Endurance Management (Crew Endurance Management, COMDTINST 3500.2) training, relaxation techniques and the provision of educational materials. The Work-Life Employee Assistance Program (EAP) provides free telephone counseling to all beneficiaries and face-to-face short term

counseling. EAP services can be accessed by calling 1-800-222-0364. Additional information about stress can be found in **Chapter seven**.

8. Prevention of Disease and Injury. Early detection of disease is a key component of the Health Promotion Program. Periodic check-ups and screenings administered by your health care provider are strongly advised. Clinical screenings provided by regional Health Promotion Managers (HPMs) include cholesterol, blood pressure and glucose testing. All hands training can be provided on a broad range of topics from sexually transmitted disease to bicycle safety.

9. Unit Health Promotion Coordinator Course. Per Weight and Physical Fitness Standards for Military Personnel, COMDTINST M1020.8 (series), all units must designate a Unit Health Promotion Coordinator (UHPC). The UHPC is responsible for the unit Health Promotion Program. The UHPC assists members with personal fitness plans and conducts mandatory fitness assessments. UHPC's shall attend a 5-day UHPC course. This course provides students with the knowledge, tools and skills necessary to fulfill the collateral duty of the UHPC. The Health Promotion Division (CG-1111) oversees the UHPC course. All regional Health Promotion Managers shall conduct this UHPC training at least annually in their AORs. Commands should refer to the Unit Health Promotion Coordinator qualifications in this chapter for more information.

H. Program Implementation.

1. Accession Points. Recruit Training Center Cape May, Training Center Yorktown, Training Center Petaluma, Officer Candidate School and the Coast Guard Academy are required to include health promotion training in their curricula.

2. Leadership and Class A and C schools. The Chief Petty Officer Academy and Chief Warrant Officer Professional Development School shall include health promotion curricula in their training schedules. In addition, an introduction to the Health Promotion Program is provided during some Class "A" and "C" schools. The curricula at Food Service Specialist Class "A" and "C" schools shall incorporate some Health Promotion elements, with a strong emphasis on Nutrition.

3. Regional Level. At Training Center Cape May, Headquarters Support Command and each Integrated Support Command, the Coast Guard's Health Promotion initiatives are carried out by a Regional Health Promotion Manager (HPM). They are the Coast Guard's subject matter experts in Health Promotion and are available to assist commands with development of their unit Health Promotion Programs.

4. Command and Unit Level. Endorsement and visible support by Command Leadership (Commanding Officer, Executive Officer, Officer-In-Charge, Executive Officer-In-Charge) is critical for the success of Health Promotion Programs at the unit level. According to Weight and Physical Fitness Standards for Military Personnel, COMDTINST M1020.8 (series), every Commanding Officer must designate, in writing, a Collateral Duty Unit

Health Promotion Coordinator (UHPC) responsible for coordinating the unit Health Promotion Program via their regional HPM and chain of command.

I. Responsibilities.

1. Commandant (CG-11). The Director, Health and Safety Directorate serves as authority over the policy and programs outlined in this manual through Commandant (CG-111), The Office of Work Life.

2. Commandant (CG-1111). The Health Promotions Division of the Office of Work-Life (CG-111) serves as the Chief of the Coast Guard Health Promotions. This position provides leadership and oversight for all division functions. Commandant (CG-1111) shall:

   a. Policy.

      (1) Develop and direct the implementation strategies for policies in this Manual.

      (2) Initiate required changes to this Manual.

   b. Program Planning.

      (1) Establish standards for Health Promotion Programs and services.

      (2) Develop key initiatives for the HP Program in collaboration with the Health and Safety Directorate (CG-11), Maintenance and Logistic Commands, Operational Medicine Division (CG-1121), Office of Military Personnel (CG-1221), Office of Safety and Environmental Health (CG-113), Office of Work Life (CG-111), Health Promotion Managers (HPMs) and Food Service personnel (CG-1111), and ISC and HSC Work-Life Supervisors.

      (3) Serve as liaison to external partners such as the Department of Defense, Centers for Disease Control and Prevention, Department of Health and Human Services, inter-agency health promotion stakeholders, President's Council on Physical Fitness and other national health organizations.

      (4) Inform key stakeholders within Commandant (CG-11) of health promotion priorities and required action.

      (5) Establish the communication and marketing plan.

      (6) Design and implement a program evaluation plan.

      (7) Establish health promotion program quality improvement tool for use by MLC staff as part of the quality improvement process with ISC Work Life health promotion staff.

c. Funding.

(1) Secure funding and provide financial oversight for Health Promotion Division programs.

(2) Develop funding structure of the HP program and communicate funding responsibilities of the Integrated Support Commands to Work-Life Supervisors.

d. Training and Education. Provide continuing education opportunities to division staff to maintain subject matter expertise.

3. Headquarters Health Promotion Program Managers. The Health Promotion Program Manager level consists of two positions: a GS civilian employee and an active duty military member. Both Health Promotion Program Managers work directly for the Division Chief. The Health Promotion Program Managers shall:

a. Program Planning.

(1) Develop and disseminate the annual Health Promotion Program strategic plan.

(2) Conduct health promotion needs assessments.

(3) Serve as liaisons to the Office of Military Personnel (CG-122) on health promotion issues associated with Weight and Physical Fitness Standards for Military Personnel, COMDTINST M1020.8 (series).

(4) Provide subject matter expertise to review waiver requests for alternative body fat methods that are submitted to Commandant (CG-122) in accordance with Weight and Physical Fitness Standards for Military Personnel, COMDTINST 1020.8 (series).

(5) Serve as liaisons to Coast Guard medical communities to support policy initiatives and collaboration with clinics and independent duty corpsmen.

(6) Serve as liaisons to Coast Guard Food Service community to support rating initiatives and collaboration with Food Service Officers and Food Service Specialists.

(7) Develop programs and curricula to improve health awareness practices.

(8) Develop programs to improve the physical fitness of Coast Guard members and beneficiaries.

(9) Coordinate regional Health Promotion Manager workgroups.

(10) Develop and maintain the health promotion website.

(10) Establish and maintain information networks such as the health promotion microsite on CG Central.

(11) Develop briefings on health promotion topics.

(12) Implement the program evaluation plan.

b. Policy.

(1) Provide policy interpretation to personnel.

(2) Assist in development of health promotion policy.

c. Funding and Procurement.

(1) Purchase and distribute health screening supplies to regional HPMs.

(2) Evaluate and select standard reference materials to be provided by Commandant (CG-1111) to all regional HPMs.

d. Training and Education.

(1) Provide resources needed by regional HPMs to conduct seminars, health risk appraisals and health screenings.

(2) Support professional development and continuing education for HPMs.

(3) Serve as Manager for the Unit Health Promotion Coordinator (UHPC) course and provide training support to Regional HPMs during their annual course.

e. Marketing.

(1) Assist in development of a communication/marketing plan.

(2) Write ALCOAST messages regarding health promotion topics.

(3) Provide program marketing materials to HPMs.

4. Maintenance and Logistics Commands (MLC) shall:

a. Assist Commandant (CG-111) in the development of Health Promotion program strategic plan and evaluation measure(s).

b. Provide a health care provider liaison with CG-111 responsible for participating in the development of disease prevention initiatives.

c. Conduct quality improvement site visits with Regional Health Promotion Work-Life staff in accordance with CG-111 instrument.

d. Support CG-111 program evaluation efforts through data calls, data collection and regular reporting.

e. Analyze program data and provide CG-111 with a periodic program summary report.

f. Participate in CG-111 teleconferences and web-based trainings.

g. Participate in annual CG-1111 health promotion conference/fitness symposium.

5. Commanding Officers, Officers-in-Charge, Executive Officers and Executive Petty Officers shall:

a. Administrative.

(1) Designate in writing a Unit Health Promotion Coordinator (UHPC) - see paragraph 6 of this chapter for UHPC qualification criteria. The member is not required to attend training before being designated by the command.

(2) Send a copy of the UHPC designation letter to the regional HPM.

(3) Ensure that the designated UHPC attends training at the next available regional training or as soon as operationally possible.

(4) Verify that all unit members have a basic fitness plan on file (Form CG-6049).

(5) Require new unit members to check in with the UHPC upon arrival.

b. Funding. Provide funding for unit Health Promotion Programs.

c. Program Planning.

(1) Establish and openly support an environment that enables unit members to routinely engage in healthy lifestyle behaviors and make informed health choices.

(2) Establish a Unit Health Promotion Program. HPMs can provide technical assistance to unit commands as needed.

(3) Grant UHPC a minimum of three hours of work time weekly to fulfill UHPC roles and responsibilities to include, but not be limited to, developing and implementing a

unit health promotion plan, coordinating unit fitness activities, administering fitness tests, and providing support to members on the weight program.

(4) Provide all personnel on active duty a minimum of three hours per week during working hours for voluntary participation in physical fitness enhancing activities (Weight and Physical Fitness Standards for Military Personnel, COMDINST 1020.8 (series)). Such physical activities should improve upon at least one of the five components of fitness (body composition, flexibility, muscular strength, muscular endurance or cardio-respiratory endurance) as outlined in chapter 4. Training centers are not required to allocate time for fitness-enhancing activities during the academic day for "A" and "C" school students.

(5) Allow civilian employees prescheduled adjustments to work hours to encourage participation in recurring physical fitness activities. It is expected that civilian employees will participate during non-duty hours, including lunch periods, when engaging in health and fitness activities for extended or indefinite time periods.

(6) Grant excused absences for civilian employees to take part in one-time or occasional programs that are of short duration. Examples of these include activities such as: officially-sponsored federal fitness day event; an agency sponsored health screening; a fitness center orientation; and a tobacco cessation program consisting of several brief classes. Any additional questions regarding the use of official duty time in health and fitness activities and its applicability to civilians should be directed to the local civilian Command Staff Advisor.

(7) Implement a Health Promotion Program evaluation measure (e.g., "100% of active duty unit members will complete a PWP", "100% of active duty unit members will complete a personal fitness plan", etc).

6. Regional Health Promotion Manager (HPM). Regional HPMs are attached to Integrated Support Commands within the Office of Work-Life and to Training Center Cape May. HPMs are health promotion subject matter experts. They shall provide guidance to commands, training to Unit Health Promotion Coordinators and provide health promotion services to Coast Guard beneficiaries. Within their Area of Responsibility (AOR), all regional HPMs shall:

a. Program Planning.

(1) Plan, develop and administer regional Health Promotion Program.

(2) Support CG-1111 Health Promotion initiatives.

(3) Establish partnership with MLC Work-Life staff.

(4) Participate in CG-1111 health promotion teleconferences and/or web-based training.

(5) Conduct health screening assessments.

(6) Assist Commandant (CG-1111) in development of updates to policies, manuals and training materials.

(7) Maintain individual unit records to include information such as current UHPC and other command contact information, copy of local health promotion instruction and record of services/training provided to unit and UHPC.

(8) Provide periodic service delivery report and program data in accordance with CG-1111 quality improvement guidelines to MLC Work-Life staff to assist with the development of program initiatives, funding requirements, and strategic plans.

(9) Leverage national, state and county health promotion programs and initiatives for use by CG beneficiaries as appropriate.

(10) Establish and maintain collaborative working relationships with HQ Health Promotion staff, Commanding Officers, Officers in Charge, Supervisors, Coast Guard Medical Officers, and Independent Duty Corpsmen, the Morale, Well-Being, and Recreation Officers, Unit Health Promotion Coordinators, the Collateral-Duty Addictions Representative, Food Service Specialists and the various members of the ISC Work-Life Staff.

(11) Establish patient care protocol (or referral process) with Medical Officers and corpsmen to ensure that members who present with clinical risk factors are provided follow-up care.

(12) Inform ISC Command senior leadership, MLC and the HP Program Manager of health promotion needs, issues, activities and outcomes occurring within their AOR.

(13) Establish a Command and HQ approved evaluation plan including both outcome and process measures.

b. Funding and Procurement. Establish and manage budget allocated from local Work-Life Office.

c. Training and Education.

(1) Contact all commands annually to review unit health promotion training needs and to establish unit health promotion priorities.

(2) Educate and encourage Coast Guard beneficiaries to adopt/maintain a healthy lifestyle by providing educational training opportunities for each core component of the program (Section G).

(3) Develop, coordinate and facilitate at least one Unit Health Promotion Coordinator (UHPC) course annually within AOR.

(4) Provide instructor support for UHPC courses out-of-district when operationally capable. (Minimum of one with supervisor approval.)

(5) Coordinate and conduct health screenings. Conduct, analyze and interpret periodic Health Risk Assessments (HRA) at each unit.

(6) Develop a lending library of up-to-date resources for use by units.

(7) Support development of UHPCs with on-going mentoring, training and resources.

(8) Develop and implement programs that address unique needs within AOR (e.g., provide seasonal affective disorder training in Alaska).

(9) Provide food service specialists with nutrition, menu review services and healthy cooking training.

(10) Assist units with environmental assessment to determine health promotion programming needs.

d. Marketing.

(1) Develop and implement a marketing strategy tailored to AOR.

(2) Market health promotion initiatives such as the Mayo Clinic Tobacco Quitline to clinic staff, corpsmen, command leadership, civilian employees and active duty members and their families.

(3) Be a role model.

7. Unit Health Promotion Coordinator (UHPC). Unit Health Promotion Coordinators are not subject matter experts in health promotion. However, following the Health Promotion Coordinator course, UHPCs will have the fundamental knowledge and skills to implement a Health Promotion Program at their unit. UHPCs shall:

a. Program Planning.

(1) Establish a health promotion committee. Suggested committee membership includes: Health Promotion Coordinator, Collateral Duty Addictions Representative (CDAR), Unit Food Service Officers or Specialists, Corpsman, Morale Officer, and other interested individuals.

(2) Conduct an environmental assessment at the unit to identify environmental factors that prohibit or support member's ability to make informed health choices and

engage in healthy lifestyle practices. Sample assessment factors include: availability of nutrition and calorie information; availability of foods that support weight management goals; a unit fitness policy; social and cultural norms that support or detract from health promotion goals.

(3) Assess the needs and interests of unit members through surveys, discussions and PWP report findings.

(4) Coordinate with morale officer for financial and other logistical support of Health Promotion Program elements such as fitness equipment.

(5) Act as an advisor to the command on Health Promotion Programs.

(6) Act as the liaison for the Regional Health Promotion Manager.

(7) At units with galley facilities, work with unit Food Service Specialist or contracted food service providers to integrate United States Dietary Association (USDA) dietary principles such as “Five-A-Day Program” concepts into menu planning.

(8) Maintain a list of local health promotion resources.

b. Funding. Partner with Command and HPM to establish funding mechanism to support unit initiatives.

c. Training and Education.

(1) Attend Unit Health Promotion Coordinator course.

(2) Coordinate all hands health promotion training at unit.

(3) Participate in regular UHPC training opportunities.

(4) Provide unit members with weight management resources.

(5) Conduct fitness tests.

(6) Assist members with personal fitness plan development.

(7) Coordinate group tobacco cessation activities as necessary.

(8) Provide resources to unit members wishing to become tobacco free.

(9) Assist the HPM with implementation of the PWP Health Risk Appraisal at the unit level.

(10) Partner with Coast Guard health care providers for health promotion activities.

(11) Identify and utilize community and Department of Defense (DoD) resources for health promotion activities.

(12) Maintain a resource list for local and national health organizations (refer to appendix A).

(13) Encourage family member participation in unit health promotion activities and programs, when permitted.

d. Program Marketing.

(1) Develop a marketing plan.

(2) Distribute health promotion bulletins, emails and presentations (electronically or hard copy) that have been approved by their HPM.

(3) Promote HQ initiatives such as the Mayo Clinic Tobacco Quitline.

(4) Establish and maintain a health promotion resource library.

e. Qualifications**.** The responsibility of being a UHPC extends beyond a passion and desire to be physically fit. Commands should make the best effort possible to assign an individual who demonstrates balanced, healthy lifestyle practices. That individual should meet the following qualifications:

(1) Be free of tobacco products for a minimum of twelve months.

(2) Be in compliance with the Weight/Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST1020.8 (series).

(3) Possess good communication and leadership skills, an approachable and empathetic demeanor and be willing to implement fitness programs and assist others in reaching their health goals.

(4) Be enthusiastic about all healthy lifestyle behaviors (not just physical fitness) and committed to the essential elements of health promotion.

(5) Abstain from alcohol or use it responsibly.

(6) Abstain from use of all illegal substances.

(7) Have at least two years remaining at a shore unit or one year remaining on an afloat unit when operationally possible.

(8) Hold rate of Petty Officer or above (exceptions made for small units). At the Commanding Officer's discretion, a reservist, auxiliarist or civilian employee may represent the unit if they meet all other qualifications.

8. Substance Abuse Program Personnel. See **Chapter 2** for information on personnel responsibilities.

9. Food Service Officer (FSO) Responsibilities.

   a. Provide nutrition information on menu items to enable patrons to make informed choices wherever possible.

   b. Serve portion sizes in accordance with the Armed Forces Recipe Service (AFRS) recommendations.

   c. Maximize use of healthy cooking techniques in meal preparation. Examples include:

      (1) Baking versus frying.

      (2) Steaming versus boiling vegetables.

      (3) Utilize oils that are low in fat and cholesterol (such as canola and extra virgin olive oil). Avoid use of butter and lard or oils high in saturated fat (palm tree or coconut oils).

      (4) Avoid use of trans-fats, such as partially hydrogenated vegetable oils, which are a common ingredient in many packaged snacks, baked goods and margarine.

      (5) Maximize use of whole grains (such as brown rice and whole wheat bread) versus processed and refined grains (such as white rice and white bread).

      (6) Offer fruit and vegetables for snacks versus chips and candy.

   d. Collaborate with the UHPC and/or the unit Health Services Technician to enhance health promotion efforts throughout the unit.

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## CHAPTER 2. SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPAT) PROGRAM.

A. Introduction. This chapter sets policy and procedures for the Coast Guard Substance Abuse Prevention and Treatment Program (SAPAT). The management of the Substance Abuse Prevention and Treatment Program lies with Commandant (CG-1111). Administration of regulations related to drug and alcohol use, including drug urinalysis testing, lies with Commandant (CG-12). Related policies and procedures can be found in Personnel Manual, COMDTINST M1000.6 (series), Chapter 20.

B. Purpose. The purpose of this program is to inform commands about substance abuse policy, provide commands and individuals with substance abuse prevention training and implement strategies to prevent alcohol misuse and the unlawful use of other drugs. Commands should be mindful that, even with the best prevention strategies and programs, there are times that a Coast Guard member requires assistance in seeking treatment and educational resources. This program outlines the steps necessary for a command to appropriately address these situations and provide members with the treatment or education to which they are entitled. Substance abuse and chemical dependence for both alcohol and drugs are diseases that affect not only the afflicted member, but their family, friends and co-workers as well. This program intends to:

1. Increase Awareness of Substance Abuse Issues. Help each member and unit understand how to approach and deal with substance abuse and chemical dependence issues.

2. Support Responsible Alcohol Use. Encourage and support the responsible use of alcohol by members through responsibility and accountability. Key behaviors for responsible alcohol use as defined by CG-1111 include:

   a. No alcohol use if under age 21.

   b. No alcohol use if driving.

   c. Developing a designated driver plan.

   d. Consuming no more than one standard alcoholic beverage per hour.

   e. Consuming no more than three standard drinks per day.

   f. If on medication, checking with health care provider to ensure it is safe to consume alcohol with prescribed medication. The number one cause of deaths related to substance abuse is due to interactions between drugs and alcohol.

3. Provide Prevention Training. Provide members with prevention training, early problem identification skills and resources for screening and treatment.

4. Support Commands. Assist commands by providing the tools and procedures to deal with the irresponsible use of alcohol.

5. Outline Zero Tolerance for Substance Abuse. Support zero tolerance for use of illegal drugs as mandated by the Coast Guard drug policy.

6. Support Mission Readiness. Ensure that members are aware of how substance abuse interferes with mission readiness and a safe work environment.

C. Policy. The policy outlined in this chapter directly correlates with the drug and alcohol related policies reflected in the Coast Guard Personnel Manual, COMDTINST M1000.6 (series). Commands should use these two instructions simultaneously to appropriately document and treat alcohol and drug related issues at their unit.

D. Applicability. Policy in this chapter applies to all Coast Guard active duty personnel. Policy related to reservist and civilian personnel is clearly indicated.

E. Responsibilities.

1. Commandant (CG-1111). Responsible for the medical, training, education and evaluation policies of the Substance Abuse Prevention and Treatment (SAPAT) program.

2. Substance Abuse Program Manager. A general schedule (GS) civilian employee serves as the headquarters manager for the SAPAT Program and as a liaison to the Department of Defense and other agencies. Specific duties of the headquarters program manager include:

   a. Coordinate with Commander Coast Guard Personnel Command (CGPC (epm)) and MLCs (kma) to provide staffing for Coast Guard Substance Abuse Prevention Specialists (SAPSs) billets.

   b. Coordinate medical guidance and clearance in development of substance abuse training and education curricula for Coast Guard personnel.

   c. Ensure health care providers involved in evaluating, screening or diagnosing substance abuse patients obtain specialized training regarding substance abuse and diagnosis (e.g., Addictions Orientation for Health Care Provider) or civilian equivalent.

   d. Develop, establish, maintain, and oversee training and educational requirements for Command Drug and Alcohol Representative (CDAR) training.

   e. Collaborate with the MLC Substance Abuse Prevention Manager to develop, implement, and maintain training and educational requirements of substance abuse program personnel.

   f. Develop policy and manage the budget of the Substance Abuse Prevention and Treatment Program.

