



COMDTINST M6200.1D
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COMMANDANT INSTRUCTION M6200.1D

Subj: COAST GUARD HEALTH PROMOTION MANUAL

- Ref: (a) Coast Guard Weight and Body Fat Standards Program Manual, COMDTINST M1020.8 (series)
(b) Coast Guard Medical Manual, COMDTINST M6000.1 (series)
(c) Coast Guard Periodic Health Assessment (PHA), COMDTINST M6150.3 (series)
(d) Crew Endurance Management, COMDTINST 3500.2 (series)
(e) Coast Guard Drug and Alcohol Abuse Program, COMDTINST M1000.10 (series)

1. PURPOSE. This Manual establishes policy, assigns responsibilities, and provides guidelines regarding physical fitness, nutrition, stress management, weight management, health risk reduction, substance abuse prevention, and unit health promotion program planning. It clarifies the roles and responsibilities of Commandant (CG-1111), the Health, Safety, and Work-Life Service Center (HSWL SC), Substance Abuse Prevention Specialists (SAPS), the Substance Abuse Prevention Program Supervisor (SAPPS), Command Drug and Alcohol Representatives (CDAR), Culinary Specialists (CS), and Health Services (HS) personnel.
2. ACTION. All Coast Guard (CG) unit commanders, commanding officers, officers-in-charge, deputy/assistant commandants, and chiefs of headquarters staff elements will comply with the provisions of this Manual. Internet release is authorized.
3. DIRECTIVES AFFECTED. Coast Guard Health Promotion Manual, COMDTINST M6200.1C, is cancelled.

DISTRIBUTION – SDL No. 168

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NON-STANDARD DISTRIBUTION:

4. DISCLAIMER. This guidance is not a substitute for applicable legal requirements, nor is it itself a rule. It is intended to provide operational guidance for CG personnel and is not intended to nor does it impose legally-binding requirements on any party outside the CG.

5. MAJOR CHANGES.
 - a. Removal of Health Promotion Managers.
 - b. Removal of Unit Health Promotion Coordinators.
 - c. Modification for age of tobacco use. Tobacco products are prohibited by law for all members under the age established by the state the member is currently in.
 - d. Modification to the Personal Fitness Plan, Form CG-6049, “the most current form must be kept on file or electronically saved by the member and supervisor”.
 - e. Removal of specific requirements for members on body fat probation.
 - f. Modification of specific requirements for commands concerning members on body fat probation. Members on weight probation will be directed to Commandant (CG-11) [Health Promotion Resources Website](http://www.dcms.uscg.mil/work-life/HealthPromotionResources/) <http://www.dcms.uscg.mil/work-life/HealthPromotionResources/> for information on weight management planning, techniques, and resources.
 - g. Removal of the requirement for units to develop a unit fitness plan.

6. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS.
 - a. The development of this Directive and the general policies contained within it have been thoroughly reviewed by the originating office in conjunction with the Office of Environmental Management, and are categorically excluded (CE) under current USCG CE # 33 from further environmental analysis, in accordance with Section 2.B.2 and Figure 2-1 of the National Environmental Policy Act Implementing Procedures and Policy for Considering Environmental Impacts, COMDTINST M16475.1 (series). Because this Directive contains guidance on documents that implement, without substantive change the applicable Directive and other guidance documents, CG categorical exclusion #33 is appropriate.
 - b. This Directive will not have any of the following: significant cumulative impacts on the human environment; substantial controversy or substantial change existing environmental conditions; or inconsistencies with any Federal, state, or local laws or administrative determinations relating to the environment. All future specific actions resulting from the general policies in this Directive must be individually evaluated for compliance with the National Environmental Policy Act (NEPA), DHS and CG NEPA policy.

7. DISTRIBUTION. No paper distribution will be made of this Manual. An electronic version will be located on the Coast Guard Directives System (CGDS) sites located at: Internet: <http://www.dcms.uscg.mil/directives>; and CG Portal: <https://cgportal2.uscg.mil/library/Directives/SitePages/Home.aspx>.

8. RECORDS MANAGEMENT CONSIDERATIONS. This Manual has been evaluated for potential records management impacts. The development of this Manual has been thoroughly reviewed during the Directives clearance process, and it has been determined there are further records scheduling requirements, in accordance with Federal Records Act U.S.C. 3101 et seq., National Archives and Records Administration (NARA) requirements, and the Information and Life Cycle Management Manual, COMDTINST M5212.12 (series). This policy does not have any significant or substantial change to existing records management requirement.
9. DEFINITIONS. Resources, definitions, and commonly used terminology are provided in Enclosure (1).
10. FORMS/REPORTS. The forms referenced in this Manual are available in USCG Electronic Forms on the Standard Workstation or on the Internet: <http://www.dcms.uscg.mil/directives> or CGPortal: <https://cgportal.uscg.mil/delivery/Satellite/CG611/FORMS>.
11. REQUESTS FOR CHANGES. Units and individuals may recommend changes in writing via the chain of command to COMMANDANT (CG-111), U. S. COAST GUARD STOP 7907, 2703 MARTIN LUTHER KING JR. AVE SE, WASHINGTON DC 20593-7907.

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CHAPTER 1. HEALTH PROMOTION PROGRAM OVERVIEW

- A. Introduction. 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 CG Health Promotion Program (HPP) attempts to adhere to recommendations made by the U.S. Centers for Disease Control and Prevention (CDC), the Department of Health and Human Services (HHS), Healthy People 2020 national goals, scientifically reputable health organizations, and the Department of Defense (DoD). The core elements of the CG HPP are:
1. Health promotion programming.
 2. Disease prevention and health risk reduction.
 3. Nicotine abstinence.
 4. Physical fitness.
 5. Nutrition and weight management.
 6. Stress management.
 7. Substance abuse prevention and treatment.
- B. Overview. A healthy and fit CG 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 are key determinants of health outcomes, risk of injury, and work performance. Implementation of this program helps participants stay physically fit for duty, maintain a healthy weight, and reduce risks attributed to lifestyle imbalances. The program also helps commands establish a work environment that supports healthy life practices. Collectively, program elements help ensure that the CG workforce is able to fulfill mission requirements and help members live healthy, balanced, and satisfying lives.
- C. Policy. All CG Active Duty (AD) and Selected Reserve (SELRES) members are required to adhere to CG physical activity and weight and body fat standards. In addition these members, as well as civilian personnel, are strongly encouraged to adopt a healthy lifestyle including eating nutritious foods that enhance performance, avoiding nicotine use, getting enough sleep, using alcohol responsibly, obtaining preventive evidence-based screening tests, and learning how to effectively manage stress. Based on the principle that leadership plays an integral part in a successful HPP, commanding officers and officers-in-charge are required to implement and adhere to all policies contained herein, particularly the requirements to annually

review the Commanding Officer Health Risk Appraisal (HRA). The following entities are responsible for implementation of the policies in this Manual:

1. Accession Points and Training Centers. Training Center Cape May, Training Center Yorktown, Training Center Petaluma, Aviation Training Center Elizabeth City, Officer Candidate School, and the CG 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 will include health promotion curricula in their training schedules. In addition, an introduction to the HPP is provided during designated Class “A” and “C” schools. The curricula at Culinary Specialist Class “A” and “C” schools will incorporate health promotion elements, with a strong emphasis on nutrition.
3. Command and Unit Level. Endorsement and visible support by command leadership (commanding officer, executive officer, officer-in-charge, command master chief, and executive petty officer) is critical for the success of the HPP at the unit level.

D. Duties and Responsibilities. This Section outlines the duties and responsibilities for overall program development. Refer to the succeeding Chapters for specific guidance related to each program element.

1. Commandant (CG-11). The Health, Safety, and Work-Life (HSWL) Directorate serves as authority over the policy and programs outlined in this Manual, which are managed by Commandant (CG-111), the Office of Work-Life.
2. Commandant (CG-1111). The Behavioral Health Services Division of the Office of Work-Life Commandant (CG-111) provides leadership and oversight for all division functions. Commandant (CG-1111) will:
 - a. Policy.
 - (1) Develop vision and a strategic plan for the HPP.
 - (2) Initiate changes to this Manual in response to organizational needs and to reflect changes in best practices and advances in health promotion.
 - b. Program Development.
 - (1) Serve as liaison to external partners including the Department of Homeland Security (DHS), Department of Defense (DoD), Department of Health and Human Services (HHS), inter-agency health promotion stakeholders, and other national health organizations.

- (2) Inform key stakeholders within Commandant (CG-11) of health promotion priorities and required action.
- (3) Establish quality improvement measurement standards in collaboration with the HSWL Service Center (HSWL SC) to evaluate health promotion field operations.
- (4) Provide oversight for research and evaluation of the health-related behavior of CG personnel.

c. Resource Management.

- (1) Secure funding and provide financial oversight for Behavioral Health Services Division programs.
- (2) Work collaboratively with the HSWL SC to identify HSWL Regional Practice (RP) staffing requirements and develop resource proposals to meet those needs.
- (3) Develop the funding structure for the Behavioral Health Services Division and communicate funding responsibilities to the Health Promotion Program Manager (HPPM), Substance Abuse Prevention Program Manager (SAPPM), and HSWL SC.

d. Marketing.

- (1) Communicate to leadership the functional benefits of the program to operational readiness.
- (2) Oversee the development of the communication and marketing plan to ensure concise and consistent promotion of program vision, services, and benefits.
- (3) Use a variety of media and technology to communicate program goals and objectives, policy, initiatives, and expected outcomes.

3. Health Promotion Program Manager (HPPM). The HPPM, under the direction of the Behavioral Health Services Division Chief, will:

a. Program Development.

- (1) Develop and disseminate the annual HPP business plan.