3. Commanders, Maintenance and Logistics Commands (MLC (kma)). Responsible for

coordinating the implementation of the Area Substance Abuse Prevention and Treatment program and for supporting HQ priority initiatives related this program. MLC Commanders shall:

a. Provide oversight and supervision of full-time Substance Abuse Prevention Specialists.

b. Advise commands on the availability of education, treatment, and rehabilitation resources and procedures for obtaining them.

c. Process requests for alcohol/drug rehabilitation, collect Rehabilitation Treatment Request Forms, CG-6043, and Command Drug and Alcohol Representative Referral and Follow-Up Forms, CG-6044, and assimilate data from these forms.

d. Oversee the support and/or aftercare plans program.

e. Provide liaison with unit commanding officers, other military services, state and federal programs, and local civilian treatment facilities as appropriate.

f. Not be assigned CDAR duties so that they may fulfill their primary duties.

g. Establish, track and maintain a Personnel Qualification Standards (PQS) for training of SAPSs (an example of which can be found in Section F of this chapter).

h. Provide Health Insurance Portability and Accountability Act (HIPAA) training related to substance abuse patient records.

i. Participate in HQ sponsored teleconferences, meetings and workgroups related to the Substance Abuse Program.

4. Commanding Officers and Officers in Charge shall:

a. Designate, in writing, an E6 or above (when possible) of any rating or an officer to fill the CDAR role. The member should be mature, reliable and fully understand the sensitive nature of this role. Commands with less than 10 members that are collocated with a Sector, AIRSTA or ISC may request permission from the Sector, AIRSTA or ISC's commanding officer to designate the larger unit's CDAR as their unit CDAR, when appropriate. Commands with ten or more members assigned shall designate a CDAR. All commands with 50 or greater members assigned shall designate, at a minimum, one primary and one alternate CDAR.

b. Place CDAR on all check-in/out lists.

c. Ensure unit CDAR attends CDAR training (within 120 days of designation) conducted by the Substance Abuse Prevention Team (SAPT) as per training and educational requirements outlined in Section F of this chapter.

d. Ensure command-related substance abuse policies as per Personnel Manual, COMDTINST M1000.6 (series), Chapter 20 and Section C of this chapter are accomplished in a timely manner that minimizes impact to their units' missions.

e. Support the CDAR in the performance of assigned duties, noting that CDAR duties are collateral and administrative in nature.

f. Ensure unit CDAR submits required Command Drug and Alcohol Representative Referral and Follow-up Reports, CG-6044, to MLC (SAPM) as per Section C of this chapter in a timely manner.

g. Accurately and completely document all substance abuse incidents and alcohol-related situations in accordance with the Personnel Manual, COMDTINST M1000.6 (series), to facilitate completion of appropriate treatment (if required) and/or corrective action (if necessary).

h. Take appropriate action in all instances of drunk driving as required by Personnel Manual, COMDTINST M1000.6 (series).

i. Promote responsible attitudes toward the use of alcoholic beverages, both on and off Coast Guard facilities.

j. Ensure an alcohol abuse prevention plan is developed and implemented. Guidelines for appropriate use of alcoholic beverages may be found in the United States Coast Guard Regulations 1992, COMDTINST M5000.3 (series).

k. Ensure members are afforded the treatment and educational opportunities outlined in Sections F, G and H of this manual.

l. Use all available resources, both military and civilian, to help set up protective factors addressing their units' specific risk factors with the help from SAPSs and Work-Life staff.

m. Treat each case individually in accordance with the Personnel Manual, COMDTINST M1000.6 (series), chapter 20, to include an environment where members can ask for help with alcohol issues without fear of judgment and retribution.

n. Ensure members being transferred who are on an aftercare or support plan have a copy of their plan forwarded to the commanding officer of their receiving unit, prior to departure.

5. Substance Abuse Prevention Specialist (SAPS). MLC personnel assigned to detached duty at major commands that form the Substance Abuse Prevention Teams (SAPT). Their primary purpose is substance abuse prevention education. SAPS shall:

a. Establish a network of unit CDARs and consistently provide updated and new

information pertaining to CDAR issues.

(1) Conduct and assist other commands' CDARs in developing and conducting general alcohol awareness as outlined in Section F of this chapter and prevention plans.

(2) Provide Substance Abuse Free Environment (SAFE) training.

(3) Advise and assist units in respective areas on all matters pertaining to substance abuse screenings and treatment.

b. When stationed at Training Center Cape May or the USCG Academy, provide recruits, officer candidates, direct commission officers and cadets with:

(1) An initial orientation on Coast Guard substance abuse policies and the effects of substance abuse within the Coast Guard.

(2) An initial survey or screening test (i.e., Substance Abuse Subtle Screening Inventory (SASSI)) to assist in identifying personnel who are at risk for substance abuse.

(3) Prevention-based educational programs to reduce the risk of future alcohol or other substance misuse for personnel identified as high risk.

(4) Educational courses such as SAFE, IMPACT and BASICS.

c. Provide support to training centers (TRACEN).

(1) Liaison and work with CDARs at TRACEN to help with Prevention Plans for both "A" and "C" schools.

(2) Conduct training with "A" school students that incorporates SAFE awareness as well as addressing specific risk and protective factors unique to the TRACENs.

(3) Conduct educational courses such as SAFE, IMPACT and BASICS for students and permanent party.

d. At the direction of the Substance Abuse Program Manager, conduct pre-screening substance abuse assessments within their area of responsibility. SAPSs are required to complete the Navy Drug and Alcohol Counselor School (NDACS) and Addiction Orientation for Health Care Providers (AOHCP) course prior to providing these assessments.

e. Shall not be assigned CDAR duties so that they may fulfill their primary duties.

6. Command Drug and Alcohol Representative (CDAR). Unit members who serve as an advisor to their command in the administration of the unit's substance abuse program. A CDAR's duties are a collateral responsibility and administrative in nature. Every unit shall

have a designated CDAR. CDARs are expected to manage substance abuse cases administratively and in a timely manner to minimize impact to their units' mission(s). CDAR shall:

a. Provide administrative information and assistance to the command regarding substance abuse prevention and treatment as per Personnel Manual, COMDTINST M1000.6 (series), Chapter 20, and this chapter.

b. Establish and document unit training plans as per Section F of this chapter to include;

   (1) Substance abuse and its effects on the members and their families.

   (2) The signs and symptoms of substance abuse.

   (3) Coast Guard policy on the responsibilities of the command to address suspected substance abuse at the unit and the responsibility of the individual member with respect to substance abuse.

   (4) Treatment programs available to Coast Guard members.

c. Work with Integrated Support Command's Health Promotion Managers (HPMs), the Employee Assistance Program Coordinators (EAPCs) and/or SAPSs to implement and promote substance abuse prevention programs.

d. Prepare unit prevention plans.

e. Establish liaison with the regional SAPSs, local federal screening/treatment facilities and civilian screening facilities, as appropriate.

f. Coordinate necessary referrals, initial screening and treatment, as per Sections F and G of this chapter.

g. Ensure that all paperwork, lab tests, and related information are completed before sending member to treatment or training. This includes ensuring HIV testing is performed prior to admittance to Navy inpatient/outpatient treatment programs. Contact treatment facility for all requirements.

h. Keep the commanding officer informed of the status of personnel undergoing treatment including expected date of completion/return, prognosis, and personal needs (pay, orders, etc.).

i. Assist and provide support for personnel undergoing or returning to duty from treatment.

j. Coordinate, implement and monitor the mandatory pre-treatment and aftercare programs with the commanding officer.

k. Work with the health records custodian to ensure that health and service record entries and information are entered and up-to-date.

l. Submit a CDAR Referral and Follow-up Report, CG-6044, to MLC (SAPM) for all members who were:

(1) Interviewed by the unit CDAR; for Self-Referral or Command Referral for suspicion of abuse, domestic violence, alcohol-related situation, or alcohol or drug incident.

(2) Referred to an approved screening, prevention, educational or addictions treatment program.

(3) Placed in the aftercare program.

(4) Transferred to another unit or discharged while in an aftercare program.

m. Submit to the receiving unit's Commanding Officer a copy of the Aftercare or Support plan for members being transferred to their command.

n. Complete annual HIPAA training related to substance abuse patient records.

7. Coast Guard Health Clinics/Health Services Personnel shall:

a. Senior Medical Officers shall facilitate substance abuse screening services when needed. (The Substance Abuse Program Manager or the Substance Abuse Prevention and Treatment Team for that AOR is usually the primary resource for this support.) Local Military Treatment Facilities, along with Tricare authorized civilian treatment facilities may be utilized for substance abuse screening services. Coast Guard Medical Officers are encouraged, in accordance with their training, professional experience, and clinical privileges, to provide substance abuse screenings. Unit-specific operational and administrative factors may require substance abuse screening services to be available at Coast Guard clinics.

b. Coast Guard Medical Officers are authorized to delegate the intake component of substance abuse screening to a senior Health Services Technician (HS), E-6 or above, provided that the training requirements outlined in section F.2.a.(3) of this chapter are met. These cases will be considered when no trained SAPS is co-located with our larger units. Both the medical officer and HS must be qualified.

c. Clinics or Health Services Personnel shall assist the CDAR as needed in order to locate needed information within the member's health record to ensure Health Insurance Portability and Accountability Act (HIPAA) compliance.

8. Member Responsibilities. Each member shall:

a. Use alcohol in a responsible manner or choose to abstain when any use may impact the readiness or safety of the member or unit.

b. Self-report DUI/DWI arrests for driving and operating while intoxicated (OWI) arrests for boating.

c. Never use illegal drugs.

F. Training and Education Requirements for Commands, Units and Members. Education and training programs will usually be provided by SAPSs, HPMs, EAPCs, CDARs and/or available local community substance abuse resources. The Coast Guard's training is available to active duty, reservists, retirees, civilian employees, auxiliarists and family members. Administrative management and treatment options, however, only pertain to active duty and reservists on active duty for more than 30 consecutive days. Training is only mandatory for Active Duty members and Reservists.

1. Substance Abuse Education Programs.

a. Initial Orientation.

(1) Cadets, officer candidates, and direct commission officers will be given orientation briefings by SAPSs on substance abuse awareness and current policies.

(2) Prior to completion of recruit training, SAPSs will brief all recruits on the drug and alcohol abuse policy and the availability of medical treatment.

b. Senior Leadership Training Courses. SAPSs will provide leadership schools (e.g., PCO/PXO, Boat Forces Command Cadre and CPO Academy) formal training related to prevention including, but not limited to the following areas:

(1) A review of alcohol policies and procedures relating to the proper referral and assistance of members with alcohol or drug related abuse or dependency issues.

(2) Tools for creating an environment which promotes responsible attitudes toward the use of alcohol onboard Coast Guard facilities and while on liberty.

(3) Detection of early signs of alcohol and drug abuse observable in the work place and the requirement to take immediate and appropriate action to mitigate these situations.

(4) Documentation techniques and requirements.

(5) Role and responsibilities of the CDAR.

(6) Command responsibilities towards the CDAR.

c. Substance Abuse Free Environment (SAFE). SAFE is a prevention-based program, conducted by members of the Substance Abuse Prevention Team, which provides uniform substance abuse training throughout the Coast Guard. SAFE offers awareness and prevention training at all levels over the course of a member's career. Commandant (CG-1111) maintains and updates the SAFE program. The goal of SAFE is to provide multi-tiered substance abuse training throughout the Coast Guard and to offer position-specific training every 3 years. SAFE education conducted at active duty units may include auxiliarists, reservists, dependents, and civilian employees who supervise military members. The SAFE program is presented in four training levels:

(1) SAFE for Managers. This training will consist of a 1-hour session usually for Commanding Officers (COs), Executive Officers (XOs), division officers, senior enlisted management positions (such as OINCs and Command Master Chiefs (CMCs)) and civilian equivalents. Training for managers will focus on evidence-based leadership strategies and tools which support substance abuse prevention goals. Training will be provided on their roles, responsibilities, and program evaluation/tracking tools. Training at this level is required every three years to provide up-to-date information on drug/alcohol trends, treatment options, and policy changes.

(2) SAFE for Supervisors. This training will consist of a 1-hour session for personnel who serve in a supervisory capacity. This training may include civilian supervisors. Supervisors will cover various subjects including Coast Guard policies, identifying signs and symptoms of substance abuse, understanding how personal choices affect unit readiness, treatment levels and resources, referral procedures, and monitoring during support plans and aftercare. This training is designed to enhance the supervisor's ability to identify and deal with substance abuse issues in the workplace. Training at this level is required every three years.

(3) SAFE Awareness. This training will consist of a 2-hour session for all personnel and will provide a basic awareness of Coast Guard Substance Abuse Program policies. Subjects covered will include signs and consequences of substance abuse, how use affects unit readiness, explanation of the term "alcohol incident" and how it can affect a member's career, other Coast Guard policy on substance abuse, early intervention and support available. Training at this level is required every three years for Active Duty members and Reservists. Civilians may be required to attend this training at Commanding Officer's discretion.

(4) SAFE IMPACT/BASICS Training and Education. These trainings will normally target members who are cited with an alcohol incident or otherwise show the signs of misuse of alcohol, but upon screening receive a "No Diagnosis, training recommended" remark. The member does not meet the criteria for Alcohol Abuse (DSM-IV code 305.0) or Alcohol Dependence (DSM-IV code 303.9).

(a) IMPACT Course. An intense, interactive preventive educational program taught

by Navy Drug and Alcohol Counselors. Designed for members who have been screened and determined "No Diagnosis" but require early education.

(b) BASICS Course. Brief Alcohol Screening and Intervention for Coast Guard Service Members. An intense, interactive preventive educational program taught by Coast Guard Substance Abuse Prevention Specialists (SAPSs). Designed for members who have been screened and determined "No Diagnosis" but require early education.

d. Unit Training. All active duty unit training plans shall include annual training for personnel, including but not limited to:

(1) Substance abuse and its effects on members and their families.

(2) Signs and symptoms of substance abuse.

(3) Coast Guard policy on personnel having alcohol/substance abuse problems, individual and command responsibilities.

(4) Substance abuse treatment programs available to Coast Guard members.

(5) Procedures for reporting unintentional or accidental intake of a known or unknown substance.

e. Training Records. Unit and member training records should reflect alcohol awareness and/or supervisor training conducted at each unit, documenting participants, subject of instruction, appropriate competency code and date. Each unit is responsible to ensure appropriate entries are incorporated into their member's/unit's training records. SAFE courses conducted by SAPSs will be entered into direct access by the Training Quota Management Center (TQC).

2. Training for Substance Abuse Prevention and Treatment Program Personnel.

a. Skills Required.

(1) The MLC SAPMs are assigned to provide support and program guidance for their area. Management skills, record keeping and an understanding of treatment and prevention resources are essential. Counseling skills are not needed.

(2) The SAPSs are tasked with providing education and prevention guidance, supporting area CDARs, developing support plans for care and aftercare programs and, in some locations administering assessment screenings. These duties require knowledge of program administration, prevention, substance abuse and dependency, family systems, treatment, and recovery issues.

(3) Some SAPSs may be required to conduct substance abuse pre-screening assessments

in addition to the duties listed above. Specific training in alcoholism therapy and counseling, a period of internship, and certification are required for these SAPSs. This training is available through the Navy Drug and Alcohol Counselor School (NDACS) course and the Addictions Orientation for Health Care Providers (AOHCP) course. Successful completion of training is required prior to SAPSs conducting aforementioned pre-screenings.

(4) CDARs are primarily a first level resource for commands and serve as administrative advisors. Some knowledge of substance abuse and dependency, administrative procedures, prevention, support plans and aftercare support is necessary. Since initial member referral does not involve therapeutic treatment, counseling training is not necessary for CDARs. The Coast Guard CDAR course is mandatory for unit CDARs and provides all training needed so that CDARs can perform this duty.

b. Funding. Prerequisite, recurrent, and elective training will be provided through designated funding sources.

(1) Commandant (CG-132) will fund prerequisite and recurrent training through annual funding. Quota allotments are then provided to Commandant (CG-1111).

(2) Requests for training and elective seminars for SAPSs, using Short Term Training Request, CG-5223, will be forwarded to Commandant (CG-1111).

(3) Requests for Addictions Orientation for Health Care Providers (AOHCP) training, using Short Term Training Request, CG-5223 or Direct Access will be forwarded to Commandant (CG-1111).

(4) Requests for CDAR training, using Short Term Training Request, CG-5223 or utilizing Direct Access will be forwarded to respective SAP Team at TRACEN Yorktown or Petaluma.

(5) Unit funds will be utilized for elective seminars and training.

c. Training Requirements. Specific training is required in conjunction with assignment to duties of SAPSs and CDARs. Additionally, personnel assigned to the SAPAT program are frequently called upon to represent the program before Coast Guard personnel, other services, and the general public. These persons should acquire the interpersonal skills needed to communicate with large and small groups. The ability to develop classroom instruction materials, prepare for public speaking engagements, and ensure the quality of locally obtained training is essential.

(1) MLC SAPM Training Requirements. Program management training is highly recommended for SAPMs. This training is available through government or community agencies and civilian programs.

(2) SAPS Training Requirements:

(a) Addictions Orientation for Health Care Providers (AOHCP) and the CDAR course within six months of assuming duties.

(b) Coast Guard's Instructor Development Course (IDC) within six months of assuming duties.

(c) Navy Prevention Specialist course within a year of assuming duties.

(d) SAPSs required to perform pre-screenings must attend Navy Drug and Alcohol Counselor School (NDACS) course prior to assuming related duties. Upon course and internship completion; these SAPSs must have professional preceptor oversight by a certified medical officer or treatment/screening facility.

(e) Additional annual or recurrent training through other agencies and civilian programs as determined by the program manager. Courses selected will be specific to the program needs.

(3) CDAR Training Requirements. All new CDARs are required to attend the Coast Guard CDAR course within 120 days of designation. A qualification code (JM, Personnel) will be assigned to all persons receiving the CDAR assignment and the training outlined in the Enlisted Qualification Codes Manual, COMDTINST M5300.2 (series).

(a) Requests for CDAR training, using Electronic Training Request on Direct Access, shall be forwarded to the respective Substance Abuse Prevention Team at Yorktown or Petaluma.

(b) Ongoing training and policy revisions will be provided to CDARs by their respective SAPSs via the CDAR network

(c) There are a variety of options available to develop group communication skills. Numerous colleges, universities, and associations offer public speaking courses. Training officers have details on application procedures.

(d) Local community colleges or state and county mental health agencies offer courses, seminars, and conferences addressing drug and alcohol abuse. This training must be funded by local commands.

G. Screening for Alcohol and/or Drugs.

1. Assessment Screening. The CDAR shall schedule a mandatory assessment screening at a local TRICARE approved Substance Abuse Rehabilitation Program, CG qualified screener, or MTF screening facility following an alcohol incident, drug incident, self or command referral, within two weeks or as soon as possible. A qualified screener shall perform the

screening.

2. Documentation. The CDAR shall ensure that appropriate documentation is sent with member (sealed in an envelope) as per Chapter 4.A.5 of the Medical Manual, COMDTINST M6000.1 (series) to include:

   a. Screening facility's required forms, completed.

   b. Personal Data Record (PDR).

   c. Health Record.

   d. Completed supervisor's evaluation.

3. Command Review of Documentation. The command shall review the written evaluation and treatment recommendations provided by the screening facility. When a member is diagnosed as Alcohol Abusive (DSM IV 305.0), Alcohol Dependent (DSM IV 303.9) or Drug Dependent (DSM IV 304.X), the command shall treat this as any other illness and ensure treatment is initiated immediately as per Section H of this chapter. A delay in treatment could jeopardize the member's health as well as the unit's readiness.

4. Action Steps. CDAR must take the following steps:

   a. Prepare Administrative Remarks, CG-3307. This should contain screening facility location, reason for referral, diagnosis, treatment recommended, and specific policy violation, as per enclosure (6) of Personnel and Pay Procedures Manual, PSCINST M1000. 2 (series).

   b. A Pre-Treatment Plan for both a diagnosis of Alcohol Abusive or Dependent will be required until the facility can initiate treatment for the member.

      (1) Administrative Remarks, CG-3307, outlining the requirements of the Pre-Treatment Plan can be found in enclosure (6) of Personnel and Pay Procedures Manual, PSCINST M1000.2 (series).

      (2) When a member is diagnosed as alcohol abusive or dependent, the command shall immediately place the member awaiting treatment on a pre-treatment plan to include; detoxification, if needed; weekly meetings with the CDAR; abstinence from consuming alcoholic beverages; and attendance of an abstinence-based twelve step program a minimum of twice a week.

   c. Chronological Record of Medical Care, SF-600, entry into health record to include screening facility, reason for referral, physician, diagnosis, treatment recommended, and pre-treatment plan with "transcribed from official records" signature/rate and duty station of transcriber.

d. CDAR Referral CG6043 and Follow-up report, CG-6044, faxed to SAPM at MLC (kma).

e. Other medical record entries

(1) Adult Prevention and Chronic Care Flow Sheet, DD-2766, for alcohol dependent members only.