- (2) Serve as liaison to the Office of Military Personnel, Commandant (CG-133), on health promotion issues associated with weight and body fat standards for military personnel, as directed by Reference (a).
 - (3) Serve as the physical fitness subject matter expert to CG programs internal and external to Commandant (CG-11).
 - (4) Serve as liaison to the HSWL SC to support policy initiatives and collaborate on all aspects of program implementation and evaluation.
 - (5) Work in collaboration with the CS Program Manager, the SAPP, and the Morale, Well-being, and Recreation (MWR) Program Managers on cross-program initiatives to ensure consistent implementation and management.
 - (6) Facilitate the development, evaluation, and implementation of education programs and training curricula in concert with FORCECOM to improve health-related behavior.
 - (7) Develop and evaluate programs to improve the physical fitness of CG members and beneficiaries.
 - (8) Coordinate as appropriate to address HPP issues and emerging initiatives.
 - (9) Establish standards for the HPP.
 - (10) Develop initiatives for the HPP in collaboration with key stakeholders.
 - (11) Develop, disseminate, and analyze the program evaluation plan in collaboration with the HSWL SC.
- b. Policy.
- (1) Serve as the subject matter expert on all health promotion policy and provide policy interpretation to personnel.
 - (2) Develop and update HPP policies.
- c. Resources.
- (1) Evaluate and/or develop select standard reference and educational materials on HPP core elements
 - (2) Participate on HSWL SC hiring panels (if requested) regarding HPP core elements.

- (3) Secure funding to support new initiatives, development, evaluation, and maintenance of the CG HPP.
- d. Training and Education. In conjunction with FORCECOM, work with all available resources to provide training to the field in program core elements of health promotions.
- e. Marketing.
 - (1) Develop a HPP communication/marketing plan to ensure concise and consistent promotion of program vision and services, to include monthly awareness campaigns and program initiatives.
 - (2) Develop messages to promulgate changes in health promotion policy and implement program initiatives.
 - (3) Provide program marketing guidance and materials regarding HPP core elements.
 - (4) Develop and maintain health promotion content on the Commandant (CG-111) website.
 - (5) Establish and maintain information networks, such as the health promotion site on the CG Portal.
 - (6) Prepare and deliver briefings on health promotion topics.
- 4. HSWL SC will:
 - a. Assist Commandant (CG-1111) in the development of the HPP business plan, marketing plan, measurement and evaluation.
 - b. Conduct quality improvement site visits with each HSWL Regional Manager (RM), in accordance with HSWL SC compliance inspection checklists.
 - c. Collect and report health promotion data quarterly to support Commandant (CG-1111) program evaluation efforts.
 - d. Analyze program data and provide Commandant (CG-1111) with a program summary report annually, and as requested due to emergent needs.

- e. Participate in Commandant (CG-1111) teleconferences, meetings, and web-based trainings as appropriate.
 - f. Manage and disburse funds in collaboration with Commandant (CG-1111) to support health promotion field operations for targeted funded activities.
 - g. Serve as liaison to CG medical communities to support policy initiatives and collaborate with clinics and Independent Duty Health Services Technicians (IDHS).
5. Commanding Officers and Officers-in-Charge will:
- a. Provide Funding. Commands are authorized to use appropriated funds for unit health promotion programs as authorized by the Financial Resource Management Manual (FRMM), COMDTINST M7100.3 (series). Non-appropriated funds may also be available to support health promotion activities, as authorized in the Coast Guard Morale, Well-Being, and Recreation Manual, COMDTINST M1710.13 (series).
 - b. Develop Program Planning.
 - (1) Establish and actively support an environment that enables unit members to routinely engage in healthy lifestyle behaviors and make informed healthy choices. This includes, work time for physical fitness training, tobacco free-environment, healthy food choices, and stress and health risk reduction. Refer to the Health Promotion Resource page <http://www.dcms.uscg.mil/work-life/HealthPromotionResources/> for info on particular topics.
 - (2) Review annually the Executive Summary of the command's HRA.
 - (3) Grant excused absences for active duty members and civilian employees to take part in one-time or occasional programs that are of short duration. Examples of these include: an officially sponsored federal fitness day event, an agency sponsored health screening, a fitness center orientation, or 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 civilian employees should be directed to the servicing field Human Resources Specialist.
6. Culinary Specialist (CS). CSs have the fundamental knowledge and skills to prepare nutritious meals that meet the following guidelines. CSs will:
- a. Provide nutrition information on menu items to enable patrons to make informed choices, wherever possible.

- b. Serve portion sizes in accordance with ChooseMyPlate.gov.
- c. Maximize use of healthy cooking techniques in meal preparation. Examples include:
 - (1) Baking versus frying.
 - (2) Steaming versus boiling vegetables.
 - (3) Avoiding use of butter and lard or oils high in saturated fat (palm tree or coconut oils). The use of trans fats are prohibited per Food Service Manual, COMDTINST M4061.5 (series).
 - (4) Maximizing use of whole grains (such as brown rice and whole wheat bread) versus processed and refined grains (such as white rice and white bread).
 - (5) Offering fruit and vegetables for snacks versus chips and candy.

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CHAPTER 2. DISEASE PREVENTION AND HEALTH RISK REDUCTION

- A. Introduction. Early detection and prevention of health risk, disease, and injury is a key component of the HPP. One of the tools the CG uses to determine and maintain the health of our members is the Periodic Health Assessment (PHA). The PHA a periodic evidence-based screenings administered by health care providers and is required for AD and SELRES personnel.
- B. Overview. Health Risk Assessments (HRA) are methods that provide information on personal and organizational health risks and specific guidance on how to reduce modifiable risk factors through behavior change. An HRA can generate a personalized report for the member and a summary report for the CG unit and the organization as a whole. The CG utilizes HRAs to enhance the health of the individual CG member and the organization. The HRA evaluates several key components of health behavior such as:
1. Nutrition and weight management.
 2. Physical activity.
 3. Risk reduction- alcohol, nicotine, and cardiovascular risk factors.
 4. Stress and sleep habits.
- C. Policy. The Fleet HRA is a mandatory health behavior survey completed annually by all military personnel during their PHA. It is a snapshot assessment that provides an overview of the health behaviors of each individual. Requirements and guidance for completion of the Fleet HRA are found in References (b) and (c). The Command HRA is a report that indicates organizational health risks and will be used to develop unit-level health promotion plans to reduce modifiable risk factors and improve overall health and readiness.
- D. Duties and Responsibilities.
1. Behavioral Health Services Division Commandant (CG-1111) will annually review HRA data to establish program goals, identify health behavior trends in the workforce, and evaluate program effectiveness.
 2. HSWL SC will assist Commandant (CG-1111) to collect and analyze data.
 3. Commanding Officers and Officers-in-Charge will:
 - a. Review the Fleet HRA Commanding Officer Report annually in order to:
 - (1) Establish unit wellness goals and objectives that support overall unit mission readiness.

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- (2) Plan, implement, and evaluate appropriate wellness interventions that ensure unit health and well-being. Contact the HSWL SC or Health Promotion Program Manager for questions.

CHAPTER 3. NICOTINE USE POLICY

- A. Introduction. This Chapter sets policies and procedures to control tobacco/nicotine use on all CG installations and bases, facilities, vehicles, ships, aircraft, and equipment. These procedures apply to all organizational elements, AD, SELRES, civilian employees, as well as all visitors, contractors and their personnel, and personnel of other agencies that operate within or visit CG facilities. For purposes of this policy, the terms “tobacco use” and “tobacco products” mean tobacco and nicotine products, including electronic or e-cigarettes, smoking (e.g., cigarette, cigar, and pipe), smokeless tobacco products (e.g., spit, lug, leaf, snuff, dip, etc.) and all other nicotine delivery systems and products as defined by Commandant (CG-1111) and or the CDC. Nicotine Replacement Therapy (NRT) products containing nicotine and approved for use by the Food and Drug Administration (FDA) are not considered “tobacco products.”
- B. Overview. Nicotine is a highly addictive psycho-active substance. Persons dependent on nicotine find it difficult to quit and often require multiple attempts using multiple intervention modalities to overcome the addiction. As with other substances of abuse, tobacco products generate physiological changes and cause significant health risks. To this end, tobacco cessation is not simply a “will power” decision, but rather requires appropriate medical and health behavior interventions. With this understanding in mind, the CG has implemented a variety of programs to help individuals remain tobacco-free.
- C. Policy. It is CG policy to discourage the use of all forms of tobacco products and to protect people from exposure to environmental tobacco smoke (ETS), unsanitary conditions created by the use of spit tobacco, and the potential addiction to nicotine products. 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-nicotine users and nicotine users, the rights of the non-user will prevail.
1. Workplace.
 - a. Use of tobacco products is prohibited by law for all members under the age established by the state the member is currently in.
 - b. It is the intent of the Commandant to create and maintain a nicotine-free environment throughout the entire CG workplace. To this end, “tobacco use” is prohibited in the workplace in order to protect the health of all persons, including nicotine users, from contact with tobacco or nicotine products. For purposes of this policy, the term “workplace” includes any area inside a building or facility, over which the CG has custody and control, where work is performed by military personnel, civilian employees, or personnel under contract to the CG.
 - c. The use of “tobacco products” is permitted only in designated areas. Tobacco use is prohibited at all times in all non-designated tobacco use areas on all CG facilities, bases, and installations. Commanding officers must designate appropriate sites for the use of tobacco products (smoking and smokeless) and ensure areas are clearly

marked. These areas must be at least 50 feet from the vicinity of building entrances and exits or areas in clear public view. It is up to the discretion of each commanding officer and officer-in-charge if and where these sites may exist. Note: Current nicotine use policies and practices must remain in effect for all CG civilian employees represented by a union. Changes to current policies and practices may only be made in accordance with statute and applicable negotiated agreements. To this end, tobacco use is prohibited in all outdoor spaces, under CG control, not designated as a tobacco use area.

- d. Where permitted, tobacco spit will be held in containers with sealing lids to prevent odor and accidental spills. Tobacco spit and other tobacco product residue will be disposed of in a sanitary manner which prevents public exposure.
- e. The use of all tobacco products is prohibited in all CG government vehicles (cars, trucks, buses, vans) by all personnel, military, civilian or auxiliary.
- f. The use of all tobacco/nicotine use is prohibited in all CG aircraft or any other aircraft contracted for use in CG operational/training missions.
- g. Cutters may designate a Section of the weather deck as a tobacco use area (smoking and smokeless). Designated areas must be a sufficient distance away from entrances and exits, so as not to allow smoke to be drawn into the interior of the ship through doors, hatches, or air intake units/vents.
- h. Tobacco/nicotine will be used only during regularly scheduled breaks available to all personnel, which includes breaks during formal training. Additional breaks for members to use tobacco will not be permitted.
- i. The use of all tobacco/nicotine is prohibited by recruits at Training Center Cape May, Coast Guard Academy Cadets, and scholars (prep school students), and officer candidates at Officer Candidate School.
- j. Shore facilities will ensure designated tobacco/nicotine 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, at least 50 feet, so as not to allow smoke to be drawn into the indoor facility through door openings, windows, and air intake units/vents.
- k. The use of tobacco/nicotine is prohibited on small boats. The risk of ETS and hazardous material interactions is higher in these environments and every precaution should be taken to eliminate these risks.
- l. Tobacco/nicotine products will not be used while aboard or operating any CG machinery, equipment, craft, or vehicle.

2. Lodging, Dormitories, and Housing.
 - a. The Policy regarding tobacco use in CG controlled individual assigned family quarters is contained in the Coast Guard Housing Manual, COMDTINST M11101.13 (series).
 - b. Tobacco use is not allowed in CG controlled bachelor living quarters.
 - c. Tobacco use is prohibited in all common spaces of family housing units and CG controlled bachelor living quarters. 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.
 - d. 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 and CG Exchange Facilities. Workers and patrons are entitled to the same protection and consideration that is afforded to our personnel in the workplace. Accordingly, smoking in CG exchanges or MWR facilities or at MWR activities is prohibited unless a tobacco use area is designated.
4. Sales of Tobacco Products.
 - a. The sale of tobacco products from vending machines is prohibited.
 - b. The sale of tobacco products is prohibited to anyone under the age of 18 years unless superseded by state law.
 - c. The distribution and advertisement of tobacco products in CG facilities, publications, and official correspondence is prohibited.
- D. Tobacco Cessation Resources. In addition to CG resources, tobacco cessation programs may be available through local hospitals, clinics, Military Treatment Facilities (MTFs), TRICARE clinics, and national health websites. Many states offer tobacco quit-lines for telephonic support. Members are encouraged to use the program or service that best helps them achieve freedom from nicotine addiction. For military personnel be sure to check with TRICARE concerning any fees involved prior to treatment.
- E. Nicotine Replacement Therapy (NRT) and Tobacco Cessation Aids.
 1. TRICARE guidelines allow patients to obtain specified smoking cessation products at no cost through MTFs and the TRICARE Mail Order Program (TMOP). For more information on this smoking cessation program, contact your local MTF or the Work-life Tobacco Cessation Web-site: <http://www.dcms.uscg.mil/Our-Organization/Assistant->

[Commandant-for-Human-Resources-CG-1/Health-Safety-and-Work-Life-CG-11/Office-of-Work-Life-CG-111/Health-Promotion-Resources/Tobacco-Cessation-Program/](#)

2. Each DoD or CG MTF establishes its own requirements for obtaining tobacco cessation aids and should be contacted directly (e.g., participation in a smoking cessation program).

F. Duties and Responsibilities.

1. Behavioral Health Division, Commandant (CG-1111), will:
 - a. Ensure CG wide tobacco awareness, education, and behavior change programs reflect the current state of tobacco cessation science to meet the needs of all categories of beneficiaries.
 - b. Establish program evaluation measures for tobacco cessation efforts throughout the CG.
 - c. Maintain a website that lists latest changes to the tobacco cessation policy and resources.
 - d. Generate messages and other CG wide marketing materials to support tobacco cessation efforts.
2. Commanding Officers and Officers-in-Charge will:
 - a. Administrative Support.
 - (1) Designate appropriate sites for the use of tobacco products (smoking and smokeless) and ensure areas are clearly marked. These areas will be at least 50 feet from the vicinity of building entrances and exits or areas in clear public view. It is up to the discretion of each commanding officer and officer-in-charge if and where these sites may exist. Note: Current nicotine use policies and practices will remain in effect for all CG civilian employees represented by a union. Changes to current policies and practices may only be made in accordance with statute and applicable negotiated agreements.
 - (2) Post notices at the entrance of all facilities that state smoking is not allowed except in designated areas.
 - (3) Enforce compliance with this policy and ensure each member of the command is familiar with this Manual.
 - b. Program Planning.
 - (1) Actively promote tobacco avoidance and cessation by use of a variety of

educational media and scheduling at least one annual all-hands tobacco awareness activity.

- (2) Ensure tobacco cessation programs address the use of smokeless tobacco products and other nicotine delivery systems and ensure that smoking restrictions do not promote the use of smokeless tobacco products.
- (3) Encourage members to use available tobacco cessation resources and when operations permit, allow members and civilian employee's time during the work day to engage in educational, prevention, and cessation activities via classroom, computer, and telephone.
- (4) Prohibit smokers from engaging in tobacco use during unscheduled break times that are not available to all crewmembers.
- (5) Hold tobacco users accountable for appropriately discarding smoking materials and/or spit tobacco.

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CHAPTER 4. PHYSICAL FITNESS

A. Introduction.

1. CG (AD and SELRES) 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 meeting physical requirements and responding to higher stress levels in operational and emergency situations. Command and individual responsibilities with respect to physical fitness readiness are covered in this Chapter. Certain operational duty assignments (e.g., Maritime Safety and Security Teams and boat crews) have specific physical fitness requirements outlined in their respective program Instructions.
2. Physical activity also has beneficial effects for general health and wellness. Engaging in regular physical activity is an effective way to reduce stress, manage weight, decrease risk of disease and injury, improve physical appearance, and improve morale. Years of research categorically supports the premise that exercise leads to improved physical function, decreased risk of chronic disease, and decreased disability.

B. Overview. Physical fitness guidelines for general health as set forth by the CDC include:

1. Two hours and 30 minutes (150 minutes) of moderate-intensity aerobic activity (e.g., brisk walking) every week.
2. Muscle-strengthening activities on two or more days a week that work all major muscle groups (e.g., legs, hips, back, abdomen, chest, shoulders, and arms).

C. Policy. In order to have an operationally physically ready workforce, and to promote general health and wellness, the following policy applies.

1. All AD and SELRES, are required to develop Personal Fitness Plans, Form CG-6049. The completed Personal Fitness Plan (PFP) must be submitted to their supervisors in the months of April and October; the most current form must be kept on file or electronically saved by the member and supervisor. In addition, commanding officers/officer-in-charge must provide all AD personnel and reservist on active duty the opportunity to participate in fitness enhancing activities, as outlined in this Manual.
2. All AD members must:
 - a. Engage in fitness activity as outlined in their PFP, a minimum of 180 minutes per week. It is strongly recommended that the fitness plan include 150 minutes of cardiorespiratory activity and 30 minutes of strength training. These requirements are based on the guidelines summarized above in Paragraph 4.B. of this Manual.
 - b. Physical activity should produce a training effect, as measured by a medium to vigorous level of intensity. (Refer to Enclosure (2) for examples of exercise

intensity.)

- (1) Because the effects of physical activity are cumulative, exercise sessions may vary in length, with a minimum of 10 minutes, in order to be beneficial. In general, physical activity sessions should be spread out over at least three days per week.
 - (2) If a member is unable to participate in fitness enhancing activity due to medical conditions, a Duty Status from their primary care manager to their current supervisor is required.
3. Reservists:
- a. Reservists on AD for 31 days or more continuously must follow the above policy for AD members in Paragraph 4.C.2.
 - b. All Ready Reservists are recommended to follow the guidance above in Paragraph 4.B.
4. For CG Academy Cadets: The Superintendent of the CG Academy must provide physical fitness standards for cadets through Regulations of the Corps of Cadets, Superintendent Instruction M5215.2 (series).

D. Duties and Responsibilities.

1. Behavioral Health Services Division, Commandant (CG-1111), must:
 - a. Provide subject matter expertise for physical fitness policy across all programs both within and outside of the HSWL Directorate, ensuring the scientific and operational validity of program content and structure.
 - b. Design educational, promotional and behavior change initiatives for improving the physical fitness of CG members and beneficiaries.
2. HSWL SC must assist Commandant (CG-1111) with evaluating physical fitness initiatives.
3. Commanding Officers and Officers-in-Charge. As an integral factor in mission readiness and an essential component of total wellness, physical fitness activities will be required at all levels of the command. To support this objective, commanding officers and officers-in-charge must:
 - a. Ensure all members (AD and SELRES) complete the Personal Fitness Plan, Form CG-6049, [http://www.dcms.uscg.mil/Portals/10/CG-1/cg111/docs/HPM/CG_6049\[1\].pdf?ver=2017-04-27-151437-937](http://www.dcms.uscg.mil/Portals/10/CG-1/cg111/docs/HPM/CG_6049[1].pdf?ver=2017-04-27-151437-937) every April and October.