H. Drug/Alcohol Treatment.

1. Length of Treatment. The length of the member's rehabilitation treatment program will be determined by the screening facility and then by the treatment facility. The length of treatment programs is typically the same between TRICARE approved facilities and MTFs. Any patient treatment exceeding 28 days must be authorized by the area MLC (kma). If the member returns to their unit in an outpatient status, the command must verify the member's compliance with all treatment aspects of the outpatient program (attendance at group or 12-step meetings and required counseling sessions) until the member completes the recommended program, including all aftercare requirements.

2. The Continuum of Care. This model is published by the American Society of Addiction Medicine (ASAM). It is based on Patient Placement Criteria. Treatment lengths will be personalized to each member and their needs. The following are the ASAM recommended levels:

a. Level I Outpatient Treatment (OP). Personnel diagnosed as Alcohol Abusive (DSM-IV code 305.0) and recommended for outpatient treatment as determined by the screening facility. When a member is referred for outpatient treatment, Military Treatment Facilities (MTFs) or TRICARE facilities that offer this type of treatment may be used. Contact servicing MLC for authorization guidance prior to start of member's treatment.

b. Level II Intensive Outpatient/Partial Hospitalization (IOP). Personnel recommended for this level by a qualified screener require a greater level of care than that provided by outpatient treatment. IOP consist of daily classroom instruction and individual/group counseling sessions. Members who are on Temporary Assigned Duty (TAD) will normally be berthed at the Bachelor Enlisted Quarters (BEQ)/Bachelor Officer Quarters (BOQ) nearest to the facility. The length of treatment will vary depending on the member's degree of need. When a member is referred for IOP, MTFs or TRICARE facilities that offer this type of treatment may be used. Contact servicing MLC for authorization guidance prior to member's start of treatment.

c. Level III Residential/Inpatient. Personnel diagnosed as alcohol dependent (DSM-IV code 303.9) are normally referred for this treatment level by the screening facility. Inpatient rehabilitation is an intensive residential treatment program that provides treatment and berthing on site. Alcohol dependent members who have other primary diagnosis which would undermine or interfere with their treatment for alcoholism may require a referral to an MTF with additional on-site treatment facilities. Contact

servicing MLC for authorization guidance prior to member's start of treatment.

d. Level IV Medically Managed Intensive Inpatient Treatment (Detoxification). Medically managed, 3-7 days in a hospital setting. This is a medical emergency! Admit the member at the nearest MTF or local civilian hospital emergency room. See alcohol screening in section G on the documentation needed.

I. Alcohol and Drug Treatment and Education Requirements.

1. Treatment Determination. Upon receipt of the assessment screening results, as per Section G, the CDAR shall schedule treatment at a Military Treatment Facility (MTF) or TRICARE Facility with guidance from the member's Primary Care Manager (PCM) and their respective MLC (SAPM). Treatment should be scheduled within 30 days, as per Medical Manual, COMDTINST M6000.1 (series), for specialty care.

2. Treatment Availability at Military Treatment Facilities (MTF) and TRICARE. Commands should seek treatment at the nearest facility that offers the specified type of treatment recommended by the screening facility. If a local MTF does not offer the recommended substance abuse treatment, commands should then seek treatment through the TRICARE network. Again, the member's PCM and the command's SAPM located at MLC (kma) should be contacted for treatment options.

3. Civilian Facilities (NON TRICARE). In some isolated cases as determined by the MLC SAPM, use of civilian facilities may be appropriate. Pre-authorization must be obtained from MLC (kma) for this non-federal medical care.

4. Transportation of Member to Treatment. Commands are strongly encouraged to transport members to and from treatment if needed. Commands should consider treatment level, acceptance of treatment, ability to travel due to physical or legal restriction (i.e., driving license suspended). Travel via privately owned vehicle to inpatient rehabilitation is not recommended and strongly discouraged.

5. Treatment Grading. Treatment programs recommended by screener shall not be downgraded to a lower level of care by command. Only higher medical authorities can change a diagnosis.

6. Pre-existing Condition. A member diagnosed as drug/alcohol abusive or dependent within the first 180 days of enlistment is considered physically disqualified for enlistment. This represents a pre-existing medical condition according to Section 3.D, Medical Manual, COMDTINST M6000.1 (series) and commanding officers shall process these members per Article 12.B.16 of Personnel Manual, COMDTINST M1000.6 (series). The Coast Guard is not obligated to offer treatment prior to separation of individuals diagnosed with conditions that existed prior to enlistment (EPTE). Commands should not offer treatment to members having conditions that EPTE if said treatment will delay separation beyond 180 days of active Coast Guard Service.

7. Treatment Placement. The CDAR will facilitate placing members into alcohol treatment and will ensure that all documentation required by the facility is complete. The CDAR will accomplish this responsibility with the assistance and guidance of the command, the member's Primary Care Manager (PCM) and MLC (SAPM). The CDAR will take the following steps:

    a. Contact the facility and ensure that all required documentation is completed. Most facilities have their own forms, which need to be completed before a member can be scheduled for treatment.

    b. Ensure that all required laboratory tests are completed for the treatment facility.

    c. Most facilities also require a copy of a Chronological Record of Medical Care, SF-600, indicating that an HIV-1 screening was performed. The confidentiality of the patients who test positive for HIV-1 is to be respected and safeguarded.

    d. Prior to seeking substance abuse treatment, the command must submit via fax, according to local SOP, a USCG Rehabilitation Treatment Request, CG-6043, to MLC (SAPM) for authorization of treatment.

8. Refusal of Treatment. Members diagnosed as alcohol abusive or dependent (DSM IV codes 305.0 or 303.9) or other drug dependence (DSM IV 304.X) who refuse treatment will be required to sign Administrative Remarks, CG-3307, acknowledging that they waive their right to benefits under the Department of Veterans Affairs (VA) for treatment for alcohol abuse/dependency or drug dependency. The member shall be processed for separation from the Coast Guard in accordance with the Personnel Manual, COMDTINST M1000.6 (series).

    a. Administrative Remarks, CG-3307, waiving VA benefits is required in addition to required screening/incident/referral paperwork.

    b. Entry in health record of the refusal of treatment as noted by the CG-3307. This refusal of care shall be entered into the health record on a Chronological Record of Medical Care, SF 600.

9. Treatment of Active Duty Members Involving Family Members. Treatment of active duty members at some Tricare approved facilities and MTFs may involve non-active duty family members as prescribed by the treatment facility. Family members become involved in treatment at the request of the treatment facility. Additionally, the member's primary treatment coordinator must deem it an essential component to successful outcome.

10. Travel for Family Members. Travel for non-active duty family members involved in the treatment of an active duty member may be available on a case-by-case basis. The authority to approve such invitational orders for non-active duty family members is approved by MLC as per Invitational Travel, COMDTINST 12570.3 (series).

J. Funding for Treatment.

1. Education. Early intervention training (e.g., BASICS, IMPACT, or civilian mandated) shall be funded by the member when ordered by civilian authority. It will be funded by the command when directed by CG required screening. This will normally involve only local travel and little or no course fee. This is not treatment.

2. Outpatient, Intensive Outpatient and Inpatient Treatment. Seeking treatment locally through TRICARE facilities and MTFs reduces the cost of travel associated with obtaining medical care. The availability of local facilities that offer substance abuse rehabilitation treatment is limited in some areas. If travel to obtain substance abuse related medical care is beyond the scope of the local area, contact servicing MLC (SAPM) for guidance on travel for treatment. NOTE: Units must submit a Treatment Authorization Request via MLC (SAPM) prior to receiving treatment.

K. Completion of Treatment and Start of Support and Aftercare Plans. Upon completion of treatment plan, member shall be required to fulfill requirements of the aftercare plan as established by the treatment facility. The aftercare plan is an essential part of the rehabilitation process for members returning from treatment. The aftercare plan provides follow-up to support and maintain the member's recovery.

L. Outpatient Support Plan for Abuse. Members who successfully complete an outpatient alcohol abuse treatment program who are not diagnosed as alcohol dependent are considered to have completed the necessary requirements for alcohol abuse treatment. The CDAR should immediately document completion in Administrative Remarks, CG-3307, see enclosure (6) of Personnel and Pay Procedures Manual, PSCINST M1000.2 (series). To assist these members in integrating the new skills acquired during treatment, their support plan should include:

1. Abstinence. Abstain from using alcoholic beverages for the first 90 days.

2. Weekly CDAR Meetings. Meet with the CDAR on a weekly basis for 90 days.

3. Support Program. Participate in a twelve-step, abstinence-based group support program at least twice weekly for 90 days.

4. CDAR Reports. Complete and submit CDAR Referral and Follow-Up Report, CG-6044, as required by Section O of this chapter.

5. Other Supporting Plans. Commands are strongly encouraged to incorporate the Individual Development Plan (IDP) and fitness plan to help with behavior change.

6. Plan for Responsible Alcohol Use. Upon completing the following limited support program, the member should be able to use alcohol in a responsible and abuse-free manner (after the initial 90 days post-treatment).

M. Support Plan Documentation.

1. Administrative Remarks. Administrative Remarks, CG-3307, to include completion of treatment, support plan, and policy shall be placed in the service record per Personnel Manual, COMDTINST M1000.6 (series). See enclosure (6) of Personnel and Pay Procedures Manual, PSCINST M1000.2 (series).

2. Secondary Administrative Remarks. A second Administrative Remark, CG-3307, to include successful completion of support plan and policy shall be placed in the service record per Personnel Manual, COMDTINST M1000.6 (series). See enclosure (6) of Personnel and Pay Procedures Manual, PSCINST M1000.2 (series).

3. Health Record Documentation. Support plans shall be documented in the health record on a Chronological Record of Medical Care, SF-600, to include successful treatment completion, treatment facility diagnosis, type of treatment, dates of treatment, and support requirements. Completion of the support plan shall also be documented on a Chronological Record of Medical Care, SF-600, and filed in the member's health record.

N. Aftercare Plan for Dependence.

1. Written Plan. The MTF or TRICARE treatment facility shall provide a written aftercare plan during the terminal phase of the outpatient and inpatient rehabilitation program. This will aid in the member's continuing recovery following completion of the formal counseling/rehabilitation program.

   a. Aftercare plans shall be documented in the health record as per this section, and in the service record as per Personnel Manual, COMDTINST M1000.6 (series).

   b. Each command is responsible for implementing, documenting, and actively supporting aftercare programs. There may be some circumstances where operational commitments may force the unit commander to modify the implementation of the aftercare plan. This plan shall be individually tailored to the member's needs and must include, but is not limited to:

      (1) Abstinence from alcohol. This is an administrative requirement for alcohol dependent members who desire continued service as per Personnel Manual, COMDTINST M1000.6 (series).

      (2) The aftercare period for alcohol dependent members is normally 12 months or more. The abstinence from alcohol requirement for dependent members is indefinite.

      (3) Meet with the CDAR on a weekly basis for 12 months.

      (4) Participation in a twelve-step or abstinence-based group support program at least twice weekly, if operations permit, for 12 months. Alcoholics Anonymous is the recommended 12 step program focusing on abstinence. Other 12 step and support groups must be approved by the MLC (SAPM) prior to use. Al-Anon, Ala-Teen, and other MLC (SAPM) approved support groups are also recommended for family

members to aid the member and the family in recovery from the effects of alcoholism.

(5) Meet with primary care manager or medical officer quarterly or as needed to ensure member receives care for any other medical issues or concerns member is facing.

(6) Voluntary supervised disulfiram (Antabuse) or Naltrexone use.

(7) Revia therapy when prescribed by a medical officer.

2. Aftercare Plan Documentation.

a. Administrative Remarks, CG-3307, to include completion of treatment, aftercare plan, and policy will be placed in the service record per Personnel Manual, COMDTINST M1000.6 (series). See enclosure (6) of Personnel and Pay Procedures Manual, PSCINST M1000.2 (series).

b. A second Administrative Remark, CG-3307, shall be placed in the service record as per Personnel Manual, COMDTINST M1000.6 (series), after successful completion of aftercare plan. See enclosure (6) of Personnel and Pay Procedures Manual, PSCINST M1000.2 (series).

c. Aftercare plans shall be documented in the health record on a Chronological Record of Medical Care, SF-600 to include successful treatment completion, treatment facility diagnosis, type of treatment, dates of treatment, and aftercare requirements. Completion of the aftercare plan shall also be documented on a Chronological Record of Medical Care, SF-600 and filed in the member's medical record.

3. Support and Aftercare Reports.

a. Reports. During recovery and support, the member, the CDAR, and the commanding officer (or representative) shall meet with the member quarterly to evaluate their progress during the 90-day support plan and twelve-month aftercare period.

(1) Initial Report. Upon the member's return to the unit, the commanding officer shall forward a copy of the narrative summary of the rehabilitative treatment, the support plan or the aftercare plan, and the initial CDAR Referral and Follow-Up Report, CG-6044, to MLC (kma) ATTN: Substance Abuse Program Manager Eyes Only. A copy of the narrative summary shall also be placed in the member's Health Record.

(2) Follow-up Reports. The command shall submit support and aftercare follow-up reports on a CG-6044, to MLC (kma) at 3, 6, 9, 12 months following completion of a rehabilitation program. Number of reports will depend on diagnosis.

b. Rehabilitation Failure. A rehabilitation failure has occurred when a member does not

complete an alcohol treatment program or aftercare plan due to noncompliance, or has an Alcohol Incident during treatment or an aftercare program. In such cases, the member shall be processed for separation in accordance with Personnel Manual, COMDTINST M1000.6 (series). Members who self-refer for an alcohol screening and receive a diagnosis of alcohol dependence or abuse must attend and successfully complete an appropriate treatment program. Because self-referred members are not identified as the result of an Alcohol Incident they are granted consideration for self-referring should a relapse occur during the aftercare phase of their treatment. The relapse shall be documented as their first Alcohol Incident and a new aftercare plan shall be instated that begins on the date the relapse was identified. If the member was not diagnosed as alcohol dependent, they shall be re-screened prior to a new support plan being instated. Should the self-referred member fail to complete the second aftercare plan they will be processed for separation.

O. Paperwork and Records Procedures.

1. Use of Information. All correspondence and health/service record entries regarding alcohol problems are "For Official Use Only" and will be marked as such. Medical and command personnel will take necessary steps to ensure that this information is not disclosed except within the Coast Guard or between the Coast Guard and the other armed forces or those components of the Veterans Administration furnishing health care to veterans.

2. CDAR Documentation.

   a. CDAR Referral and Follow-Up Report, CG-6044. Anytime a member is referred to the unit CDAR, the CDAR shall fill out the appropriate section of the CDAR Referral and Follow-up Report, CG-6044, and submit the completed report to the regional MLC (SAPM).

   b. A CDAR Referral and Follow-Up Report, CG-6044, shall be completed by the unit CDAR each time a member is interviewed, screened, attends and completes treatment and is seen by the CDAR for quarterly aftercare follow-up.

   c. USCG Rehabilitation Treatment Request Form, CG-6043. Anytime a member needs to receive treatment for Alcohol Abuse or Chemical Dependence the CDAR shall refer to their local MLC SOP for guidance and form requirements.

3. Administrative Documentation.

   a. Service Record Entries. All documentation surrounding alcohol/drug problems must be documented in the member's service record. The CDAR, together with the command, will ensure that all entries made in the member's service record completely and accurately document the incident, self-referral, or command referral, and all actions/counseling afforded to the member. At a minimum, such documentation will include:

(1) Treatment, treatment facility and dates of treatment, recommended aftercare program and aftercare program instituted. Details if such treatment is not completed. Narrative summaries from the treatment facility shall be obtained and filed in the health record.

(2) Aftercare interviews conducted and reports submitted to appropriate MLC. Appropriate notation when aftercare report status is completed.

(3) Referral for reevaluation, revision of treatment or aftercare plan, or institution of a second aftercare plan.

(4) Any rehabilitation failures.

4. Health Record Entries.

a. Any medical actions resulting from alcohol problems shall be documented in the member's health record. The CDAR together with the health record custodian will ensure that entries are made in the member's health record on a Chronological Record of Medical Care, SF-600, to document medical actions taken or appropriate reports/summaries are added to the health record. At a minimum, such documentation shall include:

(1) Results/recommendations from alcohol screening for alcohol-related problems, the reason for referral, physician and facility evaluating the member, and diagnosis (dependent, abusive, or no diagnosis).

(2) Details of pre-treatment plan or intervention prior to discharge from the Coast Guard.

(3) Details of outpatient or inpatient treatment completed (to include treatment facility, type of treatment, and dates of treatment), recommended aftercare program and actual aftercare program instituted. Written details if treatment plan is not completed. Narrative summaries from the treatment facility shall be obtained and filed in the health record.

(4) Aftercare interviews conducted and reports submitted to appropriate MLC. Appropriate notation when aftercare report status is completed.

(5) Referral for re-evaluation, revision of treatment or aftercare plan, or institution of a second aftercare plan.

(6) A Chronological Record of Medical Care, SF-600, entry when rehabilitation failure occurs.

5. Record Keeping. Under no circumstances shall CDARs maintain case files on members in regard to alcohol-related problems. All required medical and personnel documentation shall

be filed in the appropriate record and reports sent to MLC (SAPM). CDARs shall not keep copies or electronic files of medical and personnel record documents.

a. CDARs may maintain a tickler list if necessary to assist in appointment scheduling or to monitor a member's progress through the various phases of alcohol abuse treatment. A copy of the aftercare or support plan may be maintained until it is completed by the patient. Upon completion of treatment all information shall be permanently destroyed by shredding.

b. MLC SAPMs shall maintain a secure tickler file system on all members for whom alcohol rehabilitation (residential and outpatient) has been requested. This record may include identifying data (name, EMPLID number, rate/rank, length of service, prior service, permanent duty status, sex, and marital status), alcohol abuse history, type, location and dates of medical screening and alcohol rehabilitation treatment, particulars of aftercare plans, tracking of aftercare reports and final disposition.

c. SAPSs qualified to conduct screenings shall keep screening records on file for 3 years.

P. Definitions and Commonly Used Terminology. The following definitions are for use within the Substance Abuse Prevention and Treatment (SAPAT) Program. They do not change the definitions found in statutory provisions, regulations, or directives, which address personnel administration, medical care, or determination of misconduct and criminal or civil responsibilities for persons, acts, or omissions.

1. Abstinence-Based. Requiring the non-use of alcohol in any form.

2. Addiction. A general reference to a compulsive or repetitive behavior in relationship to the use of various addictive substances (alcohol, caffeine, food, supplements, prescription or illicit drugs, etc.) or experiences (gambling, exercise, sex, etc.).

3. Aftercare or Support Plan. A monitored program of continued care, immediately following completion of a formal inpatient or outpatient treatment program for substance abuse or dependency.

4. Al-Anon. The Al-Anon family groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope to solve their common problems of fear, insecurity, lack of understanding of the alcoholic, and disordered personal lives resulting from alcoholism. Al-Anon is listed in the telephone directory. The Al-Anon Family Group Headquarters address is 1600 Corporate Landing Parkway, Virginia Beach, VA 23454-5617. Their telephone is 1-888425-2666, and their website is http://www.al-anon.alateen.org./

5. Ala-Teen. Ala-Teen is a fellowship of young people, 12 to 20 years of age, who are the offspring of alcoholics. They meet together to help themselves and each other to learn about alcoholism, to cope with the troubles brought about by alcoholism, to make a new

life, and to set goals for themselves. Ala-Teen is listed in the telephone directory or information can be obtained through Al-Anon. The Ala-Teen address is the same as shown above for Al-Anon. The website is http://www.al-anon.alateen.org/.

6. Alcohol Abuse. A maladaptive pattern of alcohol use that meets the following criteria as published in the Diagnostic and Statistical Manual, (Current) Edition (DSM), code number 305.0: (1) a member consumes alcohol which causes other (performance of duty, health, behavior, family, community) problems or interferes with safety; (2) abuse has lasted at least one month; and (3) the member has never met the criteria for alcohol dependence.

7. Alcohol Dependence. A diagnosis made by a psychiatrist, psychologist or medical officer using specific criteria published in the DSM, diagnostic code number 303.9. Once a member has been diagnosed as alcohol dependent the diagnosis shall not be downgraded to alcohol abusive.

8. Alcoholic. General reference to individuals who are alcohol dependent.

9. Alcoholics Anonymous (A.A.). A.A. is a worldwide fellowship of men and women who share their experiences, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism. Local A.A. chapters can be found in the white/yellow pages of almost any telephone book. The A.A. World Services address is 475 Riverside Dr., New York, NY 10115, (212) 870-3400 or via the web at http://www.aa.org/. A.A. World Services may also be contacted for information on A.A. Internationalists/Loners for members who are stationed aboard ship or on isolated duty.

10. Alcohol Incident. Any behavior in which alcohol is determined, by the commanding officer, to be a significant or causative factor that results in the member's loss of ability to perform assigned duties, brings discredit upon the Uniformed Services, or is a violation of the Uniform Code of Military Justice, Federal, State, or local laws. The member need not be found guilty at court-martial, in a civilian court, or be awarded non-judicial punishment for the behavior to be considered an Alcohol Incident. The member must actually consume alcohol for an alcohol incident to have occurred. Under age drinking by itself is considered an alcohol incident.

11. Alcoholism. Same as alcohol dependence.

12. Alcohol-Related Situation. An Alcohol-Related Situation is defined as any situation where alcohol was involved or present, but was not considered a causative factor for a member's undesirable behavior or performance. A member does not have to consume alcohol to meet this criterion, e.g., purchasing alcohol for minors. Commands shall not use the term "Alcohol-Related Situation" when the behavior in question clearly meets the criteria of an Alcohol Incident.

13. Addictions Orientation for Health Care Providers (AOHCP). A training course for

medical officers performing drug and alcohol assessment screenings and newly assigned Substance Abuse Prevention Specialists. The AOHCP course is conducted at various locations.

14. Brief Alcohol Screening and Intervention for Coast Guard Service Members (BASICS). An intense, interactive preventive educational program taught by Coast Guard Substance Abuse Prevention Specialists (SAPSs). Designed for members who have been screened and determined "no diagnosis" but who require prevention education.

15. Command Drug and Alcohol Representative (CDAR). Unit members who serve as consultants and advisors to their command in the administration of the unit substance abuse program. A CDAR's duties are a collateral responsibility and non-medical in nature. Every unit shall have a designated CDAR. CDAR's are expected to manage substance abuse cases administratively and in a timely manner to minimize impact to their units' mission(s).

16. Command Referral. A Commanding Officer or Officer-in-Charge (OINC) may direct a member to be screened when substance abuse or dependency is suspected.

17. Continuum of Care. A medical model of care provided by Department of Defense and civilian substance abuse/dependency treatment facilities. Members recommended for abuse/dependency treatment will be referred to the appropriate level of treatment as determined by a qualified screener utilizing the Patient Placement Criteria (PPC). The member's care requirements will be continually evaluated throughout the multilevel treatment process ensuring individual needs are met.

18. Detoxification. The medically-supervised process of eliminating excess alcohol (or other drugs) from the body. This is usually done in an inpatient setting for a period of 3 to 7 days.

19. Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychiatric Association. A manual used by mental health professionals, which establishes uniform criteria and diagnostic codes for mental health problems including alcohol abuse and dependence. For purposes of this instruction, substance abuse-related diagnoses should be reported using DSM-IV criteria.

20. Intoxication. A state of impaired mental and/or physical functioning resulting from the presence of alcohol or other intoxicants in the body. Intoxication may be legally defined as per Uniform Code of Military Justice (UCMJ) Manual, Article 111, and terms that are outlined by state and/or local laws.

21. IMPACT Course. An intense, interactive preventive educational program taught by Navy Drug and Alcohol Counselors. Designed for members who have been screened and determined "no diagnosis" but who require prevention education.

22. Medical Officer. Physicians, Physician Assistants (PAs/PYAs), and Nurse Practitioners

(NPs) who are members of the Coast Guard or Public Health Service detailed to the Coast Guard. Civilian medical practitioners (under contract to the Coast Guard or GS employees) assigned to a medical treatment facility are considered medical officers to the limits defined by the language of their contract and/or job description.

23. Patient Placement Criteria (PPC). Personnel are evaluated for placement in the Continuum of Care, utilizing the following seven dimensions reflecting the severity of the individual's problem.

    a. Acute intoxication and/or withdrawal potential.

    b. Biomedical conditions or complications.

    c. Emotional and behavioral conditions.

    d. Treatment acceptance and/or resistance.

    e. Relapse potential.

    f. Recovery environment.

    g. Operational commitments/patient availability for care.

24. Primary Care Manager (PCM). The medical officer or civilian TRICARE provider charged with managing healthcare, including the authorization of referrals for a prescribed area.

25. Qualified Screener. A Coast Guard medical officer, other licensed physician, or psychologist who is trained and privileged to provide diagnostic screening for substance abuse or dependency. Substance Abuse Prevention Specialists who have attended Navy Drug and Alcohol Counselor School (NDACS) and have completed the required internship may be designated as a qualified screener. Coast Guard medical officers may request drug and alcohol screening privileges to the Professional Review Committee through the normal privileging process. Attendance at the Navy Addictions Orientation for Health Care Providers (AOHCP) or equivalent program, or documented professional experience and training in substance abuse and dependency, are required for obtaining drug and alcohol screening privileges. The Professional Review Committee will evaluate non-AOHCP training and experience requests for drug and alcohol screening privileges.

26. Recovering Alcoholic. A person whose alcoholism has been suppressed through abstinence and whose sobriety is maintained through a continuing personal program of recovery.

27. Rehabilitation. Restoration to a normal or optimum state of health and constructive activity through medical treatment, physical and/or psychological therapy.

28. Responsible Alcohol Consumption. Per the National Institute of Alcohol Abuse and Alcoholism, responsible alcohol use is defined as no alcohol consumption under 21 years of age, no driving under the influence of alcohol, no more than one standard drink per hour and no more than three standard drinks per occasion.

29. Self-Referral. Members who, on their own accord, seek personal assistance for a perceived alcohol-related problem without occurrence of an alcohol incident.

30. Substance Abuse. The use of a substance by a member, which causes other (performance of duty, health, behavior, family, community) problems or places the member's safety at risk.

31. Substance Abuse Free Environment (SAFE). A prevention-based program that provides uniform substance abuse training throughout the Coast Guard. SAFE offers awareness and prevention training at all levels over the course of a person's career. Commandant (CG-1111) maintains and updates the SAFE program. SAFE is required every three (3) years throughout a member's career.

32. Headquarters Substance Abuse Program Manager. The person assigned to Commandant (CG-1111) who manages policy, administration and financial resources of the Coast Guard's Substance Abuse Prevention and Treatment Program.

33. Substance Abuse Program Manager (SAPM). The CWO (MED) assigned to each Maintenance and Logistics Command (MLC) for primary duty as a Substance Abuse Program Manager for the respective area (Atlantic/Pacific). The SAPM provides guidance on substance abuse treatment resources and collects required CDAR report data.

34. Substance Abuse Prevention Specialists (SAPS). MLC personnel assigned to detached duty at major commands that form the Substance Abuse Prevention Teams (SAPT). Their primary purpose is substance abuse prevention education.

35. Substance Abuse Rehabilitation Program (SARP). Navy's Substance Abuse Rehabilitation Program. The program encompasses facilities formally known as Counseling and Assistance Centers (CAACs), Addiction Rehabilitation Centers (ARCs), and Addiction Rehabilitation Departments (ARDs).

36. Tolerance. The cumulative resistance of the body to the pharmacological effects of alcohol or drugs, gradually increasing as use continues and the body adapts to it. Tolerance is evident when repeated administration of a given drug dose produces a decreasing effect.

37. Treatment. Includes inpatient/outpatient medical treatment, counseling, or other appropriate care administered to the recovering or alcohol abusive/dependent member in an effort to redirect life patterns and attitudes.

38. Twelve Step/Support Group Meetings. Support groups that meet to help individuals and/or their families cope with the various residual affects of alcohol use and abuse. The only Twelve Step or Support Group meetings authorized for CG members' aftercare must be "Abstinence-Based".

39. Withdrawal Symptoms. Characteristic reactions and behaviors resulting from abruptly stopping the use of alcohol or drugs that the body has become dependent upon. Withdrawal symptoms vary in intensity depending on the time, duration and amount of a substance used. Common reactions include insomnia, anxiety, tremors ("the shakes"), sweating, seizures ("rum fits"), and hallucinations ("DTs"). Withdrawal symptoms from alcohol and various drugs can be fatal.

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## CHAPTER 3. TOBACCO USE POLICY.

A. Introduction. This chapter sets policies and procedures to control tobacco use in Coast Guard facilities, vehicles, ships, and aircraft. These procedures apply to all organizational elements, active duty, reservists, civilian employees, as well as all visitors, contractors and their personnel, and personnel of other agencies that operate within or visit Coast Guard facilities. Tobacco use includes all smoking (cigarette, cigar, pipe) and smokeless tobacco products (spit, lug, leaf, snuff, and dip) as defined by the Centers for Disease Control and Prevention. Further, this chapter provides guidance on tobacco use prevention and cessation within the Coast Guard.

B. Discussion. The Surgeon General of the United States has determined that tobacco use is the leading cause of preventable illness, disability, and death in the U. S. Results from the WELLSOURCE Personal Wellness Profile administered to Coast Guard beneficiaries show that the Coast Guard experiences a higher prevalence of tobacco use when compared to national tobacco use rates. The Coast Guard Health Promotion Program strongly discourages the use of all tobacco products and has implemented policies that support tobacco-free environments, programs that prevent tobacco use initiation and services to help CG beneficiaries quit their use of tobacco. The Health and Safety Directorate, (CG-11) views tobacco control as a prevention priority and supports efforts to decrease needless death and disability caused by tobacco use.

1. Readiness. Tobacco use impedes operational readiness by decreasing lung capacity and impairing an individual's ability to maintain an enhanced level of performance. Smoking can increase the level of member absenteeism due to aggravated coughs and common colds brought on by the detrimental effects smoking has on the respiratory system. The American Cancer Society reports that cigarette smokers are absent from work 6.5 days per year more than nonsmokers and approximately eight percent of a smoker's working hours are spent on smoking rituals. Controlling the use of tobacco products will enhance operational readiness and organizational efficiency by maximizing human resources.

2. Second-Hand Smoke. Environmental Tobacco Smoke (ETS), a combination of the smoke from a burning cigarette and the smoke exhaled by the smoker is a proven human carcinogen, containing over 4000 chemicals, at least 60 of which have been shown to cause cancer according to the American Cancer Society. Simple separation of smokers and non-smokers within the same airspace may reduce, but does not eliminate ETS exposure. The U.S. Surgeon General reports that there is no risk-free level of exposure to secondhand smoke. Nonsmokers exposed to secondhand smoke at home or work increase their risk of developing heart disease by 25 to 30 percent and lung cancer by 20 to 30 percent. The finding is of major public health concern due to the fact that nearly half of all nonsmoking Americans are still regularly exposed to secondhand smoke. Given the close operational and living quarters of many Coast Guard units, attention to the effects of second-hand smoke is not only important in understanding health risk but is required by law.

3. In the Home. Although ETS is harmful to all individuals, it poses greater health risks for infants, children, and the elderly. It has also been shown to be especially harmful to the unborn fetus. ETS has been linked to decreased lung efficiency and function, increased frequency of Sudden Infant Death Syndrome (SIDS) and increased frequency and severity

of childhood asthma, aggravation of sinusitis, rhinitis, cystic fibrosis, chronic respiratory problems such as cough and postnasal drip, increased incidence of colds and sore throats and increased frequency and duration of ear infections in children. In children under the age of two, ETS exposure enhances the likelihood of bronchitis and pneumonia. Smoking during pregnancy and exposure to second hand smoke have been associated with miscarriage, stillbirth, premature birth, low birth weight, and health problems associated with low birth weight and a higher incidence of crib death. Children of mothers who smoked during and after pregnancy are more likely to suffer behavioral problems such as hyperactivity. It is the responsibility of every Coast Guard member to protect his or her family from the dangers of tobacco use in the home.

4. Smokeless Tobacco. Smokeless tobacco is **NOT** a safe alternative to smoking and is highly discouraged. It is a highly addictive substance associated with an increased incidence of oral cancer. It damages the teeth and gums as well as oral soft tissue. Additionally, spitting into open containers, wastebaskets, or on the ground presents a potential health risk to others and results in an appearance **NOT** in keeping with the highest uniform standards of the Coast Guard.

C. Policy. It is Coast Guard policy to discourage the use of all forms of tobacco products and to protect non-users from exposure to ETS and unsanitary conditions created by the use of spit tobacco. The use of any tobacco product in public detracts from a sharp military appearance and is discouraged. Where conflicts arise between the rights of non-tobacco users and tobacco users, the rights of the non-tobacco user shall prevail.

1. Workplace.

   a. Use of tobacco products is prohibited by law for all members under the age of eighteen, except in Alaska where the legal age for purchase and use of tobacco products is nineteen.

   b. The Coast Guard prohibits the use of smoking tobacco and smokeless tobacco in the workplace in order to protect the health of all its workers. The workplace includes any area inside a building or facility, over which the Coast Guard has custody and control, where work is performed by active duty personnel, civilian employees, or personnel under contract to the Coast Guard.

   c. The use of tobacco products (smoking or smokeless) is permitted only in designated areas. Smoking or smokeless tobacco use is prohibited at all times in all non-designated tobacco use areas. Additionally, where smokeless tobacco use is permitted, tobacco spit shall be held in containers with sealing lids to prevent odor and accidental spills. Tobacco spit and residue shall be disposed of in a sanitary manner which prevents public exposure.

   d. When in view of the general public, personnel in uniform are strongly discouraged from tobacco use (smoking and smokeless).

e. The use of all tobacco products (smoking and smokeless) is prohibited in all Coast Guard government vehicles (cars, trucks, buses, vans) by all personnel, active duty, reserve or civilian.

f. The use of all tobacco products (smoking and smokeless) is prohibited in all Coast Guard aircraft or any other aircraft contracted for use in Coast Guard operational/training missions.

g. A section of the weather deck on afloat units may be designated as a tobacco use area (smoking and smokeless). In the event that weather conditions or operational requirements do not make the space available, an indoor space may be assigned provided the designated space vents directly to the external atmosphere. The safety officer/engineer will assist the command in determining the space aboard a ship that does not re-circulate tobacco odors/smoke. The following spaces will not be designated tobacco use areas (smoking and smokeless) even if they meet ventilation requirements: workspaces, watch stations, berthing areas, lounges, messing areas, exercise areas, medical spaces, areas where computers and electronic gear/equipment is used or stored, engine rooms' fuel storage section, or any other areas not considered safe. All tobacco use is prohibited during drills, special sea details, mooring stations and other all-hands evolutions.

h. Tobacco products (smoking and smokeless) shall only be used during regularly scheduled breaks **available to all crewmembers**, which includes breaks during formal training. Additional breaks for members to use tobacco will not be permitted.

i. The use of all tobacco products (smoking and smokeless) is prohibited by recruits at Training Center Cape May and officer candidates at Officer Candidate School. Tobacco awareness training and tobacco cessation programs shall be offered at each of these accession points.

j. The Cadets at the Coast Guard Academy will follow the policies set in the Cadet Regulations.

k. The expenditure of appropriated funds for structural and nonstructural changes to construct a designated smoking area with separate ventilation to the outside is discouraged.

l. Designated tobacco use (smoking and smokeless) areas will be away from entrances and exits and will not be located in areas commonly used by non-tobacco users. Designated areas must be a sufficient distance away, approximately 50 feet, so as not to allow smoke to be drawn into the indoor facility through door openings, windows and air intake units/vents.

m. The use of tobacco products (smoking and smokeless) is **strongly discouraged** while small boats are underway. The risk of ETS and hazardous material interactions is higher in these environments and every precaution should be taken to eliminate these risks.

Members aboard these afloat units must comply with all smoking and container regulations set forth by their CO or OINC.

2. Lodging, Dormitories and Housing.

   a. Smoking is permitted in individually assigned family quarters as long as the quarters of smokers do not share a common heating/ventilation/air conditioning (HVAC) system with the quarters of non-smokers. Smoking is strongly discouraged in common areas of family units that house children. Smoking will only be allowed in quarters with a common HVAC system if an air quality survey can establish that the indoor air quality protects non-tobacco users from ETS. NOTE: The American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) has established that 20 cubic feet per minute per person of outside fresh air is required. The carbon dioxide ($CO_2$) level should not exceed 1000 parts per million (PPM).

   b. Tobacco use (smoking and smokeless) is not allowed in Coast Guard-owned bachelor living quarters. Tobacco use (smoking and smokeless) is prohibited in all common areas. Common space is defined as any space within a building that is common to occupants and visitors. These areas include, but are not limited to, corridors, laundry rooms, lounges, stairways, elevators, lobbies, storage areas and restrooms.

   c. If smoke or odor from tobacco products from a designated tobacco use area (smoking and smokeless) seeps into common areas, the rights of the non-user (including children) will prevail.

3. Recreational Facilities. Workers and patrons are entitled to the same protection and consideration that is afforded to our personnel in the workplace. Accordingly, smoking in Coast Guard controlled service clubs, bowling centers and recreational facilities is prohibited unless a smoking area, which meets the air quality standards above, is provided separately. Workers shall not be required to enter such areas while smoking is ongoing.

4. Sales of Tobacco Products.

   a. The sale of tobacco products is prohibited in all health care facilities.

   b. The sale of tobacco products from vending machines is prohibited.

   c. The sale of tobacco products to anyone under the age of 18 years (19 years in Alaska) is prohibited.

   d. The distribution and advertisement of tobacco products in Coast Guard facilities, publications, and official correspondence is prohibited.

D. Tobacco Cessation Resources.

1. Mayo Clinic Tobacco Quitline. Through funding provided by Commandant (CG-1111), the Mayo Clinic Tobacco Quitline for the Coast Guard (888-642-5566) provides a telephone-based counseling service for all Coast Guard Active Duty, their families, reservists, and civilian employees who want to quit using tobacco products.

   a. Counseling Service Provided. Individuals who call the Quitline will speak directly with a counselor trained in guiding them through the tobacco cessation/behavior modification process. The counselor will complete a thorough assessment of the individual's tobacco use history and stage of readiness to quit. The counselor will then design a treatment plan that is tailored to the caller's unique circumstances and triggers for tobacco use. Once enrolled, the counselor will arrange convenient times for follow-up calls, 10 to 15 minutes each, scheduled just before and after the individual's quit date, to answer questions and provide the support and encouragement needed to quit successfully.

   b. Medication Service Provided. If it is recommended by a Mayo Clinic Tobacco Quitline counselor that a Quitline enrollee use nicotine replacement therapy (NRT) to aid in a quit attempt, these medications may be distributed directly by the Mayo Clinic Tobacco Quitline Mail Order Distribution Center at no cost to the Coast Guard beneficiary if that person is eligible for such benefits.

      (1) Individuals must be enrolled and actively participating in the Mayo clinic Quitline in order to be eligible for no-cost NRT.

      (2) NRT will only be provided to enrollees age 18 or older.

      (3) Eligible enrollees will be entitled to a maximum of 2 twenty-eight day supplies of NRT through the Mayo Clinic Tobacco Quitline. Beneficiaries must maintain active enrollment in the telephone counseling program to receive the second supply of NRT.

      (4) NRT distributed by the Mayo Clinic Mail Order Distribution Center will be limited to nicotine patches, nicotine gum and nicotine lozenges. If additional medication is recommended by a Mayo Clinic Counselor, members will have to seek approval and prescription from a Coast Guard physician.

      (5) Members who obtain NRT through the Mayo Clinic Mail Order Distribution Center must report use of these medications to their primary care physicians.

   c. Contact Numbers. The Quitline can be accessed toll-free at 1-888-642-5566 from anywhere in the United States or internationally via special access numbers by following the website instruction at HTTP://WWW.Business.ATT.com/BT/Tollfree.JSP

   d. Hours of Operation. Quitline hours of operation are Monday through Friday, 0800 to 2300 EST and Saturday 1100 to1700 EST.

e. Participation Verification. Active duty members will be sent an official letter from Mayo Clinic to verify program participation.

2. Other Resources. Additional cessation programs may be available through local hospitals, clinics and national health websites. Many states offer their own tobacco quitlines for state residents. Members are encouraged to use the program or service which best helps them achieve freedom from nicotine addiction. Regional HPMs can be contacted for further information on tobacco cessation programs.

E. Nicotine Replacement Therapy (NRT) and Tobacco Cessation Aids.

1. Eligibility. Pharmacologic support for treating nicotine addiction is available free of charge to active duty Coast Guard personnel and reservists on active duty enrolled in an approved tobacco cessation program through the Mayo Clinic Tobacco Quitline or through a CG clinic or CG pharmacy program. Non-active duty beneficiaries may be eligible for over-the-counter NRT products at no charge when provided by the Mayo Clinic as part of their tobacco counseling program for the Coast Guard.

2. Guidelines for Obtaining Aids. All eligible Coast Guard beneficiaries wanting to quit using tobacco are encouraged to participate in the Mayo clinic Quitline and receive non prescription NRT free of charge through that program. Prescription medications used for the treatment of nicotine dependence are not available through the Mayo clinic. The following guidelines apply for any individual wishing to obtain NRT:

a. Active duty personnel and reservists on active duty who are provided NRT by the Mayo clinic must provide their CG clinic health care provider with an enrollment letter and counseling summary/treatment report from Mayo before additional prescription therapy will be considered by their health care provider.

b. Coast Guard active duty members and active duty reservists may also receive certain types of tobacco cessation pharmacotherapy from their local Coast Guard clinic or unit corpsman. However, before pharmacotherapy can be provided, the member must be able to provide the clinician with proof that he/she is enrolled in an approved tobacco cessation program. In addition, he/she must first follow the established CG medical protocol for securing medications. This includes scheduling an appointment, seeing a health care provider and discussing his/her tobacco use history, related medical history and cessation plan.

c. Because NRT and tobacco cessation aids are not a TRICARE covered benefit, active duty members desiring to use NRT or tobacco cessation aids which are not received from the Mayo Clinic Tobacco Quitline program must be aware of the following guidelines:

(1) Members may obtain NRT agents outside of CG clinics or without MLC pre-authorization, but are responsible for all costs incurred.

(2) Coast Guard clinics and sickbays will have a limited selection of NRT products available.

(3) Members must present their medical provider with verification of enrollment in an approved tobacco cessation program. The Mayo Clinic Tobacco Quitline for the Coast Guard is the Health Promotion Program's recommended cessation program.

(4) Medical providers will then make the ultimate determination of the member's need for NRT products.

(5) Active duty members without access to a CG clinic who wish to be reimbursed for NRTs must first obtain approval through their respective MLC before purchasing NRT or tobacco cessation aids at a local pharmacy. To obtain such authorization for non-federal health care, active duty members should contact their unit HS or YN to submit a request through their respective MLC (kma).