- b. Operations and workload permitting, allow all military members (AD and SELRES) time for exercise and physical activity a minimum of 180 minutes per week during normal working hours. Commands do not have to comply when the unit is on a tropical hours schedule or deployed; however, military members are still required to adhere to the 180 minutes per week exercise standards as outlined in Paragraph B.1. in this Chapter. Commanding officers of training centers may waive fitness enhancing activity and PFP requirements for military students if they determine course requirements fulfill the fitness enhancing activity requirement, or if fitness enhancing activity cannot be reasonably accommodated in the training schedule. In efforts to follow this policy, commanding officers and officers-in-charge may:
 - (1) Limit the working hours during which fitness activity may be performed to prevent or mitigate disruptions to unit or work-group efficiency and effectiveness.
 - (2) Exclude participation by incumbents of civilian employee positions assigned activities that cannot be paused during assigned working hours without adversely affecting work being performed by other members, employees or work-groups, due to activity interdependency.
- c. Reflect compliance with this policy in the member's personnel evaluation under health and wellness parameters.
- d. Consistent with the provisions of Paragraph.D.3.b of this Chapter, operations permitting, allow all civilian general schedule, wage grade, and senior executive service employees work time for voluntary participation in physical fitness activities in accordance with the following:
 - (1) Excused absences must not exceed 60 minutes, inclusive of time for showering and changing, on any given day, up to 180 minutes each week. Unused time must not carry over to any subsequent pay period. Excused absence can be combined with authorized breaks or in conjunction with the regularly scheduled lunch period with supervisory approval. It may not be used before an employee reports for duty or to allow for an employee's early departure. Participants must physically report to work before engaging in their fitness activity and must report back to work if the fitness activity is prior to departure at the end of the day.
 - (2) Excused absence of civilian employees for exercise must be recorded in Web TA or other approved time and attendance systems.
 - (3) Use of time for physical fitness activities by part-time employees should be prorated to correspond with the number of hours worked per pay period. When calculating such time, the number of hours worked bi-weekly should be divided by 80 to come up with the percentage of the maximum time allowed for part-time employees. (Example: Employee works 40 hours per pay period 40 divided by

80 equals .50. .50 multiplied by 180 min (amount of time allowed to work out) equals 90 minutes per week.)

- (4) Physical fitness activities are subject to approval, based on office/team workload, operational tempo, or other mission priorities. The Commanding Officer will have the final authority to determine when (day and time) the employee may participate, and may modify or suspend participation without notice based on workload. Commands are strongly encouraged to support this program whenever possible.
- (5) Employees with a current unsatisfactory annual performance evaluation, or who are operating under a Performance Improvement Plan are prohibited from participation in the program. Further, whenever performance or conduct issues arise, the supervisor, at his/her discretion, may restrict, deny, or revoke employee participation in this program until the performance or conduct issues have been satisfactorily resolved. Failure to adhere to the program guidelines and procedures may result in disciplinary action.
- (6) An eligible employee must complete a Personal Fitness Plan, Form CG-6049, and submit it to his/her supervisor along with an electronic or written request to participate in physical activity. Employees can obtain this form at: <http://www.dcms.uscg.mil/directives>.
- (7) The supervisor will review the Personal Fitness Plan, Form CG-6049, and either approve or disapprove the request. Employees and supervisors may contact the HPPM for guidance and/or assistance with completing, reviewing, and/or revising the Personal Fitness Plan, Form CG-6049.
- (8) The supervisor will maintain the approved request on file and provide the employee with a copy.
- (9) An eligible employee approved to participate in the program must maintain a current written or electronic log of their exercise activity. Employees can obtain a sample exercise log at: <http://www.dcms.uscg.mil/work-life/HealthPromotionResources/> or from the HPPM. The log must be provided to the supervisor upon request.
- (10) Employees voluntarily participating in the physical fitness program may be allowed to engage in activities located outside the confines of the CG base, installation, or facility. Examples of these activities include walking, jogging, biking, and working out at an offsite health facility.

CHAPTER 5. NUTRITION AND WEIGHT MANAGEMENT

- A. Introduction. There are individual and organizational benefits associated with personnel eating nutritiously and maintaining healthy weight and body fat composition. While compliance with Commandant weight standards supports a positive military appearance and promotes awareness of diet and exercise, members should work to achieve healthy standards that lower risk factors and maximize mission readiness.
- B. Overview.
1. Nutrition. A healthy diet supports maximum performance and fitness. It protects against disease and illness. When personnel are eating the right foods in the right amounts at the right time, performance opportunities are greatly enhanced. Low fat and cholesterol-free products are examples of foods that enhance health and reduce the risk of disease. A properly fed workforce is more mission ready and physically capable, which will typically result in lower health care costs. This is accomplished by focusing on:
 - a. Food intake for performance.
 - b. Caloric intake for successful weight management.
 - c. Policy that supports an environment for healthy food choices.
 2. Dietary Supplements.
 - a. A dietary supplement (DS) is a preparation intended to supplement the diet and provide nutrients, such as vitamins, minerals, fiber, fatty acids, amino acids, or micronutrients that may be missing or may not be consumed in sufficient quantities in a person's diet. DS's are consumed for many reasons, including weight loss/gain, muscle growth, physical performance enhancement and recovery, disease prevention, and to cure disease or illness.
 - b. Because DSs are not classified as either a food or a pharmaceutical product, they are not regulated by the FDA unless a product or ingredient is proven to be harmful. Product labels must list ingredients but the efficacy of product claims, quality, and quantity of ingredients may not be accurate. Consequently, a DS product may contain ingredients which pose a health risk, are prohibited for AD and reserve personnel, or may cause harmful side effects when used with prescribed or over the counter medications. As a preventive measure, all personnel are strongly encouraged to be informed health consumers when DS products are used, primarily considering the efficacy, health risk, legality, and CG prohibition/restrictions before using a product. CG / DoD Health care providers, and CG sanctioned resources, such as the Human Performance Resource Center website: <http://humanperformanceresourcecenter.org> should be the primary source for guidance.

- c. Choosing Healthy Options for Wellness (CHOW) is an assessment that evaluates the types of food options available at a unit or base, encourages policy that educates and supports healthy eating, and identifies environmental factors that promote healthy food choices. It utilizes a scoring system to assess how well a unit is doing in promoting healthy eating and providing individuals with the opportunity to make healthy food choices. The following web site contains a link to the CHOW evaluation form <http://www.dcms.uscg.mil/work-life/HealthPromotionResources/>.
- C. Policy. Healthy weight management is largely an issue of personal accountability. However, it is also the responsibility of leadership throughout the CG to support healthy weight management behaviors by, creating work environments that support healthy behavior, and lead by example. To ensure healthy environments Commanding Officers will:
1. Annually review the Fleet HRA Commanding Officer report, and contact HSWL SC or the CG HPPM for recommendations on how to improve the nutrition at your unit.
 2. Annually complete applicable Sections of the CHOW assessment.
- D. Duties and Responsibilities.
1. Behavioral Health Services Division, Commandant (CG-1111), will:
 - a. In coordination with the CS PM, ensure nutrition information and Instructions in healthy cooking methods are included in the CG Culinary School curricula.
 - b. Annually collect CG-wide data to analyze the eating behavior trends of the workforce.
 - c. Establish goals with outcome measurements for improving healthy eating and weight management behaviors.
 - d. Work in coordination with the Office of Military Personnel, Commandant (CG-133), and the Office of Health Services, Commandant (CG-112), to address issues and develop policies related to performance nutrition, DS use, and weight management.
 - e. Inform CG senior leadership about the latest trends and state of the science in nutrition, DS, weight loss science management, and policy as promulgated by DoD, CDC, the National Institutes of Health, and other government agencies and scientific institutions. Review and disseminate state of the science information on healthy eating and weight management behavioral change.
 - f. Develop methods to assess healthy food choice environment in the workplace, to include policy, food choices, and food services.
 2. HSWL SC will assist Commandant (CG-1111) in implementing the CG nutrition and weight programs initiatives.

3. Commanding Officers and Officers-in-Charge will:
 - a. Direct members on weight probation to the Commandant (CG-11) Health Promotion Resources Website <http://www.dcms.uscg.mil/work-life/HealthPromotionResources/> for information on weight management planning, techniques, and resources.
 - b. Annually complete applicable Sections of the CHOW assessment. Units should coordinate with the unit CS or HPPM for any assistance to complete this assessment or how to make improvements.
4. Medical Officers will:
 - a. Promote Commandant (CG-1111) sponsored weight management initiatives and programs.
 - b. Promote CG sponsored DS resources.
 - c. Discuss weight management options with members on weight probation, including but not limited to:
 - (1) Exercise,
 - (2) Nutrition, and
 - (3) Health Coaching.
5. Unit CS will plan menus to ensure all members have daily access to nutritionally sound food choices.
6. Members on weight probation must be familiar with the resources available on the Health Promotion web page (health coaching, nutrition, exercise, and DS resources) <http://www.dcms.uscg.mil/work-life/HealthPromotionResources/>.

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CHAPTER 6. STRESS MANAGEMENT

- A. Introduction. Operational readiness and safety are closely tied to the ability of personnel to endure the physical, mental, and environmental demands of work, social, and family systems. Effective stress management promotes operational risk reduction by enhancing personal readiness. The purpose of effective and healthy stress management programs for the CG is to identify and control risk factors that can reduce human endurance and thereby compromise safety and operational readiness. Appropriate referral to an individual trained in stress management includes but is not limited to, a Medical Officer, Employee Assistance Program Manager (EAPM) and a Chaplain.
- B. Overview. When managed effectively, stress can help individuals reach personal and job performance goals. However, when ineffective or inappropriate coping responses are used, the results can be harmful and unhealthy to the individual, the family, and operational readiness.
- C. Policy. Assessing and responding to the impact of stress on crewmembers and unit readiness is the responsibility of leaders at all levels. CG leadership will assist members in managing stress in the following ways:
 1. Become familiar with Operational Stress Control (OSC) as modeled by the following Stress Continuum:

READY (Green Zone)	REACTING (Yellow Zone)	INJURED (Orange Zone)	ILL (Red Zone)
<p>Definition</p> <ul style="list-style-type: none"> - Adaptive coping and mastery - Optimal functioning - Wellness <p>Features</p> <ul style="list-style-type: none"> - Well trained and prepared - Fit and focused - In control - Optimally effective - Behaving ethically - Having fun 	<p>Definition</p> <ul style="list-style-type: none"> - Mild and transient distress or loss of optimal functioning - Always goes away - Low risk for illness <p>Features</p> <ul style="list-style-type: none"> - Irritable, angry - Anxious or depressed - Physically too pumped up or tired - Loss of complete self control - Poor focus - Poor sleep - Not having fun 	<p>Definition</p> <ul style="list-style-type: none"> - More severe and persistent distress or loss of function - Leaves a "scar" - Higher risk for illness <p>Causes</p> <ul style="list-style-type: none"> - Life threat - Loss - Inner conflict - Wear and tear <p>Features</p> <ul style="list-style-type: none"> - Panic or rage - Loss of control of body or mind - Can't sleep - Recurrent nightmares or bad memories - Persistent shame, guilt, or blame - Loss of moral values and beliefs 	<p>Definition</p> <ul style="list-style-type: none"> - Persistent and disabling distress or loss of function - Clinical mental disorders - Unhealed stress injuries <p>Types</p> <ul style="list-style-type: none"> - PTSD - Depression - Anxiety - Substance abuse <p>Features</p> <ul style="list-style-type: none"> - Symptoms and disability persist over many weeks - Symptoms and disability get worse over time
Unit Leader Responsibility	Individual, Peer, Family Responsibility		Caregiver Responsibility

Table 6-1: Operational Stress Control Continuum

2. Know personnel well enough to recognize when members are “not in the Green Zone.”
3. Take appropriate actions when personnel are found to be “Reacting,” “Injured,” or “Ill” (Yellow, Orange, or Red Zones).
4. Be aware of and understand the four sources of stress injuries: loss, trauma, inner conflict, and wear and tear.
5. Recognize that many personnel will experience stress injuries sooner or later and that early command response is essential to keep personnel from becoming further injured or ill.