(6) NRT or tobacco cessation aids are not available through the TRICARE Mail Order Program (TMOP).

F. Responsibilities.

1. Health Promotion Division Commandant (CG-1111) shall:

a. Program Planning, Evaluation and Support.

(1) Establish and facilitate a Tobacco Cessation Work Group with Coast Guard Headquarters Health Services Division Commandant (CG-112), the MLCs (PAC and LANT) and the Health Promotion Program Managers.

(2) Establish program evaluation measures for tobacco cessation efforts throughout the Coast Guard.

b. Funding and Procurement.

(1) Provide funding and support materials for The Mayo Clinic Tobacco Quitline for the Coast Guard as well as other cessation aids and interventions.

2. Health Promotion Program Managers shall:

a. Program Planning and Support.

(1) Support Commandant (CG-1111), Coast Guard Medical and Dental Officers and Regional Health Promotion Managers in upholding these policy guidelines.

b. Funding and Procurement.

(1) Provide contractual support for tobacco cessation programs including the Mayo Clinic Tobacco Quitline for the Coast Guard.

(2) Provide necessary educational materials to Regional Health Promotion Managers for tobacco awareness and cessation programming.

c. Training and Education.

(1) Support and encourage continuing education training for Regional HPMs in the area of tobacco awareness and cessation.

(2) Generate ALCOASTS and other CG-wide marketing materials to support tobacco cessation efforts.

3. Commanding Officers and Officers in Charge shall:

a. Administrative Support.

(1) Post notices at the entrance of all facilities which state smoking is not allowed except in designated areas.

(2) Enforce compliance with this policy and ensure each member of the command is familiar with this instruction.

(3) Designate appropriate sites for the use of tobacco products (smoking and smokeless) and ensure areas are clearly marked for both visitors and attached personnel. These areas shall be removed from the vicinity of building entrances and exits or areas in clear public view.

b. Program Planning.

(1) Ensure tobacco cessation programs address the use of smokeless tobacco products and ensure that smoking restrictions do not promote the use of smokeless tobacco products.

(2) Encourage members to use available tobacco cessation resources, including The Mayo Clinic Tobacco Quitline for the Coast Guard (888-642-5566).

(3) Prohibit smokers from engaging in tobacco use during unscheduled break times that are **not available to all crew members.**

(4) Hold tobacco users (smoking and smokeless) accountable for appropriately discarding smoking materials and/or spit tobacco.

4. Coast Guard Clinic Staff or Unit Health Services Technicians shall:

a. Administrative Support.

(1) Appoint a medical provider as the POC to assess the appropriateness of nicotine replacement therapy, contraindications for use, and prescribe therapy when needed.

(2) Utilize the fax referral system for enrolling Coast Guard members in the Mayo Clinic Tobacco Quitline for the Coast Guard.

(3) Act as a liaison between the Coast Guard Clinic Staff and units within their AOR. Provide smoking cessation materials and educational information, including Provider Information Packets from the Mayo Clinic to the clinics and dentists within their AOR.

b. Program Planning and Support.

(1) Maintain a supply of educational materials on the risks of tobacco use and provide support materials for cessation programs available to help members end tobacco addiction.

(2) Require medical and dental providers to inquire about the member's tobacco use history during medical and dental examinations.

(3) Implement standards of care in accordance with the Smoking Cessation Clinical Practice Guidelines (AHCPR pub 96-0692) published by the U.S. Department of Health and Human Services.

(4) Provide information on tobacco use cessation programs, including the Mayo Clinic Tobacco Quitline for the Coast Guard, to active duty members, eligible beneficiaries, attached commands and independent units within AOR.

(5) Ensure all tobacco users receive, if desired, assistance and/or referral for cessation.

(6) In conjunction with Regional Health Promotion Managers, promote organizational and local tobacco cessation resources which incorporate cognitive and behavioral change strategies and the use of nicotine replacement therapy when appropriate. Establish monitoring requirements for conducting these cessation programs to obtain authorized prescriptions of cessation aids as approved by the Office of Health and Safety.

5. Regional Health Promotion Managers shall:

a. Program Planning and Support.

(1) Provide promotional materials for the Mayo Clinic Tobacco Quitline to all units and medical facilities within the AOR.

(2) Use the fax referral process to assist members with enrolling in the Quitline.

b. Training and Education.

(1) Maintain supplies of tobacco use educational material and a resource list for services and materials.

(2) Identify local resources within the AOR that can assist members with their tobacco cessation efforts.

(3) Recommend and conduct tobacco prevention and control awareness training.

(4) Assist units with establishing tobacco cessation programs.

6. Unit Health Promotion Coordinators shall:

a. Administrative Support. Assist the command with enforcing this policy.

b. Program Planning and Implementation.

(1) Brief members reporting in to unit on this policy and resources available for cessation.

(2) Ensure tobacco cessation programs are made available (including afloat units) to active duty members, family members, and retirees and to other federal employees on a space available basis.

c. Program Marketing. Maintain supplies of tobacco use educational material and a resource list for services and materials, including information related to the Mayo Clinic Tobacco Quitline for the Coast Guard.

# CHAPTER 4. PHYSICAL FITNESS PROGRAM.

A. Introduction. Coast Guard personnel have a duty to be operationally ready to respond to situations affecting public safety and/or national security. A physically fit member has a greater chance of successfully coping with physical requirements and higher stress levels placed upon them in operational and emergency situations. Although the Coast Guard does not currently require mandatory physical fitness testing for all members, Command and individual responsibilities with respect to physical fitness do exist and are covered in this chapter. Specific duty assignments including BTM, BO, LEDET, TACLET, MSST, MSRT, boat crew, and rescue swimmers do have mandatory physical fitness requirements not covered here.

B. Background.

1. Healthy People 2010. In 1990, following a three-year national study involving health professionals, the U.S. Public Health Service published a set of national health promotion and disease prevention objectives. This report, Healthy People 2000, recognized the need for people to develop healthier habits to improve their quality of life. According to Healthy People 2000, "physical activity and fitness," was recognized as the top health promotion priority. New information published in Healthy People 2010 confirmed the importance of regular physical exercise and activity, as perhaps the most significant variables associated with positive health.

2. Negative Effects. Research shows that a lack of frequent physical activity is clearly recognized as a major risk factor for heart disease, obesity, hypertension, diabetes, osteoporosis, and depression. Additionally, a lack of physical activity has adverse effects on one’s emotional health. It is linked to chronic stress and anxiety, thereby lowering an individual’s ability to complete activities of daily living.

3. Positive Effects. Physical fitness improves physical and mental health, stamina, productivity, appearance, self-esteem and overall quality of life. A physically fit person can go from rest to intense activity, sustain that activity and recover faster than an unfit person. As a result, in emergency situations, unfit people present greater risks to themselves and others with whom they are working. Many jobs in the Coast Guard are physically demanding and require a high level of physical fitness for mission success. For these reasons, a regular physical training program is strongly advised for all Coast Guard members.

4. Weight/Physical Fitness Standards for Coast Guard Military Personnel. In 2004, Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series) was updated to mandate basic physical fitness plans for all Coast Guard military members. Monitored physical fitness activities, detailed personal fitness plans and monthly fitness testing are required for those found to be over their maximum allowable weight (MAW) and maximum allowable body fat standards.

C. Discussion.

1. Personal Accountability. One of the cornerstones of health promotion is the concept of personal accountability. Individuals, rather than the medical and health promotion communities, are ultimately responsible for their own health and well being.

2. Components of Physical Fitness. There are five components of physical fitness: (1) body composition, (2) flexibility, (3) muscular strength, (4) muscular endurance, and (5) cardiorespiratory endurance.

3. Guidelines. Less than one-quarter of Americans engage in regular physical activity despite its potential benefits. A complete list of guidelines for developing a fitness program and completing a basic or detailed personal fitness plan can be found in Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series), Enclosure (7). According to the Center for Disease Control, to maintain good health, physical activity should be **moderate** or **vigorous** and add up to at least 30-60 minutes a day most days of the week. For successful weight management moderate or vigorous physical activity should be performed 60-90 minutes a day at least five days a week.

   a. Moderate Physical Activities.

      (1) Walking briskly (about 3 ½ miles per hour).

      (2) Hiking.

      (3) Gardening/yard work.

      (4) Dancing.

      (5) Golf (walking and carrying clubs).

      (6) Bicycling (less than 10 miles per hour).

      (7) Weight training (general light workout).

   b. Vigorous Physical Activities.

      (1) Running/jogging (5 miles per hour).

      (2) Bicycling (more than 10 miles per hour).

      (3) Swimming (freestyle laps).

      (4) Aerobics.

      (5) Walking very fast (4 ½ miles per hour).

      (6) Heavy yard work, such as chopping wood.

      (7) Weight lifting (vigorous effort).

(8) Basketball (competitive).

4. Medical Clearance. Physical activity is important for people of any age and most can start a physical fitness program without medical clearance as long as they participate in regular medical examinations. However, before starting a new program, members are strongly encouraged to answer the short list of questions in the Physical Activity Readiness Questionnaire (PARQ), CG Form 6200. If they answer "yes" to any of the questions, a physician should be consulted before beginning an exercise program.

5. Use of Health Risk Assessment. Command leadership and individual members are strongly encouraged to participate in the Health Risk Assessment service provided by the Health Promotion Program. Results and feedback provided by this assessment can assist members in designing and implementing their own personal wellness plan. The UPHC or regional HPM may administer a Wellsource PWP Health Risk Assessment. More information on the health risk assessment can be found in **Chapter 5.**

D. Responsibilities. This section contains fitness specific responsibilities in addition to those contained in Chapter 1, Section E of this Manual.

1. Health Promotion Division (CG-1111).

a. Provide professional oversight for physical fitness initiatives, ensuring the scientific and operational validity of program content.

b. Establish curriculum and provide instruction and course materials for the Unit Health Promotion Coordinator Course.

c. Devise educational and promotional initiatives for improving the physical fitness of Coast Guard members and beneficiaries.

2. Commanding Officers and Officers in Charge. As an important factor in mission readiness and an essential component of total wellness, physical fitness should be strongly encouraged at all levels of the command. Commanding Officers and Officers in Charge shall:

a. Enroll a qualified Coast Guard member in the Unit Health Promotion Coordinator Course to serve as a health promotion advocate and resource for unit personnel and family members. According to Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series), the CO or OINC must designate this individual, in writing, to the Regional HPM.

b. Empower and encourage the unit Health Promotion Coordinator to implement innovative and effective unit physical fitness programming.

c. Promote and support efforts of members to improve personal fitness and physical readiness for duty.

d. **Strongly encourage** members to complete the PARQ before participating in any physical fitness program or testing.

e. Ensure members are completing Personal Fitness Plans in accordance with requirements in Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

f. Ensure supervisors are addressing the existence of and adherence to the annual fitness plan during a member's performance evaluation period.

g. Allow time during the workday (a minimum of three hours per week) for military personnel and to carry out their Personal Fitness Plans.

h. Allow civilian personnel flexibility in their work hours to encourage fitness activity. It is expected that civilian employees will participate during non-duty hours, including lunch periods, when engaging in health and fitness activities for an extended or indefinite period of time.

i. Grant excused absences for civilian employees to take part in one-time or occasional programs that are of short duration. Examples of these include activities such as: An officially sponsored Federal Fitness Day Event; an agency sponsored health screening; a fitness center orientation and a smoking cessation program consisting of several brief classes. Any additional questions regarding the use of official duty time in health and fitness activities and its applicability to civilians should be directed to the local Command Staff Advisor.

j. Ensure that monthly physical fitness testing and monitored fitness activities for those members found to be over their Maximum Allowable Weight (MAW) take place in accordance with Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

3. Regional Health Promotion Manager (HPM) shall:

a. Provide professional guidance for physical fitness initiatives, ensuring the safety and scientific validity of program content

b. Provide on-site unit fitness training when requested.

c. Provide technical support and assistance for unit physical fitness assessments.

d. Devise educational and promotional initiatives for improving the physical fitness of Coast Guard members and beneficiaries in their AOR.

4. Unit Health Promotion Coordinator (UHPC). Designated Unit Health Promotion Coordinators shall:

a. Be innovative and flexible in promoting physical fitness. Potential tools that can be used include: all-hands training, awards programs, on-duty workout time, unit challenges and educational e-mails or newsletters.

b. Schedule appropriate fitness-related activities and events for unit members and family members.

c. Assist CO or OINC in **strongly encouraging** members to fill out the PARQ before beginning a physical fitness program or testing.

d. Assist members in development of useful and appropriate Personal Fitness Plans (CG6049).

e. Monitor the physical fitness activities of those found to be over their MAW and body fat standards.

f. Assist the command, as necessary, with requirements related to physical fitness in Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

5. Coast Guard Active Duty Members and Reservists shall:

a. Be in compliance with MAW/Body fat standards at all times and adhere to the regulations outlined in Weight/Physical Fitness Standards for Military Personnel COMDTINST M1020.8 (series).

b. Complete and adhere to a Personal Fitness Plan (Form 6049) which has been approved by immediate supervisor and submitted during the performance evaluation period for review.

c. Be strongly encouraged to take advantage (operations permitting) of allowed voluntary workout hours in accordance with Weight/Physical Fitness Standards for Military Personnel, COMDTINST M1020.8 (series).

d. Strive to be an example of a physically fit and healthy Coast Guard member.

6. Coast Guard Employees (Civilian and Auxiliarists) shall use all available resources to implement health and well-being into their everyday lives.

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## CHAPTER 5. HEALTH RISK APPRAISALS.

A. Introduction. Health Risk Assessments (HRA) are tools that provide individuals and organizations with information on personal and organizational health risks and specific guidance on how to reduce modifiable risk factors through behavior change. The Personal Wellness Profile (PWP) by Wellsource is the sole HRA authorized for use by the Coast Guard Health Promotion Program. Based on the results of the HRA, the Wellsource PWP generates a personalized report for the member and a summary report for the CG unit. The employee report informs users of areas where they may be at risk for disease or disability while the unit report include non-identifiable aggregate data which is used to determine Health Promotion Program priorities and to track organizational behavior change over time. The PWP gathers a combination of three types of data: self-reported data using the lifestyle questionnaire, clinical data (blood pressure, resting heart rate, cholesterol, height, weight, and waist-to-hip ratio) and physical fitness data (body fat, sit-ups, push-ups, run or walk times, and flexibility).

B. Discussion. The Coast Guard utilizes the PWP HRA to enhance the health of both the individual Coast Guard member and the organization as a whole.

1. Individual Benefits. The PWP provides each member who completes a questionnaire with a personalized report on their health habits with recommendations for improvement. This report can also be used to assist members in designing their own personal health and fitness plans.

2. Organizational Benefits. The data collected from members provides a database (e.g., body weight, blood pressure, cholesterol data, dietary habits, tobacco use, tobacco cessation, etc.) for measuring the overall health of the Coast Guard. This enables an evidence-driven focus for Health Promotion Program efforts and a measure of the effectiveness of existing programs. The data is compiled into a group format that can be used to identify and track common risk factors within a unit, a specific portion of the Coast Guard population (rank, rate, age, gender, etc.), and/or the organization as a whole. Additionally, the PWP is a needs assessment that assesses individual and community needs for health education activities. Data from the PWP determines the nature and emphasis of health education program planning.

C. Procedure. The HRA selected for use by the Coast Guard is used for the following reasons:

1. Scientific Validity. The HRA is developed from a well-recognized scientific database and uses health guidelines established by eighteen leading international health organizations and research teams using over twenty years of accumulated data.

2. Population Appropriate. The Coast Guard HRA is appropriate to our population. The HRA developed by Wellsource Inc. Health Assessment and Prevention Systems is designed to service a population ranging in age from 15 to 69. The questionnaire

and feedback materials utilize simple terminology and set achievable goals for behavior changes.

3. Confidentiality. All information collected by the HRA is confidential. The data collected from the HRA will be used in the following limited applications:

   a. Preparation of individually sealed reports returned to the participant.

   b. Development of anonymous group reports for organizational needs.

   c. Research application to track and measure health promotion program effectiveness.

   d. Improve health care delivery and job site safety. The information is not used for any other administrative or disciplinary purposes.

   e. The collected information is held in a secure, limited access database at Coast Guard Headquarters under the direct control of Commandant (CG-1111).

4. Confidentiality Exception. The one exception to the confidentiality of the HRA is if a participant answers positively to questions relating to taking one's own life or the life of another person. In these rare cases, the HPM will notify the servicing Employee Assistance Program Coordinator (EAPC) to take the appropriate action.

5. Easy Format and Feedback. The HRA is designed in an easy to use format for both participant and administrator. Personal feedback takes two forms, qualitative and quantitative. Organizational feedback can be adapted to meet specific needs. All participant feedback documents are provided in an environment that provides facilitated feedback either by the regional HPM or through an approved video feedback tool. The regional HPM is available in person or by phone to answer any generated questions.

D. Implementation. The Personal Wellness Profile (PWP) as developed by Wellsource, Inc. is the Health Risk Appraisal (HRA) authorized for use in the Coast Guard Health Promotion Program.

1. Medical Exams. The HRA is not considered a substitute for a complete medical exam and does not substitute for or supersede any existing organizational policies for medical examinations. All information collected is treated as medical data and as such is fully confidential.

2. Accession Points. All recruits and officer candidates will complete the HRA at the time of accession into the Coast Guard (during recruit training or officer candidate school).

3. Command Mandated. Commands may choose to make participation in the HRA mandatory for all military personnel. This type of Command-wide HRA event may be scheduled through the UHPC or regional HPM. Commands will be provided

with a summary report of the unit health status but, due to confidentiality, will not have access to individual members' reports.

4. Leadership Schools. All those attending the CPO Academy and CWO Professional Development School will complete a PWP.

5. MAW Requirements. In accordance with Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series), all members found to be over their maximum allowable weight (MAW) and maximum allowable body fat shall complete a Personal Wellness Profile questionnaire. All members within ten pounds of their MAW are highly encouraged to complete the PWP.

6. Implementation Guidance. Appendix D of this manual gives guidelines for conducting the Wellsource PWP including conducting physical assessments, explanations of the physical assessment protocols and guidelines for conducting the PWP. The Health & Fitness Assessment Data Sheet, CG Form 6200A, provides an assessment data sheet that can be used by participants to record information during clinical and physical fitness portions of the PWP for easy transfer to the actual questionnaire.

7. Supplies. HRA materials and supplies will be ordered semi-annually and distributed through Commandant (CG-1111) to the regional HPMs. Supplemental supplies needed throughout the year will be ordered through the local Integrated Support Command (ISC). Regional HPMs are responsible for conducting HRAs at the unit upon request and for supplying HRA questionnaires to units on an as needed basis.

8. Report Processing and Distribution.

   a. Although UHPCs may administer the HRA, in order to protect the members' confidentiality, they must return completed questionnaires to regional HPMs for individual and unit reports to be generated. Completed HRA questionnaires will be forwarded to the regional HPM. The regional HPM will conduct all data processing and report generation in order to maintain confidentiality.

   b. Due to the confidential nature of the data being gathered and processed, no other Coast Guard entities are authorized to purchase this or similar software packages for local use. Commandant (CG-1111) will authorize expanded distribution of the software package on an as needed basis.

   c. Some units, such as CPO Academy and CWO Professional Development School, may have the ability to administer PWPs online. In these instances, upon completion of the questionnaire, the report will immediately be generated for the individual. Organizational data will still be collected annually and reported to Commandant (CG-1111).

   d. When a regional HPM cannot be present to return individual reports and discuss HRA results, sealed feedback booklets will be returned to the member's UHPC for distribution. UHPCs may schedule group or individual sessions for review

of the feedback material and conduct question and answer sessions. Videos to assist in facilitating these meetings are available from the regional HPM.

e. Any member receiving a feedback booklet that is unsealed or has a broken seal shall report the same to their regional HPM and UHPC so that these entities can ensure that no breach of confidentiality has occurred.

E. Responsibilities.

1. Health Promotion Division (CG-1111). The Health Promotion Division at Coast Guard Headquarters shall:

   a. Provide funding to support the Coast Guard's HRA program.

   b. Distribute supplies as needed to regional HPMs, CPO Academy, CWO Professional Development School and other designated report processing sites.

   c. Ensure that all HPMs have completed Privacy Act and HIPPA training, including refresher training on a regular basis. This training is available online.

   d. Ensure that all HPMs are properly protecting the confidentiality of those participating in the PWP by providing policy guidance on proper handling, storage, and disposal of PWP questionnaires and printed reports.

   e. Annually collect Coast Guard wide PWP data and analyze to determine direction of future Health Promotion Programs as well as identify health behavior trends in the population.

2. Commanding Officers and Officers in Charge. Commanding Officers and Officers in Charge shall:

   a. Ensure all members over their MAW and body fat standards complete a PWP in accordance with Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

   b. Have the authority to mandate PWPs for all military members in an effort to evaluate the overall mission readiness of the unit as it relates to health and well-being.

3. Regional Health Promotion Managers. Regional Health Promotion Managers shall:

   a. Work with commands and UHPCs in their AOR to ensure that PWPs are being properly administered.

   b. Provide overall PWP data downloads for their AOR to Commandant (CG-1111). This will usually be required annually at the end of the FY; however, Commandant (CG-1111) will request data on an as needed basis.

c. Follow Commandant (CG-1111) policy on storage and other physical security protections of completed PWP questionnaires and reports.

4. Unit Health Promotion Coordinators (UHPCs). Unit Health Promotion Coordinators shall:

a. Ensure that all members at their command over their MAW and body fat standards complete a PWP.

b. Work with the regional HPM to ensure any crewmember or beneficiary wishing to complete a PWP is able to do so.

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## CHAPTER 6. NUTRITION AND WEIGHT MANAGEMENT.

A. Introduction. Weight management is a process that keeps your body weight at a healthy level and involves balancing calories consumed with calories expended. To achieve and maintain a healthy weight two key elements are required: a moderate diet and regular exercise. Other factors, such as understanding eating patterns and developing positive stress management techniques also impact weight management success. As a uniformed service, compliance with weight standards supports a positive military appearance and contributes to fitness for duty requirements critical for successful mission performance.

B. Purpose. Although weight management is largely an issue of personal accountability, this chapter outlines the responsibilities and resources throughout the Coast Guard that support effective weight management strategies. Specifics on weight and body fat standards can be found in Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

C. Discussion. Modern society continues to strive for the easy way to lose weight. Diets without regard to the nutritional value of foods and/or total caloric intake, coupled with sedentary lifestyles, contribute to rising national obesity rates and higher incidences of type two diabetes. Successful weight management requires healthy eating and regular physical activity for a lifetime. The Health Promotion program defines healthy foods as those that are nutrient-dense, high in vitamins and minerals, and have lower calorie and saturated fat values.

D. Resources.

1. Weight-Management Self-Help Guide. The Weight Management Self-Help Guide, COMDTPUB P6200.3 was developed through a concerted effort of the Coast Guard's regional HPMs located at TRACEN Cape May, Headquarters Support Command, and each of the Integrated Support Commands. The guide was created to provide employees and their families assistance with managing their weight.

2. Regional Health Promotion Managers. While the Weight Management Self-Help Guide is essentially self-explanatory, maximum benefit and support can be realized by seeking the advice of regional HPMs. Health Promotion Managers can provide a wide variety of support in the area of nutrition, fitness, stress and weight management. They can assist Food Service Personnel with menu planning and healthy cooking techniques, conduct all-hands training on weight management strategies, and assist beneficiaries develop an effective plan that supports their weight management goals.

3. Health Risk Appraisals (HRA). After completing a PWP HRA questionnaire, members receive a personalized report based on their answers to health-related questions. The report includes recommendations on behavior modifications for weight management.

4. Unit Health Promotion Coordinators. Although not subject matter experts in the areas of nutrition and weight loss, the UHPC is provided training from the regional HPM that equips

them with knowledge and skills needed to assist members in their weight management efforts.

5. Unit Food Service Specialist. Diet is a significant part of the weight management equation. Many of the Coast Guard's Food Service Specialists (FSs) have special training in nutrition and healthy cooking techniques. FS personnel are valuable resources for information and play a major role in the availability of healthy food choices at their dining facilities.

6. 5-A-Day Program. The 5-A-Day program is a national health education program that encourages Americans to eat at least five servings of fruits and vegetables a day to promote better health and reduce risk of cancer. Fruits and vegetables are usually low in calories and full of vitamins, minerals and phytochemicals that work with other nutrients to protect against disease and help slow the aging process. Eating at least five servings of fruits and vegetables daily is key element of a nutrient rich diet that will help keep us healthy. The Coast Guard's 5-A-Day Program is called "Make Way To Five-A-Day." Program criteria include:

   a. All fruits and vegetables, with the exception of avocados, coconuts, olives, and nuts may be used to promote recipes that meet the 5-A-Day Recipe Criteria.

   b. All fresh, frozen, canned and dried fruits (except avocados, coconut, olives, and nuts) that do not have added fat or sugar.

   c. All recipes and food products with sodium content under 480mg / 8oz serving.

   d. All juice products that are 100% juice or juice concentrate that do not contain added fat or sugar.

   e. All recipes and food products with no more than 30% of calories from fat. Of that 30%, no more than 10% can be saturated fat or have over 100mg of cholesterol.

   f. All promotions of fruits and vegetables done in association with the program must retain the nutrient integrity of fruits and vegetables as low-fat, lower calorie foods.

   g. What is a serving?

      (1) A medium piece of fruit.

      (2) ½ cup of raw or cooked fruit or vegetable.

      (3) 1 cup of leafy salad greens.

      (4) ¼ cup of dried fruit.

      (5) 6 ounces (3/4 cup) of juice.

(6) ½ cup cooked beans or peas (e.g., lentils, pinto beans, kidney beans).

E. Responsibilities.

1. Office of Military Personnel (CG-122). The administrative aspects of the Coast Guard's weight and body fat standards including the weight probation program remains with Commandant (CG-122).

2. Commanders, Maintenance and Logistics Commands (kma). Commanders, Maintenance and Logistics Commands shall:

   a. Provide liaison with unit Commanding Officers, other military services, TRICARE providers, state and federal programs, and local civilian treatment facilities as required.

   b. Ensure access is available to nutritional counseling for members needing these services. Treatment for diagnosed eating disorders will be handled in accordance with Chapter 5.B.18.d. of the Medical Manual, COMDTINST M60001.C.

   c. Advise commands on the availability of educational, treatment, and rehabilitation resources.

3. Commanding Officers and Officers in Charge. Commanding Officers and Officers in Charge shall:

   a. Conduct semi-annual weigh-ins in accordance with Weight and Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

   b. Refer all members exceeding the maximum allowable weight or percent body fat for their age and gender to a Coast Guard Medical Officer for evaluation.

   c. Refer members to their UHPC or regional HPM for information on weight management planning, techniques and resources.

   d. Obtain resources from Commanders, Maintenance and Logistics Commands (kma) for members who require educational, treatment or rehabilitation resources.

   e. Ensure that all members placed on the Coast Guard weight program be provided access to The Weight Management Self-Help Guide, COMDTPUB P6200.3.

4. Regional Health Promotion Manager (HPM). Regional Health Promotion Managers shall:

   a. Provide weight management training and education to medical personnel upon request.

   b. Provide weight management training and education to units.

c. Provide basic counseling to individual members on weight management planning and techniques, and provide appropriate referral to licensed professionals as needed.

d. Assist unit food services personnel in planning menus and activities which promote healthy, nutritional food choices, and promote the 5-A-Day program.

e. Establish and determine appropriate educational resources for weight management.

5. Unit Health Promotion Program Coordinator (UHPC). The Unit Health Promotion Coordinator shall:

a. Provide members with information on nutrition, weight management, and the 5-A-Day program.

b. Implement the list of resources for weight management and nutritional counseling provided by the regional HPM. Members requesting assistance beyond the scope of the UHPC's training should be referred to their regional HPM for further guidance.

c. Provide all members requesting additional information on weight management with the Weight Management Self-Help Guide, COMDTPUB P6200.3.

d. Operations permitting, coordinate a minimum of one nutrition or weight management all-hands training session annually.

e. Coordinate programs and activities with unit galley to insure that all members have access to daily healthy food choices.

6. Unit Food Service Specialist shall:

a. Plan menus to ensure that all members have daily access to nutritionally sound food choices daily.

b. Collaborate with regional HPM and UHPC to increase knowledge and program effectiveness.

c. Enhance techniques of nutrition adequacy and healthy cooking.

d. Promote the Coast Guard 5-A-Day program.

## CHAPTER 7. STRESS MANAGEMENT.

A. Introduction. Safety and operational readiness are closely tied to the ability of personnel to endure the physical, mental and environmental demands of work, social and family systems. Stress management supplements operational risk management programs by focusing specifically on risks that pertain directly to the wear and tear of stress on personnel. The purpose of effective and healthy stress management programs is to identify and control factors that can reduce human endurance and thereby compromise safety and operational readiness.

Stress is tension or pressures that are a natural part of every day life and is an ever-present reality for military members and their families. When managed effectively, stress can help individuals reach personal and operational goals. However, when ineffective management techniques are used, the results can be harmful to the member, their family and to operational readiness. The impact of stress on crewmembers and unit readiness should be a concern for leaders at all levels.

The Health Promotion Program assists Coast Guard members by providing stress management skills training.

B. Description. Stress is defined as an elevation in physical and psychological arousal or “readiness” that results from exposure to a stimulus or demand. Stress evokes the natural "fight or flight" response, which is the body’s survival mechanism for dealing with danger. During this state of arousal the body produces adrenaline and prepares to deal with danger or threat, whether physical or psychological. This "Stress Response" is recognized as a necessary source of energy to perform whatever action is necessary to cope, such as escaping a violent attack or getting up to talk in front of a crowd. In the normal course of events, the threat is overcome and the body returns to normal. However, if the source of stress is on-going, like a child custody battle or a difficult work environment, the body often does not switch itself off; instead it maintains a constant state of alertness. In this case, what began as an adaptive response to a danger or threat can become something that actually impedes the ability to function. Under these circumstances, the ability to "switch off" the stress response is needed.

C. Discussion. The person who is most susceptible to the negative consequences of stress is often the one who is least aware of the effect that their stress is having on them. Therefore, it one of the critical elements in effective stress management is being able to identify personal stressors and the physical signs of stress.

1. Common Stressors. In the Coast Guard, common work-related causes of stress are:

   a. Danger from weapons used during operational missions.

   b. High tempo operational missions.

   c. Physical and environmental challenges related to mission operations.

d. Long work days, standing duty, and rotating schedules.

e. Training accidents.

f. Moving oneself or one's family to new assignments.

g. Lack of support from or conflict with family members over new assignments.

h. Sudden deployments and separation from family and friends.

i. Living and working in close quarters.

j. Illness or traumatic events during deployments.

k. Responsibility for the safety of others.

l. Lack of information on operations.

m. Administrative actions such as Captain's Mast or Court Martial, that could potentially impact their careers.

2. Signals of Stress. While each person's responses to stress are unique there are general symptoms that indicate stress overload. Some of the most typical signals include:

a. Chest pain and difficulty breathing.

b. Hypertension.

c. Dehydration.

d. Irregular heart beat.

e. Confusion.

f. Difficulty making decisions.

g. Problems focusing.

h. Poor recall of familiar names, objects, or functions.

i. General anxiety or panic attacks.

j. Exaggerated or loss of emotional control.

k. Low affect or energy.

l. Uncontrolled rage or ongoing low-level irritability.

m. Substance abuse or eating disorders.

n. Sleep disturbances

D. Stress Management. To optimally manage stress, individuals need to understand personal stress triggers, their response to these triggers and determine if the response improves or worsens the situation and/or their health. Successful stress management is a key factor in achieving a healthy work-life balance. Following are common examples of harmful and helpful stress management behaviors.

1. Harmful Stress Management Techniques.

a. Tobacco Use. Tobacco use does not solve problems and actually causes more stress than it relieves. Smoking may provide short term mood improvement, however as nicotine depletion occurs, tobacco users experience a significant increase in stress and tension. The overall effect of tobacco use is to increase stress levels, increase nicotine dependency and increase risk of preventable death and disability.

b. Drinking Alcohol. Alcohol is often abused during times of stress because it can mask the pain associated with the tension or pressure. However, excessive alcohol adversely affects behavior, judgment, and physical coordination and is related to almost all cases of domestic violence and assault and at least fifty percent of reported suicidal behavior in the Coast Guard.

c. Using Other Drugs. Any type of drug use deteriorates an individual's coping skills and will only mask the symptoms of the stress. The use of non-prescription narcotics is strictly prohibited by the Coast Guard. Members suspected of substance abuse should be immediately referred to the Command for treatment according to the guidelines outlined in Chapter Two.

d. Disordered Eating. The feeling of satiety that follows eating produces a relaxed state that chemically reduces stress and provides feelings of control. However when using eating as a coping mechanism for stress, health problems such as weight gain and loss of productivity may occur.

e. Addictive and Compulsive Behavior. These coping behaviors include spending excessive amounts of time engaging in "escapist" activities such as computer game-playing, watching television/ DVDs, gambling, or other behaviors that consume large amounts of time negatively impact job performance, relationships and work-life balance.

2. Productive Management Techniques.

a. Exercise. Moderate physical activity can affect brain chemistry, causing an elevation in mood and a respite from the stressful situation. Physical activity, especially aerobic exercise, can manage the adrenaline boost that accompanies a stressful situation, helping an individual to balance the body's reaction to the stress. Exercise can also reduce blood pressure and the feelings of anxiety which are often elevated during times of stress.

b. Performance Nutrition. During times of stress, hunger triggers may increase because the brain is signaling the body that it needs energy to combat the stressful situation. To avoid excess weight gain during stressful periods, personnel are encouraged to choose foods that are nutrient dense, such as whole grains, protein, fruits and vegetables and to avoid "junk" foods such as candy bars, chips and foods high in saturated or trans fats. A healthy, balanced diet supplies the body with the energy and nutrients needed to support healthy stress management and contributes to effective outcomes.

c. Sleep. Adequate sleep is critical to brain function. Stress often disrupts sleep patterns contributing to decreased mental performance and increased risk of mishaps. When you don't get enough sleep your body produces extra stress hormones making you more vulnerable to stress symptoms such as moodiness, headaches, irritability and unclear (fuzzy) thinking. With adequate sleep (an average of 7 – 8 hours), mood improves and optimal mental and emotional functioning are achieved.

d. Social Support. When people have strong social support to share fears, frustrations and joys, they are happier and less affected by everyday stressors. Individuals who lack these strong support systems should reach out to the support services provided by the Work Life office and EAP program within their AOR. These services are available to all Coast Guard employees and active duty family members.

e. Communication. Effective communication is important in every situation, especially when it comes to coping with stress and anger. Employing proper communication techniques to deal with a stressful situation can help to lower anxiety, enhance understanding and increase the likelihood of healthy resolution.

f. Spiritual Wellness. Spiritual wellness or connection to a group or organization that shares common values and beliefs enhances an individual's ability to cope and manage stress. Spirituality can encourage social support, healthy habits, a positive attitude and relaxation.

g. Time Management. Having an effective time management strategy can alleviate many of the emotions that arise from feeling overwhelmed or overburdened by work and home pressures. Individuals should seek to balance their time so that they can honor commitments to work and family without having to continually compromise the time they take for themselves.

3. Risk Factors. Various assessments outlined in paragraph four assist personnel in identifying stress risk factors. Risk factors include but are not limited to:

a. Ineffective coping behavior.

b. Stress signals- physical, mental, behavioral or emotional.

c. Low energy levels.

d. Feelings of worthlessness/inadequacy.

e. Seldom calm or peaceful- constant arousal state.

f. Inability to relax and have fun.

4. Resources. Commandant (CG-1111) (Health Promotion Program), along with Commandant (CG-1112) (Employee Assistance Program), provides CG members with the following resources to help manage stress at home and in the workplace.

a. Stress management training and literature.

b. Unit and Personal Stress Climate Assessments.

c. Health Risk Assessments.

d. Critical Incident Stress Management, COMDTINST 1754.3 (series).

e. Coast Guard Employee Assistance Program, COMDTINST 1740.7 (series).

f. Crew Endurance Management, COMDTINST 3500.2 (series).

E. Responsibilities.

1. Health Promotion Division (CG-1111) shall:

a. Provide professional oversight for stress management initiatives.

b. Establish subject matter training materials at annual UHPC course training.

c. Provide funding for stress management supplies and education materials.

2. Employee Assistance Program (CG-1112) shall:

a. Provide oversight of the Coast Guard EAP Program.

b. Provide oversight and training for the Critical Incident Stress Management (CISM) program.

c. Assist the Health Promotion Program in its efforts to design and implement effective stress management programs.

3. Commanding Officers and Officers in Charge are **highly encouraged to:**

   a. Be aware of the unit's stress climate and the signals of stress members may display.

   b. Ensure crews and individuals receive appropriate and timely assistance to avoid stress breakdown and burnout.

   c. Proactively create stress awareness during operational transitions and high stress situations such as:

      (1) PCS moves.

      (2) Underway deployments.

      (3) Disaster relief missions.

      (4) High evolution operational tempos.

   d. Empower and encourage stress management training and implementation of resources and tools.

   e. Direct UHPCs to provide training and education to crew members.

   f. Promote and support individual members on implementing proper stress management techniques at work.

   g. Make use of Critical Incident Stress Management, COMDTINST 1754.3 (series) services as needed.

   h. Conduct Crew Endurance Risk Assessments in accordance with Crew Endurance Management, COMDTINST 3500.2 (series). Commandant (CG-1133 can address technical questions regarding this reference.

   i. Conduct safety stand-downs to include crew endurance and stress management training.

4. Regional Health Promotion Manager (HPM) shall:

   a. Provide professional guidance for stress management education and practices.

   b. Organize logistics and provide instruction for UHPC exportable training within their AOR.

c. Provide support and assistance for stress management education materials for unit training.

d. Devise educational and promotional initiatives for improving the stress level of Coast Guard members in their AOR.

e. Upon request, provide stress climate assessments and/or resources for Commands within their AOR.

5. Unit Health Promotion Program Coordinator (UHPC) shall:

a. Schedule unit all-hands stress management training.

b. Be innovative and flexible in promoting healthy stress management. Potential tools that can be used are:

(1) All hands training.

(2) Training guides and materials provided by regional HPM.

(3) Early warning and risk detection tools.

(4) Self-assessment tools.

c. Serve as a resource for members who request information and education on stress management.

d. Work with regional HPM to provide stress assessment tools for all unit personnel during operational transitions and high stress times.

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## APPENDIX A. RESOURCE LIST.

A. Health Promotions Division Chief, Commandant (CG-1111), (202) 475-5145

B. Health Promotion Program Manager (active duty member), Commandant (CG-1111), (202) 475-5146

C. Health Promotion Program Manager (civilian), Commandant (CG-1111), (202) 475-5153

D. Substance Abuse Program Manager, Commandant (CG-1111), (202) 475-5148

E. Substance Abuse Program Representative, MLCLANT(kma) (757) 628-4339

F. Substance Abuse Program Representative, MLCPAC(kma) (510) 637-1215

G. Regional Health Promotion Managers can be reached at the following numbers**:**

1. ***Alameda*** (510) 437-2736
2. ***Boston*** (617) 223-3244
3. ***Cleveland*** (216) 902-6354
4. ***Headquarters Support Command*** (202) 372-4085
5. ***Honolulu*** (808) 842-2088
6. ***Ketchikan*** (907) 463-2126
7. ***Kodiak*** (907) 487-5525 x 273
8. ***Miami*** (305) 278-6664/6672
9. ***New Orleans*** (504) 253-6370/6371
10. ***Portsmouth*** (757) 686-4031/4093
11. ***San Pedro*** (310) 732-7581
12. ***Seattle*** (206) 217-6614
13. ***St. Louis*** (314) 269-2347
14. ***TRACEN CAPE MAY*** (609) 898-6886

**Other resources:**

H. Food Pyramid (USDA) http://www.mypyramid.gov

I. American Cancer Society (connects to regional chapter) (800) 227-2345 http://www.cancer.org/docroot/home/index.asp

J. American Heart Association (connects to local chapter) (800) 242-8721 http://www.americanheart.org/

K. American Lung Association (connects to local chapter) (800) 586-4872 http://www.lungusa.org/

L. American Red Cross http://www.redcross.org/

M. American Institute for Cancer Research (800) 843-8114 http://www.aicr.org

N. American Running and Fitness Association (800) 776-2732 http://www.americanrunning.org

O. American College of Sports Medicine http://www.acsm.org/

P. Ask the Dietician http://www.dietitian.com/

Q. Centers for Disease Control and Prevention (404) 639-3311 http://www.cdc.gov/

R. Weight/Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series)

http://cgweb2.comdt.uscg.mil/CGDirectives/Welcome/htm

S. Food and Drug Administration (FDA) (202) 205-4168 http://www.fda.gov

T. National Cancer Institute (800) 422-6237 http://www.nci.nih.gov

U. National Center for Nutrition and Dietetics (312) 899-0040 ext. 4653 http://www.eatright.org

V. National Clearinghouse for Alcohol and Drug Information (800) 729-6686 http://ncadi.samhsa.gov

W. National Institutes of Health (NIH) (301) 496-4461 http://www.nih.gov

X. World Health Organization (WHO) http://www.who.int/

Y. U.S. Department of Agriculture Food & Nutrition Service http://www.usda.gov

Z. USCG Weight Management Self-Help Guide, COMDTPUB P6200.3

AA. 5-A-Day information – http://www.5aday.com

## APPENDIX B. EXERCISE GUIDELINES

A. Physical Fitness**.** The American Council on Exercise defines physical fitness as "the condition resulting from a lifestyle that leads to the development of an optimal level of cardiovascular endurance, muscular strength, and flexibility as well as the achievement and maintenance of ideal body weight." Physical fitness can also be defined as the ability to carry out daily tasks with vigor and alertness, without undue fatigue, and with ample energy remaining to enjoy leisure-time pursuits and to meet unforeseen emergencies. Physical fitness has many components. Some of these components are related to a particular sport or activity, while others are related to overall health. The five components with the most significant impact on general health include the following: (1) **cardio-respiratory endurance**, (2) **flexibility**, (3) **muscular strength,** (4) **muscular endurance**, and (5) **body composition**.

1. Cardiorespiratory Endurance (CRE). CRE is the ability to perform large-muscle, prolonged, dynamic exercise at moderate to high levels of intensity for prolonged periods. CRE is probably the single best indicator of your physical fitness level from a health standpoint because it reflects the function of your heart, lungs and circulatory system. As cardio-respiratory fitness improves, the heart does not have to work as hard during rest or exercise, and can better withstand the strains and stresses of everyday life. Conversely, poor cardio-respiratory fitness is linked with heart disease.