D. Duties and Responsibilities.

1. Behavioral Health Division, Commandant (CG-1111) will:
 - a. Provide professional oversight for stress management initiatives.
 - b. Review, procure, and disseminate appropriate stress management awareness, education, and behavior change materials.
2. The EAPM will design and implement effective stress management programs.
3. HSWL SC will support EAP related programs and disseminate information regarding these programs to the field.
4. Commanding Officers and Officers-in-Charge will:
 - a. Be aware of the unit’s stress climate and the signals of stress that members may display. Refer to: <http://www.dcms.uscg.mil/Our-Organization/Assistant-Commandant-for-Human-Resources-CG-1/Health-Safety-and-Work-Life-CG-11/Office-of-Work-Life-CG-111/Health-Promotion-Resources/Stress-Management-Program/>
 - b. to access the Navy and Marine Corps Combat and Operational Stress Control for tools to evaluate stress.
 - c. Ensure information is available to all members on support resources such as CG SUPRT (Employee Assistance Program) at 1-855-CGSUPRT (247-8778) or www.CGSUPRT.com.
 - d. Ensure crews and individuals receive appropriate and timely assistance to avoid stress injury or illness.

- e. Proactively create stress awareness during operational transitions and high stress situations such as, PCS moves, underway deployments, disaster relief missions and, high evolution operational tempos.
- f. Promote and support individual members on implementing proper stress management techniques at work.
- g. Conduct Crew Endurance Risk Assessments in accordance with Reference (d). Commandant (CG-1133) can address technical questions, support, and resources regarding this Reference.
- h. Conduct safety stand-downs to include crew endurance and stress management training.

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CHAPTER 7. SUBSTANCE ABUSE PREVENTION (SAP) PROGRAM

A. Introduction.

1. Policy in this Chapter applies to all CG AD personnel, including reserve members on AD. In accordance with Section 703 of the 2012 NDAA, reservists in an Inactive Duty Training (IDT) and Active Duty Training (ADT) drilling status are entitled to behavioral health support screenings, such as assistance with substance abuse. Reservists no longer in an IDT or ADT drilling status are responsible for any follow up care required as a result of behavioral health support screenings unless a Line of Duty investigation determined that the issue was incurred or aggravated in the Line of Duty. See Administrative Investigations Manual, COMDTINST M5830.1 (series), for more guidance.
2. Senior leadership should establish clear and quantitative guidelines for the health and readiness of the members they lead. Evidence-based medicine should be used to establish those guidelines when possible. A positive command climate that promotes responsible low risk alcohol use and provides alcohol-free alternatives for off-duty recreation is essential to minimizing personnel and operational risks. Commands and leaders should be mindful that, even with the best prevention strategies and programs, there are times that a CG member requires assistance in seeking treatment and educational resources.
 - a. Spectrum Use Disorder. This program outlines the steps necessary for a command to appropriately address these situations and provide members with alcohol use guidelines, treatment, and/or education they are entitled regardless of any personnel action associated with alcohol misuse or abuse. Substance abuse is a spectrum use disorder. This requires education and treatment that coincides with the severity of the disorder and where the member is on this spectrum (e.g., abstinence, use, misuse, abuse, dependency).
 - b. National Guidelines. The strategy of the CG SAP Program is to reduce the negative consequences related to substance use. This policy encourages self-control, personal responsibility, and supports a zero tolerance illicit drug policy. The CG uses the National Institute of Alcohol Abuse and Alcoholism (NIAAA) guidelines for responsible drinking. Detailed information on these guidelines can be found at <http://niaaa.nih.gov/alcohol-health>. CG members are encouraged to either abstain or engage in low risk alcohol consumption guidelines.
 - c. Medical Model. Drug abuse and dependency, which includes the abuse of or dependency on alcohol is a brain disease. Drug abuse and dependency are seen as a continuum or constellation of symptoms. Addiction in all of its forms including gambling affects not only the afflicted member, but also society, family, friends, co-workers, and commands.

B. Overview. The goals of this program are to provide guidance. This guidance comes in the form of suggested national guidelines whose intent is to inform commands about substance abuse; establish policy; provide commands and individuals with substance abuse prevention training; implement strategies to prevent substance misuse and abuse; consult with commands on substance related issues when requested; and finally, educate commands about substance use and abuse. This program intends to:

1. Raise Awareness of Substance Abuse Issues. Help each member and command understand how to approach and deal with substance misuse, abuse, and chemical dependence, which are referred to as Substance Use Disorders (SUD).
2. Encourage, Teach, and Support Low Risk Guidelines for Alcohol Use. The SAP Program has adopted a risk management model for alcohol consumption. Low Risk drinking guidelines have been established by the NIAAA. Key behaviors for low risk alcohol use as defined by Commandant (CG-1111) include the 0,1,2,3 model. These guidelines suggest:
 - a. There are occasions where “zero” drinks is the low risk option. Examples are when one is driving, using machinery, cleaning a weapon, pregnant, or on medication.
 - b. Consuming no more than one “standard alcoholic beverage” per hour.
 - c. Two standard drinks per occasion and never to exceed three.

{Note: The CG is aware of the complexities, intricacies and delicate nuances related to education, socio-economic influences, gender, and ethnicity issues as they relate to drinking guidelines both nationally and internationally. Therefore, the CG has decided to use a gender neutral set of low-risk drinking guidelines: 0,1,2,3. Gender guidelines have been established by the NIAAA because males and females process alcohol differently. Citations are included in this Section to elucidate the physiological and absorption differences for males and females. For further clarification, please see: <http://rethinkingdrinking.niaaa.nih.gov/IsYourDrinkingPatternRisky/WhatsLowRiskDrinking.asp> and <http://health.gov/dietaryguidelines/dga2010/dietaryguidelines2010.pdf>.

- d. The World Health Organization (WHO) released their 2014 World Cancer Report <http://www.meltingmama.net/files/noamountofalcoholissafe.pdf> noting that “no amount of alcohol is safe and is causally related to several cancers.”
- e. Check with a health care provider to ensure it is safe to consume alcohol with prescribed medication or diagnosed medical condition (e.g., pregnancy).
- f. Avoid any activity requiring strict focus and attention or coordination and balance (e.g., cleaning a weapon, climbing a ladder, operating machinery).

3. Provide Periodic Prevention Training. Provide members, cadets, recruits, and commands with prevention training, early problem identification skills, and resources for screening and treatment in conjunction with FORCECOM.
4. Support Commands. Assist commands by providing the tools and procedures to deal with irresponsible use of alcohol.
5. Outline Zero Tolerance for Drug/Substance Misuse and Abuse. Support zero tolerance for the intentional and wrongful use of illegal drugs and the wrongful misuse of prescription medication. This also pertains to the wrongful use of any non-controlled substance used with the intent to induce intoxication, excitement, or impairment of the central nervous system. This will also pertain to “substances” used for the purposes for obtaining a “high” which includes but is not limited to, gases, aerosols and manufactured or yet to be manufactured designer drugs (e.g., spice, bath salts, etc.).
6. Support Mission Readiness. Ensure that members are aware of how substance abuse interferes with CG mission readiness and a safe work environment.

C. Policy.

1. Commanding Officers will institute a substance abuse prevention plan that leverages all unit leaders. Guidelines for development of this plan are provided in depth to the Command Drug and Alcohol Representative (CDAR) via the CDAR course.
2. The policy outlined in this Chapter directly correlates with the drug and alcohol related policies reflected in Reference (e). Commands will use Reference (e) and this policy to appropriately document and handle alcohol-related issues at their unit.

D. Duties and Responsibilities.

1. Commandant (CG-1111). In concurrence with FORCECOM, Commandant (CG-1111) is responsible for the medical training, education, and evaluation policies of the SAP Program.
2. Substance Abuse Program Manager (SAPM). The SAPM serves as the manager for the SAP Program within Commandant (CG-1111) and as a liaison to the DoD and other agencies. Specific duties of the SAPM include:
 - a. Coordinate with CG Personnel Services Command (PSC) and the HSWL SC to provide staffing for CG Substance Abuse Prevention Specialist (SAPS) billets.
 - b. Coordinate with FORCECOM in developing substance abuse training and education curricula for CG personnel both on-line and face-to-face.
 - c. Ensure CG Medical Officers involved in evaluating, screening, or diagnosing

substance abuse patients are afforded the opportunity to receive the CG Addictions Orientation for Health Care Provider-Medical Officer (AOHCP MO) course or civilian equivalent specialized training regarding substance abuse and diagnosis.