2. Flexibility. Flexibility is defined as the ability of a joint to move freely through its full range of motion. Flexibility is dependent on a number of factors and is specific to each joint. For example, you may be very flexible at the shoulder and inflexible at the hip, or vice versa. Maintaining or improving flexibility aids mobility, increases resistance to muscle injury and soreness, prevents lower back and other spinal column problems, helps with postural alignment, and promotes graceful movement and enhanced motor skills. Many injuries and musculoskeletal problems, particularly back problems, may be related to a lack of flexibility. About 80% of all lower back problems in the U.S. are due to improper alignment of the spine and hip; a direct result of poor flexibility at the hip joint and poor strength of the abdominal and low back muscles.

3. Muscular Strength and Endurance. Muscular strength is the maximum amount of force a muscle or muscle group can exert in a single effort. Muscular endurance is the ability of a muscle to exert a sub-maximal effort repeatedly or continuously over a period of time. Strong muscles are important for health because they help keep the skeleton in proper alignment, preventing leg and back pain and providing support necessary for good posture. Strong muscles also help ease the performance of everyday activities and help reduce injuries. Greater muscle mass also means a higher metabolism and as a result, more efficient management of a healthy body composition.

4. Body Composition**.** Body composition is the relative amount of fat tissue to lean tissue (muscle, bone, fluids, etc.) in one's body. It is normally expressed in percent body fat (%BF) by weight. This is a more meaningful figure than total body weight, as total weight does not account for differences in lean mass among individuals. A 6'0", 210 lb. active athlete may have a substantially different body composition than

a 6'0", 210 lb. sedentary individual, yet they would be classified as equally overweight if a height/weight chart is the only criterion. In reality, neither, either or both of the above persons may be over-fat, which is the important issue in terms of health. An individual with excess body fat is more likely to experience health problems such as diabetes, high blood pressure, joint problems, heart disease, and some types of cancer. For healthy body fat ranges, see Weight Management Self-Help Guide, COMDTPUB P6200.3.

B. Cardiorespiratory Training Guidelines.

1. The following summarizes the American College of Sports Medicine (ACSM) exercise guidelines for improving and/or maintaining cardiorespiratory fitness.

   a. Frequency (How Often?). To build cardiorespiratory endurance, you should exercise 3 – 5 days per week. Beginners should start with 3 and work up to 5 days per week. Training more than 5 days per week can lead to injury and isn't necessary for promoting wellness.

   b. Intensity (How Hard?). You must exercise intensely enough to stress your body so that fitness improves. One way to monitor your intensity level is to measure your exercise heart rate against your Target Heart Rate Range (THRR). According to the ACSM, you should exercise at 65-90% of your maximum heart rate. The formula for determining your heart rate range is as follows:

      220-Your Age = _____ (Max Heart Rate)
      Max Heart Rate X 65% = _____ Lower End of THRR
      Max Heart Rate X 90% = _____ Upper End of THRR.

      During exercise, you can find your pulse at the carotid artery (in the groove of the neck) or at the radial artery (on the side of the wrist just below the thumb). Count your heart rate for 10 seconds and multiply this number by 6. The number you derive should fall in between the lower and upper end of your THRR.

      (1) Another way to monitor your intensity is to monitor your perceived level of exertion (rate of perceived exertion or RPE). Using the RPE scale below, your exertion levels should be "somewhat hard" to "hard" or 12-16 on the RPE scale.

RPE SCALE

6
7 Extremely Light
8
9 Very Light
10
11 Light
12

| | |
|---|---|
| 13 | Somewhat Hard |
| 14 | |
| 15 | Hard (heavy) |
| 16 | |
| 17 | Very Hard |
| 18 | |
| 19 | Extremely Hard |
| 20 | Maximal Exertion |

c. Duration (How Long?). A total duration of 20-60 minutes is recommended. Exercise sessions can take place in a single session or in multiple sessions lasting 10 or more minutes.

d. Mode (What type?). Dynamic, large muscle, rhythmic, continuous exercises such as biking, jogging, walking, rowing, stair stepping, skiing, aerobic dance classes, and rollerblading.

(1) One complete cardiorespiratory exercise session should include a warm-up, aerobic activity, stretching exercises, and a cool-down. Your warm-up can be the same activity you plan to perform for your workout session at a lower intensity. Gradually increase your pace over 3-5 minutes. Transition into your exercise session. When you have met your duration goal for the exercise (20 to 60 minutes), begin to decrease your intensity (cool-down). Continue this gradual decline for 3-5 minutes. Stretch the major muscles you used during the exercise session. Hold each stretch 10-30 seconds with no bouncing.

C. Strength Training Guidelines.

1. The following summarizes the ACSM exercise guidelines recommended for improving and/or maintaining muscular strength and endurance: Perform at least one set of 8–12 repetitions of 8-10 exercises that work the major muscle groups at least 2 days per week.

2. Examples of exercises for each major muscle group.

| Major Muscle Groups | Sample Exercises |
|---|---|
| Quadriceps | Leg extension machine, Leg lunges |
| Hamstrings | Leg curl machine, Squats |
| Lower back | Low back machine |
| Abdominals | Abdominal machine, Abdominal crunches |
| Chest | Chest press, Push-ups |
| Upper back | Upright rows, Reverse flys |
| Shoulders | Lateral raises machine, Overhead presses |
| Biceps | Bicep curl machine, Dumbbell curls |
| Triceps | Tricep extension machine, Tricep dips |

3. Resistance training is not limited to traditional exercise machines and free weights. Strength gains can be accomplished by using exercise bands, tubing, and other resistance measures, including your own body weight.

4. A safe recommendation for progression is to increase your training resistance by about 5% whenever you can complete 12 repetitions.

5. It is advisable to perform your strength exercise in a slow and controlled manner, taking about 2-4 seconds for each lifting movement and at least 2-4 seconds for each lowering movement.

6. You should perform your resistance exercise through a full range of movement.

7. A minimum of 48 hours is necessary to recover from a strength training session. Build rest days into your regular routine.

8. Avoid holding your breath when performing strength exercises. As a rule of thumb, exhale during the lifting movements and inhale during the lowering movements of most exercises.

C. Exercise Precautions.

1. Report Any Chest Pain Immediately. If you have any symptoms during or soon after exercise, report them to your physician immediately.

2. Start off Slowly. Many people try to undo numerous years of inactivity in a few days or weeks. This type of trauma to your body is guaranteed to result in sore muscles and joints. Build your exercise program gradually.

3. Avoid "All Out" Efforts. You do not have to be exhausted at the end of a workout in order to improve your cardiorespiratory endurance or strength. Never push yourself through pain.

4. Listen to your Body during Illness. Certain illnesses can be aggravated by exercise while others can be improved by moderate bouts of physical activity. A good rule of thumb is the "neck-check". If your symptoms are above the neck such as nasal congestion, runny nose or a mild sore throat, exercise participation would most likely not pose a threat to your health. Symptoms "below-the-neck" such as a hacking cough, diarrhea, fever, body aches or chills are more severe and exercise should be discontinued until symptoms disappear.

5. Modify Your Program when Pregnant. If you become pregnant, please consult your regional HPM or medical personnel for specific prenatal exercise guidelines.

6. Wear Appropriate Clothing.

   a. Exercise clothing should be comfortable, let you move freely, and allow your body to cool itself.

b. Avoid clothing that constricts normal blood flow or is made from nylon or rubberized fabrics that prevent evaporation or perspiration.

c. If you sweat heavily when you exercise and find that too much moisture accumulates in cotton clothing, try fabrics containing synthetic materials such a polypropylene that wick moisture away from the skin.

d. Dress appropriately for your geographical climate. In colder climates, you will want to avoid materials which keep sweat and moisture on the surface of the skin, like cotton.

e. Socks made with moisture-wicking compounds may be particularly helpful for people whose feet sweat heavily.

7. Drink Plenty of Fluids. Your body depends on water to carry out many chemical reactions and to regulate body temperature. Sweating during exercise depletes your body's water supply and can lead to dehydration if fluids aren't replaced.

a. Serious dehydration can cause reduced blood volume, increased heart rate, elevated body temperature, muscle cramps, heat stroke, and even death.

b. Drinking water before and during exercise is important to prevent dehydration and enhance your performance.

c. Thirst is not a good indicator of how much you need to drink because one's sense of thirst is quickly depressed by drinking even small amounts of water. As a rule of thumb, try to drink about 8 ounces of water (more in hot weather) for every 30 minutes of heavy exercise.

d. Bring a water bottle when you exercise so you can replace your fluids while they're being depleted. Water, preferably cold, and diluted carbohydrate drinks are the best fluid replacements.

8. Choose Appropriate Footwear.

a. When choosing athletic shoes, first consider the activity you've chosen for your exercise program. Shoes appropriate for different activities have very different characteristics. For example, running shoes typically have highly cushioned midsoles, rubber outsoles with elevated heels, and a great deal of flexibility in the forefoot. The heels of walking shoes tend to be lower, less padded, and more beveled than those designed for running. Court shoes have straight, non-flared heels that provide substantial support and allow for safe and easy lateral movements.

b. Foot type is another important consideration. If your feet tend to roll in excessively (over-pronate), you may need shoes with additional stability features on the inner side of the shoe to counteract this movement. If your feet tend to roll outward excessively (over-supinate), you may need flexible and cushioned shoes that promote foot motion.

c. Shop at an athletic shoe or specialty store that have personnel trained to fit athletic shoes and a large selection of styles and sizes.

9. Wear Sunscreen. To protect your skin from prolonged exposure to ultraviolet rays during outdoor activity, wear sunscreen during every outdoor exercise session. Seek coverage over all exposed skin with a sunscreen of SPF 15 or higher. Look for a sports sunscreen that can withstand sweating.

## APPENDIX C. ACRONYM LIST.

**A**

AA - Alcoholics Anonymous
AECC - Aeromedical Evacuation Coordination Center
APA - Addictions Program Administrator
APR - Addictions Program Representative
APS - Addictions Prevention Specialist
AOR - Area of Responsibility
ATF - Alcohol Treatment Facility

**B**

BF - Body Fat

**C**

CAAC - Counseling and Assistance Center
CDAR - Collateral Duty Addictions Representative
CPR - Cardiopulmonary Resuscitation
CRE – Cardio-Respiratory Endurance

**D**

DABSII - Drug and Alcohol Beneficiaries System II
DAC - Drug and Alcohol Counselor
DBW - Desired Body Weight
DSM - Diagnostic & Statistical Manual for Mental Disorders
DUI - Driving Under the Influence
DWI - Driving While Intoxicated

**E**

EPA - Environmental Protection Agency
ETS - Environmental Tobacco Smoke

**F**

FS - Food Service Specialist

FSO - Food Service Officer

**H**

HPM - Health Promotion Manager

HDL - High Density Lipoprotein

HRA - Health Risk Appraisal

**L**

LBM - Lean Body Mass

LDL - Low Density Lipoprotein

**O**

1RM – One Repetition Maximum

O&P - Outreach and Prevention Specialist

**P**

PARQ - Physical Activity Readiness Questionnaire

PDR - Personal Data Record

PPC - Patient Placement Criteria

PREVENT - Personal Responsibility, Values Education & Training

PWP - Personal Wellness Profile

**S**

SAFE - Substance Abuse Free Environment

SASSI - Substance Abuse Subtle Screening Inventory

**U**

UHPC - Unit Health Promotion Coordinator

**APPENDIX D. COORDINATING HEALTH RISK APPRAISALS**

A. Purpose. Guidelines in this appendix are for use by the UHPC when administering the Wellsource Personal Wellness Profile (PWP) to the general Coast Guard population. Although similar, this should not be confused with the monthly physical fitness assessment required by those not in compliance with Coast Guard weight and body fat standards. Specific guidance for that special population can be found in Weight/Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series).

B. Discussion.

1. The PWP is a comprehensive self-administered questionnaire that is used as a tool for evaluating lifestyle habits and providing suggestions to modify risky behaviors.

2. The PWP provides the participant with an individualized, personalized report with an evaluation of risk associated with current lifestyle practices and recommendations for reducing those risks factors. Areas addressed include the following: overall wellness, fitness, heart health, nutrition, substance abuse, stress/coping, safety, and cancer risk.

C. Administration.

1. The PWP assessment includes three components:

   a. The Health Risk Appraisal or PWP Questionnaire. A nine page, confidential health survey that participants complete as part of the program.

   b. Fitness Assessments. This includes a sit and reach flexibility test, a one-mile walk or 1.5 mile run, a sit up or curl up test, a push up test, and a calculation of body fat percentage. Scores are compared to a standard that has been set for age and gender groups. All screening/fitness tests are optional, but strongly recommended.

   c. Clinical Screening. This includes a fasting or non-fasting cholesterol/glucose testing (HDL, Total Cholesterol, Glucose, Risk Ratio). This screening is optional but recommended. Blood pressure and resting heart rate screening are also recommended.

2. Implementation. Administration of all three of the PWP components (health questionnaire, fitness assessments, and clinical screening) is not necessary to receive a PWP printed report. Individuals may simply complete the PWP questionnaire to receive an individual report. However, having participants complete as many components as possible will increase the predictive accuracy of a risk factor assessment and will result in a more comprehensive health summary for the member.

3. Executive Summary. In addition to individual reports, an Executive Summary is provided to the Unit Health Promotion Coordinator and the Command for units with greater than twenty members. The Executive Summary summarizes the primary health findings for those individuals who completed the PWP. Unit health needs and risks are presented along

with recommendations for initiating risk reduction and health enhancement programs. This information is very helpful in planning a comprehensive health promotion program for the Unit.

D. Planning Protocols.

1. Obtain command approval.

2. Try to schedule the test as either “all hands” or “command required” to maximize participation.

3. Ensure appropriate facilities for testing (soft surface for sit ups, flat course for run, etc).

4. Ensure that privacy is provided for all participants regarding test scores and health risk appraisal responses.

5. Arrange to have all necessary supplies and back up supplies on hand.

6. For blood tests, contact the regional HPM or other skilled technician to administer the appropriate testing protocols (fasting, non-fasting) for cholesterol testing. Dispose of blood contaminated and biohazard materials appropriately.

7. Inform and train staff and volunteers regarding testing protocols. This ensures that results are valid.

8. Check to make sure Health Risk Appraisal Forms are coded correctly. Health reports cannot be generated from miscoded forms. Pages D15 and D16 provide specific direction for coding and an example to illustrate correct coding processes.

9. Pregnant women should not participate in fitness testing unless doctor’s permission is obtained.

10. PAR - Qs should be used for all nonmilitary participants and are encouraged for all military participants (CG Form 6200).

11. Ensure that required equipment (blood pressure cuffs, stop watch, flexibility box, etc.) is accessible and available.

12. Ensure that emergency protocols are in place (CPR trained tester desired, etc).

13. Inform participants when and how they will receive their results.

14. Screen participants for health problems (bad back, joint problems, flu etc). Participants who report these symptoms should not participate in the fitness assessment portion of the health screening.

15. To assist members with PWP recommendations, have referral material available for Coast Guard and community-based health promotion programs.

16. Conduct assessments according to established protocols. In order to derive accurate data for research, it is critical that established protocols are followed (pages D3–D11).

17. The Health & Fitness Assessment Data Sheet (CG Form 6200A) may be utilized to record fitness and clinical assessment data.

E. Physical Activity Readiness Questionnaire (PAR-Q). A PAR-Q should be completed by all nonmilitary participants (civilians, beneficiaries, retirees, and auxiliarists). It is highly encouraged for all military participants.

F. Waist to Hip Ratio.

1. Purpose. To evaluate the distribution of fat on the body. The higher the waist-to-hip ratio, the greater the risk of certain diseases, such as cardiovascular diseases and non-insulin dependent diabetes.

2. Required Equipment. Cloth measuring tape.

3. Procedures. It is best to obtain these measurements against bare skin. Therefore, only males should test males, and females test females when possible.

4. Waist Measurement.

   a. Participant should stand very straight with the abdomen relaxed and feet together.

   b. The cloth tape measure is placed around the body in a horizontal plane at the level of the natural waist. This should be the narrowest part of the torso. The measurement should not be taken at the level of the umbilicus (navel) – this value would be too great.

   c. The measurement should be taken at the end of a normal breath (exhale) and the tape should not compress the skin.

   d. Record value to the nearest tenth of an inch.

5. Hip Measurement.

   a. The participant should stand very straight with the abdomen relaxed and the feet together.

   b. The cloth measure is placed around the hips in a horizontal plane at the level of the maximum (widest) extension of the buttocks.

   c. The tape should not compress the skin.

d. Record the value to the nearest tenth of an inch.

Score:_____

6. The Waist-to-Hip "High" category risk level scores are based on Canadian Standardized Test of Fitness Guidelines.

| Risk Level | Men | Women |
|---|---|---|
| Low | <.85 | <.75 |
| Moderate | .85-.95 | .75-.80 |
| High | >.95 | >.80 |

G. 1.5 Mile Run Test.

1. Test Description. This is an aerobic fitness test designed for young people and runners. The runner covers a distance of 1.5 miles in as short a time as possible without undue strain. Aerobic capacity is determined from total elapsed time.

2. Strengths.

a. No expensive equipment.

b. Participation of several persons concurrently.

c. Results correlate very closely with $VO_2$ max treadmill tests and are very accurate in accessing improvement in subsequent follow-up testing.

3. Precautions. This test is appropriate only for healthy people accustomed to running. Participants should be able to run continuously for 2- 3 miles without undue strain before attempting this test.

4. Required Equipment.

a. Stop watch to time the run to the nearest second.

b. An accurately measured, flat, 1.5 mile course or ¼ mile track (6 laps = 1.5 miles).

5. Test Administration.

a. Participants should be in good health and currently used to running, not beginners. Before testing, verify that the pre-test screening items have been completed (i.e., PAR Q). The tester should have participants warm-up and cool down after the run.

b. Participants should be dressed in clothes ready to exercise, preferably exercise shorts or pants and running shoes.

c. Instruct participants to:

(1) Warm up by walking at a moderate pace for 2 – 5 minutes.

(2) Do their best, covering the 1.5 miles quickly but without overexerting themselves.

(3) Pace themselves.

(4) Remember the test is not a race. If participants experience any pain or severe shortness of breath or other abnormal signs, they should immediately ease off. If symptoms persist they should walk or stop and, seek medical attention if necessary.

(5) When running on a ¼ mile track, participants should pay attention to how many laps they have completed.

(6) At the end of the 1.5 mile run, participants should note their finishing time to the closest second.

(7) Participants should walk at an easy pace for a few minutes or for one or more laps to cool down properly.

| ***Men*** | **<20 years** | **20 – 29 years** | **30 – 39 years** | **40 – 49 years** | **50 – 59 years** | **60-69 years** |
|---|---|---|---|---|---|---|
| Excellent | <8:42 | <9:12 | <11:06 | <12:33 | <14:00 | <18:14 |
| Desirable | 8:42 - 9:01 | 9:12 – 10:50 | 11:06 – 11:38 | 12:33 – 13:36 | 14:00 – 15:19 | 18:14 – 19:42 |
| Needs Improving | 9:02 – 11:55 | 10:51 – 13:13 | 11:39 – 13:59 | 13:37 – 15:49 | 15:20 – 17:33 | 19:43 – 21:27 |
| Caution | >11:55 | >13:13 | >13:59 | >15:49 | >17:33 | >21:27 |

| ***Women*** | **<20 years** | **20 – 29 years** | **30 – 39 years** | **40 – 49 years** | **50 – 59 years** | **60-69 years** |
|---|---|---|---|---|---|---|
| Excellent | <12:33 | <13:37 | <14:25 | <15:50 | <18:57 | <22:28 |
| Desirable | 12:33 – 13:36 | 13:37 – 14:24 | 14:25 – 16:22 | 15:50 – 17:33 | 18:57 – 20:32 | 22:28 – 24:45 |
| Needs Improving | 13:37 – 15:19 | 14:25 – 16:56 | 16:23 – 18:56 | 17:34 – 23:33 | 20:33 – 25:59 | 24:46 – 29:16 |
| Caution | >15:19 | >16:56 | >18:56 | >23:33 | >25:59 | >29:16 |

H. Reliability & $VO_2$ Calculation. For information on reliability and calculation of $VO_2$ max, please see your Health Promotion Manager (HPM).

1. References.

a. *ACSM's Guidelines for Exercise Testing and Prescription*, 7th Edition, Lippincott, Williams & Wilkins, 2006.

b. The Cooper Institute, *Physical Fitness Assessments and Norms,* 2006.

c. Protocols from the Wellsource Fitness Assessment Manual.

I. One Mile Walk Test.

1. Test Description. The 1-mile walk is an easy and safe way to determine aerobic capacity using an activity everyone is familiar with – walking. The test subject must walk 1 mile at a constant pace and as quickly as possible. At the end of one mile, a heart rate measurement must be taken and the finish time recorded.

2. Strengths.

a. Good estimate of aerobic capacity.

b. Can be administered by non-medical personnel.

c. No expensive equipment required.

d. Simple, safe test appropriate for most.

e. Not too strenuous, good for sedentary people, overweight individuals, and older populations.

3. Required Equipment.

a. Stop watch to time walking test to nearest second and obtain accurate post exercise heart rate.

b. An accurately measured, flat, 1-mile course or ¼ mile track (4 laps = 1 mile).

4. Optional Equipment.

a. Stethoscope and BP equipment for checking heart rate and blood pressure.