- d. Collaborate with the Substance Abuse Prevention Program Supervisor (SAPPS) and ensure Medical Officers, SAPPS, SAPSs, and CDARs complete required training.
 - e. Develop policy and manage budget for the SAPP.
 - f. Establish and oversee performance standards for the SAPPS and SAPS.
 - g. Remain current with outcome and research activities in the areas of substance abuse, prevention, screening, diagnosis, treatment, and follow-up care. When possible, create actionable items that provide efficiencies in the aforementioned areas.
 - h. Establish collaborative and effective communication pathways with the SAPPS, SAPSs, CDARs, and other field components.
 - i. Provide oversight, implementation, and modifications to the substance abuse segment of the electronic case management system or its electronic health record (EHR) equivalent.
3. Substance Abuse Prevention Program Supervisor (SAPPS). Responsible for coordinating the implementation of the SAP policy and for supporting all Commandant (CG-1111) priority initiatives related to this program. The SAPPS will:
- a. Provide direction, oversight, and supervision of SAPSs.
 - b. Advise commands on the availability of education, treatment, rehabilitation resources, and procedures for obtaining them.
 - c. Process all requests; self, command, and incident referrals for alcohol/drug rehabilitation.
 - d. Approve selection of the medical screening provider.
 - e. Oversee implementation and maintenance of support and aftercare plans.
 - f. Liaison with unit commanding officers, other military services, state and federal programs, and local civilian treatment facilities as appropriate.
 - g. Establish, track, and maintain Personnel Qualification Standards (PQS) for the SAPS.

- h. Complete annual Health Insurance Portability and Accountability Act (HIPAA) training related to substance abuse patient records.
 - i. Ensure SAPSs complete annual HIPAA training.
 - j. Participate in Headquarters-sponsored teleconferences, meetings, and workgroups related to the SAP Program.
 - k. Assign each SAPS an area of responsibility (District) with oversight for CDARs assigned to that AOR.
 - l. Supervise field operation of the electronic data collection system as designated by Commandant (CG-1111).
 - m. Provide quality assurance standards and oversight to the SAPSs to include accurate and timely documentation of cases in the electronic data collection system.
 - n. Oversee compliance of SAPSs with all applicable policies and procedures and related competencies.
 - o. Establish and maintain collaborative and effective communication pathways with the SAPM, SAPS, and other field components.
 - p. Inform the SAPM of all issues affecting program implementation and/or effectiveness that require Commandant (CG-1111) visibility, guidance, and/or intervention.
 - q. Produce reports for Commandant (CG-1111) as directed.
 - r. Advocate for the needs of the SAPSs and the SAP Program.
4. Substance Abuse Prevention Specialist (SAPS). HSWL SC personnel assigned to provide a number of functions, including but not limited to prevention training, education, and screening for treatment services. However, one critical function is to provide case management. This clinical role ensures members are appropriately screened and referred for treatment. It is vital that clinical roles remain separate from command roles (i.e., those that CDARS perform); therefore, SAPS will not serve as CDARs. SAPS will:
- a. Maintain a roster of unit CDARs within the assigned area of responsibility (AOR).
 - b. Connect with CDARs on a frequent basis to ensure all referrals (self, command and incident) are being captured in the electronic data collection system. Notify

CDARs of any changes in program policy or procedures.

- c. Notify the SAPPS of all issues affecting program implementation and/or effectiveness.
- d. Assist CDARs in developing unit prevention plans and conducting general alcohol awareness and prevention education as outlined in Section F.1. of this Chapter.
- e. Assist CDARs with developing support and aftercare plans.
- f. Advise and assist AOR units on all matters pertaining to policy interpretation, substance abuse screenings, treatment, and aftercare. NOTE: Never diagnose or infer a diagnosis. Failure to comply will result in removal from position and may lead to further administrative action.
- g. Approve selection of a CG Addiction Orientation for Health Care Provider (AOHCP) trained medical screening provider or obtain guidance from the SAPPs when needed.
- h. Ensure complete and accurate data entry into the electronic data collection system for all alcohol incidents and referrals within the assigned AOR through timely input from CDAR.
- i. Provide guidance and quality assurance to CDARs for reporting substance related issues, as directed by the SAPPs and SAPM.
- j. When stationed at Training Center Cape May or the U.S. CG Academy, provide recruits, officer candidates, direct commission officers, and cadets with:
 - (1) An initial orientation on CG substance abuse policies and the impact of substance abuse on the CG.
 - (2) An initial survey or questionnaire (e.g., Alcohol Use Disorders Identification Test) 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 to fulfill basic alcohol education requirements, as outlined by the SAPM.
- k. Conduct prevention training as outlined in Section F.1 of this Chapter.
- l. Complete the AOHCP SAPS course.

- m. Complete annual HIPAA training related to substance abuse patient records.
 - n. Ensure CDARs complete annual HIPAA training.
 - o. Promote education and awareness activities intended to prevent or reduce problematic gambling.
5. Commanding Officers and Officers-in-Charge will:
- a. Designate a CDAR in writing.
 - (1) Commands with less than 15 members and collocated with a larger command may request permission from that command to designate the larger unit's CDAR as their unit CDAR.
 - (2) Commands with 15 or more members will designate a CDAR.
 - (3) Commands with 50 or greater members will designate, at a minimum, one primary and one alternate CDAR.
 - (4) Members designated as a CDAR:
 - (a) Must be an E-5 to E-8 of any rating or an officer (O-1 to O-4).
 - (b) Must not be a member of the command cadre (CO, XO, etc.) or at the department head level.
 - (c) Should be mature, reliable, and fully understand the sensitive nature of this role.
 - (d) Understand that he/she works as an extension of the command and as a resource for the member.
 - b. Place the CDAR on all unit check-in/out lists and collateral duty lists.
 - c. Ensure members selected for CDAR attend the CDAR course prior to accepting the appointment. Training is conducted by the SAP as per training and educational requirements outlined in Section F of this Chapter.
 - d. Ensure unit CDAR submits updates to the SAPPs in accordance with Sections G, H, and I of this Chapter.
 - e. Ensure required steps are completed by the CDAR to accurately and completely document all substance abuse incidents in accordance with Reference (e), to include:

- (1) Assist with implementation of a pre-treatment plan.
 - (2) Facilitate completion of appropriate treatment (if required).
 - (3) Document corrective action (if necessary).
 - (4) Assist with implementation, oversight and monitoring of aftercare.
- f. Promote responsible attitudes toward the use of alcohol, both on and off CG facilities. Guidelines for appropriate use of alcohol may be found at the NIAAA web site: <http://rethinkingdrinking.niaaa.nih.gov/>.
 - g. Ensure a unit Alcohol Abuse Prevention Plan is developed, implemented and updated yearly. SAPSs are available to assist as referenced in Section E.4.e of this Chapter.
 - h. Ensure that the CDAR participates in one or more of the following unit committees: safety, morale, or health promotion.
 - i. Ensure members are afforded the treatment and educational opportunities outlined in Sections F, G, and H of this Chapter.
 - j. Use all available CG approved resources (e.g., CG SUPRT, Work-Life staff, TRICARE providers) to identify potential risk factors for substance abuse within a unit and establish protective factors to address and reduce the risk.
 - k. Cultivate an environment where members can seek assistance for actual or perceived issues with substances (reduce stigma and increase help seeking behavior).
 - l. Ensure the CDAR provides copies of all documentation to the receiving command when members on an aftercare plan are transferring.
 - m. Remove member as the CDAR if they have a negative consequence (e.g. arrest, DUI, drug incident, conduct unbecoming) as a result of substance abuse. Commands should contact SAPPS or Commandant (CG-1111) for guidance.
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. CDAR is a collateral duty and is administrative and educative in nature. Each CDAR will:
 - a. Contact the SAPS within 24 hours of commanding officer notification of a potential substance related issue.
 - b. Collaborate with the SAPS to provide administrative support to command regarding prevention strategies and treatment options.

- c. Collaborate with the SAPS to prepare the appropriate Administrative Remarks, Form CG-3307.
 - d. Schedule and document required unit alcohol training in accordance with Section F of this Chapter.
 - e. Prepare and prominently display prevention awareness materials.
 - f. Collaborate with the SAPS to initiate substance abuse screenings, referrals, treatment, Aftercare, and Support plans. NOTE: Never diagnose or infer a diagnosis. Failure to comply will result in removal from position and may lead to further disciplinary action.
 - g. Ensure that all documentation is complete before arranging treatment or training via the SAPS.
 - h. Keep the command informed of the status of personnel undergoing treatment, including expected date of completion and/or return, prognosis, and personal needs (e.g., pay, orders, etc.).
 - i. Collaborate with the SAPS to develop support and aftercare plans.
 - j. Monitor the mandatory pre-treatment and aftercare plans with the commanding officer.
 - k. Provide updates to the SAPS for all members who are:
 - (1) Assigned an aftercare plan.
 - (2) Transferred or separated from service while in aftercare.
 - l. Transferred or separated from service while in aftercare.
 - m. Provide copies of all documentation to the receiving command when members on an aftercare plan are transferring.
 - n. Complete annual HIPAA training related to substance abuse patient records.
7. CG Health Services Personnel.
- a. Medical Officers will:
 - (1) Facilitate substance abuse screening services when needed, in coordination with the SAPS or SAPPS. For ships underway, where an IDHS is the senior medical authority, the IDHS should contact the DMOA and schedule a

screening immediately upon return to homeport or port call where an AOHCP or equivalent trained MO is available. Contact a SAPPS for guidance and use telemedicine as appropriate.