5. Test Administration.

a. Participants should possess an adequate fitness level before attempting this test. They should be able to easily complete a mile walk.

b. Participants should be dressed in clothes ready to exercise, preferably exercise shorts or pants and walking shoes.

c. Instruct participants to:
(1) Warm up by walking at a moderate pace for 2 – 5 minutes.

(2) When walking, walk at a brisk pace, covering the 1-mile as quickly as possible (walking only, no running is allowed) without strain. Keep pace as constant as possible.

(3) Remember the test is not a race. Participants who experience any pain or severe shortness of breath or other abnormal signs should be advised to immediately ease off. If symptoms persist they should stop and seek medical attention if necessary.

(4) At the end of the mile, record finishing times for participants to the closest second. Next, have each participant get an accurate pulse. Have participants start taking their pulse within five seconds of completing the walk. Take pulse for 10 seconds and multiply by six. It is a good idea to have participants practice getting their heart rate before the walk begins to ensure they are able to find their pulse. For a more accurate pulse, use a heart rate monitor. This will provide an immediate heart rate reading at the end of the test. Write down results as soon as possible. Advise participants to use the radial (wrist) or carotid (neck) pulse to find their heart rate. Do not allow participants to use their thumb to "feel" the pulse.

(5) Walk at an easy pace for a few minutes to cool down properly.

6. Reliability. For information on reliability and calculation of $VO_2$ max, please see your Health Promotion Manager (HPM).

7. References.

a. James Rippe et al, "Walking for Health and Fitness", JAMA, May 13, 1988.

b. Med Sci Sports Exer, 19:253 – 259.

c. Protocols from the Wellsource Fitness Assessment Manual.

J. Push Up Test.

1. Test Description. This is an easily administered test for upper body strength and endurance. The subject attempts as many consecutive push-ups as he/she can do without stopping to rest. Men do push-ups from the toe, women from the knee.

2. Required Equipment. Gym mat or suitable flooring is all that is required to properly administer this test.

3. Test Administration.

   a. Test subject should be screened for shoulder or lower back impairment or pain. Persons suffering back pain or high, uncontrolled blood pressure, should not do this test.

   b. Be sure participants are well instructed in the proper technique. Describe and if needed, demonstrate the correct technique. They may want to practice once or twice before beginning the test.

   c. Instruct the subjects to:

      (1) Lie on their stomach on a mat, legs together.

      (2) Place hands pointed forward, positioned under shoulders.

      (3) Pushup, keeping back straight. Pivot from toes for men, from knees for women.

      (4) Return to starting position, but only let chin touch the mat (chest and legs should not touch the mat). In the downward phase, the chest should be a fist's distance from the mat.

      (5) Do as many push-ups using this technique as possible, without undue strain, and without stopping to rest.

      (6) Not overstrain or hold their breath, but rather, to breath rhythmically, exhaling on the upward phase, inhaling on the downward phase.

      (7) Stop the test when they are unable to maintain the proper technique over two consecutive push ups, have to rest even briefly, or show signs of excessive straining.

4. Push Up Norms for Men.

| Age (years) | 15 - 20 | 20 - 29 | 30 – 39 | 40 - 49 | 50 - 59 | 60 - 69 |
|---|---|---|---|---|---|---|
| Excellent | 35+ | 34+ | 27+ | 21+ | 17+ | 16+ |
| Desirable | 27 - < 35 | 27 - < 34 | 21 - < 27 | 16 - < 21 | 11 - < 17 | 10 - < 16 |
| Needs Improvement | 18 - < 27 | 17 - < 27 | 12 - < 21 | 10 - < 16 | 7 - < 11 | 5 - < 10 |
| Caution | < 18 | < 17 | < 12 | < 10 | < 7 | < 5 |

5. Push Up Norms for Women.

| Age (years) | 15 - 20 | 20 - 29 | 30 – 39 | 40 - 49 | 50 - 59 | 60 - 69 |
|---|---|---|---|---|---|---|
| Excellent | 31+ | 26+ | 24+ | 22+ | 17+ | 15+ |
| Desirable | 23 - < 31 | 20 - < 26 | 17 - < 24 | 14 - < 22 | 10 - < 17 | 10 - < 15 |
| Needs Improvement | 12 - < 23 | 10 - < 20 | 8 - < 17 | 5 - < 14 | 2 - < 10 | 2 - < 10 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Caution | < 12 | < 10 | < 8 | < 5 | < 2 | < 2 |

Pushup norms are based on the Canadian standardized test of fitness (3). Values shown represent the minimum number of push-ups to be in that category. For example, if a 30-year-old woman did eight push ups, she would be rated as "Needs Improvement". Generally, everyone should strive to be in the "Desirable" or "Excellent" categories.

6. References.

   a. *ACSM's Guidelines for Exercise Testing and Prescription*, 7th Edition, Lippincott, Williams & Wilkins, 2006.

   b. *ACSM's Resource Manual for Guidelines for Exercise Testing and Prescription*, Lippincott Williams & Wilkins, 2006.

   c. Government of Canada, Fitness and Amateur Sport, Canadian Standardized Test of Fitness, 1986 Operation Manual.

   d. Protocols from the Wellsource Fitness Assessment Manual.

K. Sit-Up Test.

1. Test Description. This is an easily administered test for measuring abdominal strength/endurance. The subject does as many bent knee sit-ups as possible in one minute.

2. Required Equipment.

   a. Gym mat or suitable flooring.

   b. Stop watch or watch with a second hand.

3. Test Administration.

   a. Test subject should be screened for lower back impairment or pain. Persons suffering back pain or high, uncontrolled blood pressure, should not do this test.

   b. Be sure participants are well instructed in the proper technique. Describe and if needed, demonstrate the correct technique. They may want to practice once or twice before beginning the test.

   c. Instruct the subjects to:

      (1) Lie on their back on a mat, knees bent at a 90 degree angle, feet shoulder width apart.

      (2) Cross arms in front, fingertips on shoulders, elbows pointed toward knees.

(3) Have their feet held by another participant if needed. If they cannot do a regular sit-up they should try the alternate test, the abdominal curl-ups.

(4) Sit-up by pressing the small of the back to the floor, then curl up, raising the shoulders from the ground. Touch elbows to knees, and then return to the lying position.

(5) Do as many sit-ups as possible in one minute without undue strain.

(6) Avoid jerky movements or hard straining.

(7) Caution participants to not overstrain or hold their breath, but rather, to breath rhythmically, exhaling while sitting up, inhaling on the downward phase.

4. Sit-Up Norms for Men.

| Age (years) | 15 - 19 | 20 - 29 | 30 – 39 | 40 - 49 | 50 - 59 | 60 - 69 |
|---|---|---|---|---|---|---|
| Excellent | 46+ | 41+ | 34+ | 30+ | 25+ | 21+ |
| Desirable | 41 - < 46 | 36 - < 41 | 30 - < 34 | 25 - < 30 | 21 - < 25 | 15 - < 21 |
| Needs Improvement | 33 - < 41 | 29 - < 36 | 22 - < 30 | 17 - < 25 | 13 - < 21 | 7 - < 15 |
| Caution | < 33 | < 29 | < 22 | < 17 | < 13 | < 7 |

5. Sit-Up Norms for Women.

| Age (years) | 15 - 19 | 20 - 29 | 30 – 39 | 40 – 49 | 50 - 59 | 60 - 69 |
|---|---|---|---|---|---|---|
| Excellent | 40+ | 34+ | 27+ | 23+ | 17+ | 15+ |
| Desirable | 35 - < 40 | 29 - < 34 | 23 - < 27 | 18 - < 23 | 11 - < 17 | 10 - < 15 |
| Needs Improvement | 27 - < 35 | 21 - < 29 | 15 - < 23 | 7 - < 18 | 3 - < 11 | 2 - < 10 |
| Caution | < 27 | < 21 | < 15 | < 7 | < 3 | < 2 |

Sit-up norms are based on the Canadian standardized test of fitness (c). Values shown represent the minimum number of sit-ups that must be achieved to be in that category. For example, if a 30-year-old woman did 17 sit-ups, she would be rated "Needs Improvement". She would have to do 5 more sit-ups a minute to move into the next category. Generally, everyone should strive to be in the "Desirable" or "Excellent" categories.

6. References.

a. *ACSM's Guidelines for Exercise Testing and Prescription*, 7th edition, Lippincott, Williams & Wilkin, 2006.

b. *ACSM's Resource Manual for Guidelines for Exercise Testing and Prescription*, 5th edition, Lippincott, Williams & Wilkin, 2006.

c. Government of Canada, Fitness and Amateur Sport, Canadian Standardized Test of Fitness, 1986 Operation Manual.

d. Hand out information taken from the Wellsource Fitness Assessment Manual.

L. Abdominal Curl Ups.

1. Test Description. The abdominal curl-up is an alternative to sit-ups when testing for abdominal strength/endurance. The advantages suggested for this test is that it puts less strain on the back, better isolates the abdominal muscles and minimizes the hip flexors. However, people with stiff backs may not be able to perform this test. In that case, they may want to do sit-ups instead. The disadvantage is that this test is more difficult to standardize.

2. Required Equipment.

a. Gym mat.

b. Ruler.

c. Small blocks for fingers to touch in order to signal person when they have moved hands 3 inches forward.

d. Stop watch of watch with second hand.

3. Test Administration.

a. Test subject should be screened for lower back pain. People suffering from back pain or uncontrolled high blood pressure should not do this test.

b. Be sure participant is well instructed in the proper technique. Describe, and if needed, demonstrate the correct technique. They may want to practice once or twice before beginning the test. To execute an abdominal curl-up the test subject must:

(1) Lie on their back on a mat with knees bent at a 90 degree angle.

(2) Place feet shoulder width apart. Feet are not secured.

(3) Place the arms by the sides, fully extended, elbows locked straight, and palms facing down.

(4) When arms are fully extended (towards feet) and are flat on the mat beside the person, mark the end of the finger tips. Then measure 3 inches further toward the feet. Place a block on the mat (on the mark 3 inches from finger tips) that can serve as a touch point for the test subject (an item such as a small block of wood, a book, ruler, etc).

(5) To do a curl-up, press the small of the back to the floor, tighten abdominal muscles raising head and shoulders from the floor. Hands must slide forward on the mat until they reach the block at the 3 inch mark for a correct curl-up. The small of the back does not leave the mat. Shoulders must return to mat before starting next curl-up. Head need not touch the mat.

(6) Instruct the subject to do as many curl-ups in one minute as they can without undue strain.

(7) Avoid jerky movements. If a person appears to be straining very hard to continue, stop the test.

c. Caution participants not to hold their breath but rather to breathe rhythmically, exhaling while curling up, inhaling while going back down.

d. Record the number of complete curl-ups, touches of the fingers to the 3 inch mark block, in 1 minute.

4. Curl-up Norms for Men.

| Age (years) | 15-20 | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 |
|---|---|---|---|---|---|---|
| Excellent | 60+ | 54+ | 45+ | 39+ | 33+ | 29+ |
| Desirable | 53 - <60 | 46 - <54 | 39 - <45 | 33 - <39 | 28 - <33 | 21 - <29 |
| Needs Improvement | 48 - <53 | 41 - <46 | 34 - <39 | 28 - <33 | 23 - <28 | 15 - <21 |
| Caution | <48 | <41 | <34 | <28 | <23 | <15 |

5. Curl-up Norms for Women.

| Age (years) | 15-20 | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 |
|---|---|---|---|---|---|---|
| Excellent | 53+ | 45+ | 36+ | 31+ | 24+ | 20+ |
| Desirable | 45 - <53 | 39 - <45 | 30 - <36 | 25 - <31 | 15 - <24 | 21- <20 |
| Needs Improvement | 40 - <45 | 31 - <39 | 25 - <30 | 19 - <25 | 6 - <15 | 5 - <15 |
| Caution | <40 | <31 | <25 | <19 | <6 | <5 |

**Note:** Abdominal curl-up norms have not yet been published. The norms listed above are based on preliminary research and should be used only as a general guideline. Persons can also use their first time test scores as a baseline by which to show future change and improvement with training.

6. References.

a. *ACSM's Guidelines for Exercise Testing and Prescription*, 7th edition, Lippincott, Williams & Wilkin, 2006

b. *ACSM's Resource Manual for Guidelines for Exercise Testing and Prescription,* 5th edition, Lippincott, Williams & Wilkin, 2006.

c. Government of Canada, Fitness and Amateur Sport, *Canadian Standardized Test of Fitness,* 1986 Operation Manual.

d. David Nieman, *Fitness and Sports Medicine, An Introduction,* Bull Publishing Company, 1990.

e. Unpublished research information from Physical Education Department, Portland State University, 1989.

M. Flexibility: Sit and Reach Test.

1. Test Description. This test for measures flexibility of the major joints, back, hips and legs. The subject sits with legs extended, feet against a flex bench. They lean forward, reaching with arms as far as possible, without flexing the knees. Flexibility is measured by how far the fingertips reach on a ruler attached to the bench. If a commercially-made bench is utilized, check with your HPM to ensure it is suitable. Changes in the distance from the end of the ruler to the footpad will affect the use of the norms.

2. Required Equipment.

   a. Gym mat.

   b. Flexibility box.

3. Test Administration.

   a. Test subject should be screened for lower back impairment or pain. Persons suffering back pain should not do this test.

   b. Be sure participants are well instructed in the proper technique. Describe and if needed, demonstrate the correct technique as follows:

      (1) Have subject warm up with slow stretching movements before attempting this test. An example of a good warm up stretch is a sitting toe touch. Sit on the mat, keep one leg straight out in front, the other on the mat but bent with the sole of the foot placed on the inside of the knee of the straight leg. Slowly stretch forward to reach toward your toes. Hold this stretch gently for 15 – 20 seconds. Do this twice on each side.

      (2) Sit on mat, shoes off, legs fully extended, with feet together and soles of feet against the flex bench. The flex bench should be against a wall to keep it from sliding forward during the stretch test.

(3) Keeping knees softly locked straight, reach forward, toward the toes. Keep palms down, fingertips together. Reach forward as far on the flex bench ruler as possible and hold for at least two seconds. Avoid jerky movements or bouncing.

(4) Repeat the stretch test at least twice. Record the best score of any of the stretches. If the subject just reaches their toes, their score would be 26 cm (10.25 inches). Record results in inches or centimeter – depending on what the test answer sheet requires. Round to the tenth of an inch. Use the best score.

(5) The stretch bench should be 12 inches tall, have a flat vertical surface for the feet to rest against, and have a ruler on top for measuring the distance reached. The "0" end of the ruler should reach back towards the subject, and the 26 cm (10 ¼ inch) mark should be even with the vertical surface the feet rest against.

(6) Caution the subjects to avoid straining themselves, but to reach as far as possible.

4. Sit and Reach Flexibility Norms for Men (inches).

| Age (years) | 15 - 20 | 20 – 29 | 30 – 39 | 40 - 49 | 50 – 59 | 60 - 69 |
|---|---|---|---|---|---|---|
| Excellent | 15+ | 15+ | 14.6+ | 13.4+ | 12.6+ | 11.8+ |
| Desirable | 13 - < 15 | 13 - < 15 | 12.6 - < 14.6 | 11 - < 13.4 | 10.6 - < 12.6 | 9.5 - < 11.8 |
| Needs Improvement | 9.5 - < 13 | 9.8 - < 13 | 9.1 - < 12.6 | 7.1- < 11 | 6.3 - < 10.6 | 5.9 - < 9.5 |
| Caution | < 9.5 | < 9.8 | < 9.1 | < 7.1 | < 6.3 | < 5.9 |

5. Sit and Reach Flexibility Norms for Women (inches).

| Age (years) | 15 - 20 | 20 – 29 | 30 – 39 | 40 – 49 | 50 – 59 | 60 - 69 |
|---|---|---|---|---|---|---|
| Excellent | 16.5+ | 15.7+ | 15.4+ | 14.6+ | 14.6+ | 13.4+ |
| Desirable | 14.6 - < 16.5 | 14.1 - < 15.7 | 13.8 - < 15.4 | 13 - < 14.6 | 12.6 - < 14.6 | 11.8 - < 13.4 |
| Needs Improvement | 11.4 - < 14.6 | 11 - < 14.1 | 10.6 - < 13.8 | 9.8 - < 13 | 9.8 - < 12.6 | 9.1 - < 11.8 |
| Caution | < 11.4 | < 11 | < 10.6 | < 9.8 | < 9.8 | < 9.1 |

Sit and reach norms are based on the Canadian standardized test of fitness (3).

6. References.

a. *ACSM's Guidelines for Exercise Testing and Prescription*, 7th Edition, Lippincott, Williams & Wilkin, 2006.

b. *ACSM's Resource Manual for Guidelines for Exercise Testing and Prescription*, 5th Edition, Lippincott, Williams & Wilkin, 2006.

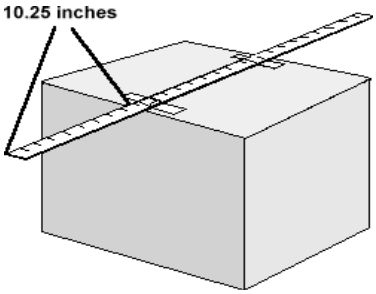
c. Government of Canada, Fitness and Amateur Sport, Canadian Standardized Test of Fitness, 1986 Operation Manual.

d. David Nieman, *Fitness and Sports Medicine, An introduction*, Bull Publishing Company, 1990.

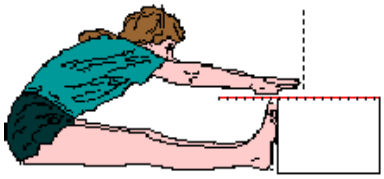
e. Protocols from the Wellsource Fitness Assessment Manual.

N. Sit and Reach Instructions (Flexibility). Wellsource Protocol. To do the Sit and Reach (flexibility) test you need a few common household items to construct the measuring device:

1. A box or stool about a foot high.
2. A yardstick.
3. Adhesive tape.
4. A small block of wood, matchbox or other small rectangular object.




1. Tape the yardstick to the top of the box or stool as shown in the illustration. Put the yardstick so that the edge of the box is at the 10¼ inch mark, which is where the feet hit. The zero (0) mark is closest to the body.
2. Put the small block of wood on the yardstick at about the 6 inch mark.



3. Sit with legs out in front, knees straight, feet against side of box. Warm up by stretching forward gently and holding for several seconds. Stretch forward slowly and push the small block of wood as far along the yardstick as you can. Record the best of three tries.

O. Wellsource Coding Overview.

1. Reports cannot be generated if the demographic information (age, height, weight, frame size, and gender) on page 1 is not completed correctly.

2. Page 1. The printed name and address of participants must be correct to ensure participants receive their PWP results/report.

3. Personal ID Number. Page 1. The participant's employee ID# is a primary data identifier and is required on page 1 if an individual wants to receive a "comparison" report the second time (one that analyzes data from both reports). The computer system will only recognize and combine identical numbers. If an individual is uncomfortable with the disclosure of his/her employee ID#, this section should be left blank.

4. Group ID Number. Page 1. You must talk to your HPM regarding the coding of the group ID number. This is a very important component related to data collection and management.

5. To ensure shaded boxes are used appropriately, open the questionnaire to page 2, and review the use of the shaded box with participants prior to their completing the survey (text only inside the box and corresponding ovals must be shaded).

6. Page 2 Question 3.17: "I have recently thought about ending my life." All questionnaires should be checked for a positive response to this question. If a positive response is found, you should discuss this with your HPM as soon as possible. If you are unable to quickly make contact with the HPM, you should contact your Employee Assistance Program Coordinator (EAPC). They will determine if counseling and further assessment is appropriate.

7. Page 3. Question 9, choice 5, also has subset questions. Point out to participants that if they choose 5 as their answer, they must also choose an answer from the subset.

8. Some participants may not feel comfortable answering certain questions. However, it is strongly recommended they complete each question for the most comprehensive report.

9. Above all, participants must be assured the information you are collecting on the PWP is confidential and will be handled appropriately; responses and reports should not be reviewed by anyone except the Health Promotion Manager and the individual who completed the questionnaire.

10. Clinical Data Coding (last page). Cholesterol screening and fitness assessments are optional, but are recommended for the most comprehensive report. See the Sample Clinical Data Coding sheet and the instructions on page D 14.

P. Clinical Data Coding Form.

1. Height and Weight. See sample coding sheet.

2. Waist and Hip Girth. Round off to the nearest half inch if recorded.

3. Body Composition testing method should be marked as "Known Percent Fat". Round to nearest whole number. Use calipers with trained screeners or foot to foot Bioelectrical Impedance Analysis (BIA).

4. Resting Pulse/Blood Pressure. See sample coding sheet.

5. Blood Test Decimal Use. Choose mg/dl (IGNORE DECIMAL) (*SEE SAMPLE CODING). Triglycerides and glucose may be included if you utilize fasting protocol blood profiles.

6. Graded Exercise Test. Choose one mile walk or 1.5 mile run.

7. Exercise HR (heart rate). Use this section if you are using the one-mile walk test.

8. Exercise Time. Time it takes participants to complete the one-mile walk or the 1.5 mile run. Use minutes and seconds (i.e. a time of thirteen minutes and six seconds would be recorded as “13” under minutes and “06” under seconds).

9. Push-ups/Sit-ups/Flexibility/Curl-ups. See sample coding sheet. Round to the nearest tenth of an inch for the flexibility test.

Example of Completed PWP Data Form