- (2) Provide substance abuse screenings in accordance with their training, professional experience, and clinical privileges as taught in the AOHCP MO or equivalent course.
 - (3) Begin screening process within 72 hours of MO notification.
 - (4) Attend the AOHCP or equivalent course and refresher training (once developed by FORCECOM).
 - (5) Notify the SAPS within 24 hours for all medical referrals and provide required data to the SAPS for entry into electronic data collection system in accordance with Section K.2 of this Chapter.
- b. Health record custodians will assist the CDAR as needed to locate required information within the member's health record. Health care providers and health record custodians will ensure entries are made on the Chronological Record of Medical Care, Form SF-600, in accordance with Section G.3.c of this Chapter.
 - c. Provide needed feedback to SAPS to "flag" duty status in electronic data collection system.
8. Member Responsibilities. Each member will:
- a. Support abstinence or low risk drinking among other service members.
 - b. Support and create a culture where members are actively supporting others in their recovery.
 - c. Use the low risk guidelines when consuming alcohol or choose to abstain when any use may affect the readiness or safety of the member or unit.
 - d. Complete all mandatory alcohol awareness and prevention trainings as required.
 - e. Seek assistance from medical (self-referral) for screening when there is concern or indication that substance use is having a negative impact.
 - f. If mandated, fully and completely follow all treatment plans (treatment, aftercare, support) as designed by the MO. Members not adhering to aspects of their prescribed treatment plan or medical direction (e.g. attending scheduled appointments, abstinence from alcohol or illicit drug consumption) may be subject to further administrative action including discharge.

- E. Training and Education Requirements. Commandant (CG-1111), in coordination with FORCECOM, is responsible for the development, implementation, and evaluation of substance abuse training and education programs. These trainings are tailored to meet the needs of CG and SAP personnel. This Section outlines these requirements.
1. CG Personnel. The SAPS will provide the following training.
 - a. Accession Points. Universal substance abuse prevention training will be conducted at Training Center Cape May and the CG Academy.
 - (1) CG Academy. Cadets, officer candidates, and direct commission officers will complete an orientation on substance abuse awareness and current policy.
 - (2) Training Center Cape May. All recruits will complete training on drug and alcohol risk management, substance abuse policy, and the availability of substance abuse treatment resources.
 - b. Training Centers. Prevention training will be conducted at all “A” and select “C” schools, to include Chief Warrant Officer Professional Development, Officer Candidate School, and Chief Petty Officer Academy.
 - c. Substance Abuse Prevention Training. Substance abuse prevention training uses a universal, selective, and indicated model. Universal prevention training is directed towards the AD population. Focus is on subgroups that are not at “high risk” for developing a SUD. Selective prevention training is directed towards members whose behavior places them at higher “risk” and warrants additional education (e.g., heavy drinkers). Indicated prevention is for members whose behavior clearly puts them “at risk” for developing a SUD. Incident, self, and command referrals would be a target population. Additional training available is:
 - (1) On-Line Mandated Training (Universal). This required training is for all AD and reserve personnel and meets the mandated training requirement. On-Line Mandated training addresses CG policy in addition to signs, symptoms, and consequences of substance abuse, including impact on readiness and morale. Civilian employees’ attendance is at the Commanding Officer’s discretion.
 - (2) Substance Abuse Prevention (All Hands). This command-driven training is for all AD and reserve personnel. This targeted, yet customized prevention training, addresses CG policy in addition to signs, symptoms, and consequences of substance abuse. The principle focus includes impact on readiness and morale. This training is conducted as a result of a commander’s concern for their unit. This training can be conducted by SAPS or Command’s designee (e.g., Chiefs Mess).
 - (3) Leadership Consultation. This training is available for senior leadership and AD and civilian supervisors and managers. This training addresses roles and

responsibilities, pre-treatment and aftercare guidance, and resources to enhance leadership's ability to identify and deal with substance abuse issues in the workplace. This should be conducted by SAPS.

2. Substance Abuse Prevention Program Training.
 - a. SAPS Training. The following training, education, and experience are required for the SAPS position.
 - (1) Proficiency with CG workstations, software/applications, and electronic records management systems (e.g., Direct Access, electronic data collection system, Coast Guard Business Intelligence).
 - (2) CDAR School prior to accepting appointment as a SAPS. If certification is older than one year, the course must be repeated.
 - (3) Complete AOHCP SAPS within 6 months of assuming duties.
 - (4) Complete Navy Substance Abuse Prevention School within 6 months of assuming duties (as resources permit).
 - (5) Additional training through government or community agencies and civilian programs as required by the SAPM.
 - (6) Complete CG Instructor Development Course (IDC) within 6 months of assuming duties.
 - b. CDAR. Attend the CDAR course prior to command designation. The CDAR competency code will be assigned upon completion of training and command designation, in accordance with the U.S. Coast Guard Competency Management System Manual, COMDTINST M5300.2 (series).
3. Primary Intervention: Prime for Life (PFL or myPRIME). An evidence-based alcohol and drug program for members who show signs of misusing alcohol.
 - a. Commands may prescribe PFL to members regardless of diagnosis. PFL is required for members who receive an alcohol incident, which is documented in accordance with Section K.3.a. of this Chapter or when recommended by a CG MO.
 - b. Other courses may be considered, but require pre-approval of the SAPPS.
 - c. This course replaces Navy's IMPACT class, Brief Alcohol Screening and Intervention for College Students (BASIC), or its civilian equivalent.

F. Medical Referrals, Screenings, and Action for Substance Abuse.

1. Referral. The preferred method of addressing potential or suspected abuse is through a medical referral (e.g., command, self, or incident). This method is a means of early intervention in the progression of substance misuse and abuse leading to a disorder.
 - a. Command Referral. Initiated by the command with the intention to ensure the member receives appropriate screening and treatment, if necessary.
 - (1) A command referral is at the discretion of the command and can be based on any credible factor that indicates substance abuse such as third person account, personal observation, or noticeable change in job performance.
 - (2) A command referral where no alcohol or drug incident has occurred and is not intended as disciplinary or punitive. A copy of the referral, screening, and treatment plan will be maintained in the member's health record. A command referral for alcohol misuse is not maintained in the member's Personal Data Record (PDR). The primary reason for this referral is the health and safety of the member.
 - (3) A command referral resulting in a diagnosis that requires treatment will result in administrative action if the member refuses, fails, or does not complete treatment. The health of the member takes priority over career and advancement. A copy of the referral, screening, and treatment plan will be maintained in the member's health record.
 - b. Self-Referral. Initiated by the member to receive appropriate screening and treatment if necessary.
 - (1) Request must be made to a Chaplain, Command, CDAR, SAPS, or healthcare care provider.
 - (2) There can be no credible evidence of involvement in an alcohol incident.
 - (3) Members may self-refer for drug abuse; however, self-referral may result in determination of a drug incident and administrative actions in accordance with Reference (e).
 - (4) A self-referral for alcohol related issues is not intended as administrative or punitive and should not be maintained in the member's PDR. A copy of the referral, screening, and treatment plan will be maintained in the member's health record.
 - (5) A self-referral resulting in a diagnosis (e.g., current version of DSM) will result in administrative action if treatment is required and the member refuses,

fails, or does not complete treatment. The member's refusal, failure, or incomplete treatment requires a copy of the referral, screening, and treatment plan be maintained in the member's health record. The health of the member takes priority over career and advancement.

- c. Incident Referral. Initiated by the command where consumption of substances were considered a contributing factor to an incident.
 - (1) A description of the criteria for an alcohol/drug incident can be found in Reference (e). The following are examples of substance-related incidents that require medical screening:
 - (a) Driving or operating motorized vehicles while impaired (e.g., DUI/DWI/OWI);
 - (b) Drunk in public;
 - (c) Drunk and disorderly conduct;
 - (d) Alcohol-related arrest;
 - (e) Domestic violence where alcohol is a factor;
 - (f) Unfit for duty due to alcohol intoxication or impairment;
 - (g) Underage drinking; and,
 - (h) Determination of a drug incident.
 - (2) Referrals resulting from an alcohol or drug incident will be documented in the PDR as per Section K.3.a of this Chapter and copies of the referral, screening, and treatment plan will be maintained in the member's health record.
 - (3) All members receiving an alcohol incident will be enrolled in the Prime for Life (or myPRIME) Program.

2. Medical Screening.

- a. Process will begin within 72 hours of a request for consult (MO notification). The MO will determine need based on severity and schedule screening accordingly.
- b. Should be conducted by an AOHCP or equivalently trained CG MO however, TRICARE approved Substance Abuse Rehabilitation Programs or DoD MTF screening facilities may be used as an alternative. In all cases, the SAPS will approve selection of the screening provider with preference for an AOHCP trained

MO.

- c. Reserve members while in an IDT or ADT drill status are authorized referral for substance abuse screening and diagnosis.
3. The following actions are taken when a member is diagnosed with a substance use disorder (alcohol or drug) and is awaiting treatment:
 - a. Commands will:
 - (1) Review the evaluation and treatment recommendations provided by the screening facility and treat this diagnosis as any other illness and ensure treatment is initiated immediately.
 - (2) Collaborate with the CDAR and the SAPS to establish a Pre-Treatment Plan. The plan will include:
 - (a) Member is to abstain from alcohol until further evaluation and recommendation from the treatment facility.
 - (b) Weekly, documented meetings with the CDAR.
 - (c) Attendance of an abstinence-based, twelve-step or “at risk” programs a minimum of twice a week.
 - b. CDAR will:
 - (1) Collaborate with the SAPS to prepare the appropriate Administrative Remarks, Form CG-3307, for incident referrals, in accordance with Section J.3.a. of this Chapter.
 - (2) Monitor the member’s Pre-Treatment Plan with the Commanding Officer and provide updates to the SAPS.
 - c. Health care providers and health record custodians will ensure the following entries are made in the member’s health record:
 - (1) Reason for referral.
 - (2) Screening facility and location.
 - (3) Diagnosis.
 - (4) Treatment recommendations; to include American Society of Addiction Medicine (ASAM) Patient Placement Criterion treatment level.

(5) Pre-Treatment Plan.

G. Treatment.

1. All treatment must be authorized by a CG MO.
2. Commands must obtain guidance from SAPS prior to pursuing treatment for a member.
3. The SAPPS must authorize any patient treatment plan with a substance abuse diagnosis. The SAPS will review all other treatment plans.
4. Commands must verify members' compliance with all aspects of outpatient treatment programs (e.g., attendance at group therapy sessions or 12-step meetings) until all requirements are completed.
5. The CG SAP follows the treatment model published by the ASAM. This model is based on Patient Placement Criteria. The following are the ASAM recommended levels:
 - a. Level I Outpatient Treatment (OP).
 - (1) Personnel diagnosed as Alcohol Use Disorder (DSM-V code 305.00, mild; 303.90 moderate) and recommended for outpatient treatment as determined by the screening facility.
 - (2) MTFs or TRICARE facilities that offer this type of treatment may be used.
 - b. Level II Intensive Outpatient/Partial Hospitalization (IOP).
 - (1) Personnel recommended for this level require a greater level of care than that provided by Level I OP.
 - (2) Level II consists of daily classroom Instruction and individual/group counseling sessions.
 - (3) Members who are assigned Temporary Duty (TDY) will normally be berthed at the Bachelor Enlisted Quarters or Bachelor Officer Quarters closest to the facility.
 - (4) The length of treatment will vary depending on the member's degree of need.
 - (5) MTFs or TRICARE facilities that offer this type of treatment may be used.
 - c. Level III Residential/Inpatient.
 - (1) Personnel diagnosed as having a SUD mild, moderate or severe (DSM-V code

- 303.9) may be referred to treatment.
- (2) Inpatient rehabilitation is an intensive residential treatment program that provides treatment and berthing on site.
 - (3) Members who have other primary diagnosis which would undermine or interfere with their treatment for a SUD may require a referral to an MTF with additional on-site treatment facilities.
- d. Level IV Medically Managed Intensive Inpatient Treatment (Detoxification).
- (1) In a medical emergency the member will be taken to the nearest MTF or local civilian hospital emergency room.
 - (2) Detoxification normally consists of three to seven days in a hospital setting.
 - (3) Refer to “Medical Screening” in Section G.2 of this Chapter for the required documentation.
6. Selection of a Treatment Facility (Treatment Placement).
- a. Treatment may be provided by a local MTF. If a local MTF does not offer the recommended treatment, a TRICARE facility should be utilized.
 - b. Vetted civilian facilities (TRICARE) may be used. Consult with your District SAPS for vetted civilian providers.
7. Treatment Grading. Treatment programs recommended by a MO, SAPPS, or authorized TRICARE provider will not be downgraded to a lower level of care by the command. Only higher medical authorities may change treatment options.
8. Pre-existing Condition. In accordance with Reference (b), Section 5.B.5., a member diagnosed within the first 180 days of enlistment as drug/alcohol abusive or dependent (or SUD moderate or severe: DSM-V) is considered physically disqualified for enlistment. Separation is based on the diagnosis, not the incident itself. Commanding officers and officers-in-charge will process these members in accordance with Military Separations, COMDTINST M1000. 4, Paragraph 1.B.12. The CG is not obligated to offer treatment prior to separation. Commands should not offer treatment if said treatment will delay separation beyond 180 days of active CG service.
9. CDAR Responsibilities for Treatment Placement. The CDAR will facilitate placing members into 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), their district SAP and the HSWL SC SAPPS. The CDAR will take the following steps:

- a. Contact your District SAPS first and foremost. The SAPS will guide and assist ensuring that all required documentation is completed.
 - b. Prior to seeking substance abuse treatment, contact SAPS for approval and authorization of treatment facility.
10. If not already handled by the SAPS, ensure that a CG Substance Abuse Screening Assessment is provided to the SAPS or MO.
11. Refusal of Treatment. Members diagnosed with a SUD (DSM-V codes beginning with 290 to 300 series, drug or alcohol) who refuse treatment will:
- a. Sign Administrative Remarks, Form CG-3307 (P&D 18), in accordance with Section K.3.a. of this Chapter, acknowledging that they may be waiving their right to benefits under the Department of Veterans Affairs (VA) for treatment for SUD.
 - b. Be processed for separation from the CG in accordance with Reference (f).
 - c. Have entered in their health record, on a Chronological Record of Medical Care, Form SF 600, the refusal of treatment as noted by the completed Administrative Remarks, Form CG-3307 (P&D 18).
12. Family Member Involvement. Treatment of AD members at some civilian and TRICARE facilities and MTFs may involve family members as prescribed by the treatment facility. Additionally, the member's primary treatment coordinator must deem it an essential component to a successful outcome. With the advent of technology, this may be achieved via multiple electronic modalities.
13. Funding for Education and Treatment. As a precondition for CG funding of treatment, commands are to ensure pre-treatment plans and pre-education plans include the following terms: "abstain from alcohol."
- a. Alcohol education (e.g., Prime for Life, myPRIME) will be funded by the member when ordered by civilian authority.
 - b. Alcohol education (e.g., Prime for Life (PFL)) 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.
 - c. Local treatment through vetted TRICARE facilities and MTFs reduces the cost of travel associated with 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,

commands must request a Treatment Authorization via the HSWL SC SAPPS prior to receiving treatment.

- d. 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, and/or legal restriction (e.g., driving license suspended). Travel by privately owned vehicle to inpatient rehabilitation is not recommended and strongly discouraged.
- e. If and when medically required and approved as a non-medical attendant, spouses may be authorized travel related to treatment. If not overseas, this travel would be accomplished using unit funds. Contact the HSWL SC for guidance to travel.

H. Support Plans for Substance Use Disorders. The Support Plan is an essential part of the rehabilitation process and members will fulfill requirements as established by the treatment facility or CG MO. For Incident Referrals, the CDAR should notify the Command, referring MO and their District SAPS so treatment milestones (or the lack of) can be recorded in the electronic data collection system as per E.4.b&h., (e.g., health record).

- 1. Level II Support Plan. For members not diagnosed as “moderate or severe (DSM V: abusive or dependent),” the plan should include:
 - a. Abstinence. Abstaining from using alcoholic beverages for at least the first 90 days.
 - b. Meet with the CDAR. Meeting with the CDAR on a weekly basis for 90 days. These meetings can be informal and are meant to be an opportunity for the member to “check-in” with the CDAR.
 - c. Support Program. Participating in a twelve-step, abstinence-based group support program at least twice weekly for 90 days.
 - d. CDAR Reports. Completing and submitting an electronic data collection system case management report. When possible, schedule a quarterly meeting with the MO and the executive officer/executive petty officer to review current case load.
 - e. Other Supporting Plans. Commands are strongly encouraged to incorporate the Individual Development Plan and a dietary and fitness plan to help with behavior change. The use of CG SUPRT is strongly encouraged to obtain assistance from a health coach.
 - f. Plan for Responsible Alcohol Use. Upon completing the support plan, the member may be allowed to use alcohol in a responsible and abuse-free manner (after the initial 90 days post-treatment). Use of the 0,1,2,3 model outlined earlier in this Instruction is strongly recommended. Members diagnosed with a SUD will follow

the aftercare/support plan established by the discharging treatment facility.

- g. Immediate inclusion into prevention education e.g. Prime for Life or myPRIME.
 - h. Adherence to Medical Direction. Members not adhering to aspects of their prescribed treatment plan or medical direction (e.g. attending scheduled appointments, completion of prevention education (PFL or myPRIME), abstinence from alcohol or illicit drug consumption) may be subject to further administrative action including discharge.
2. Level II Support Plan Documentation. The support plan will be documented in the member's health record on a Chronological Record of Medical Care, Form SF-600, to include successful treatment completion, treatment facility diagnosis, type of treatment, dates of treatment, and support requirements.
 3. Aftercare Plan for SUD.
 - a. Aftercare Plan. The MTF, TRICARE, or civilian treatment facility will provide a written aftercare plan during the terminal phase of the rehabilitation program.
 - b. The 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 will be individually tailored to the member's needs and must include, but is not limited to the following:
 - (1) Abstinence is the only low risk option for a member with a severe SUD diagnosis.
 - (2) The aftercare period for a severe SUD diagnosis is normally 12 to 18 months.
 - (3) Because relapse is a condition of the disease of SUD, non-compliance with the abstinence portion of the member's treatment plan in itself is not reason for separation. Behaviors associated with relapse, (e.g., "slips," intoxication, being late or leaving early from work, on the job injury, declining work performance, mood change, irritability, argumentativeness, isolation, another alcohol-related incident) may provide sufficient justification for further administrative action.
 - (4) Meet with the CDAR on a weekly basis for the first six months. The CDAR will then determine the frequency of meetings thereafter.
 - (5) Participation in a 12-step or abstinence-based group support program at least twice weekly, operations permitting, 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 SAPS.

- (6) Al-Anon, Ala-Teen, and other family support groups are also recommended to aid the member and the family in recovery from the effects of SUDs.
 - (7) Meet with the primary care manager or MO quarterly or as needed.
 - (8) The voluntary use of alcohol-inhibiting drugs, such as Disulfiram (Antabuse) or Naltrexone is recommended when clinically supported.
 - (9) Pharmacotherapy such as Campril or other “anti-craving” medications may be prescribed.
4. Documentation for Aftercare Plan for SUD.
- a. Aftercare plans must be documented in the member’s health record on a Chronological Record of Medical Care, Form SF-600 to include:
 - (1) Successful treatment completion.
 - (2) Treatment facility diagnosis.
 - (3) Type of treatment.
 - (4) Dates of treatment.
 - (5) Aftercare requirements.
 - b. All electronic data collection defined by the SAPM will be completed.
5. Progress Reports for SUD Cases.
- a. Quarterly Meeting. The member, the CDAR, and the Commanding Officer/Officer-in-Charge (or representative) will meet quarterly to evaluate progress during the required aftercare period.
 - b. Initial Report. Upon the member’s return to the unit, the CDAR will forward a copy of the following to the SAPPS (Eyes Only), and a copy of the narrative summary will be placed in the member’s health record:
 - (1) Narrative summary of the rehabilitative treatment.
 - (2) Support plan or the aftercare plan.
 - (3) Initial CDAR referral and follow-up report.
 - c. Follow-up Reports. If designated, the CDAR will submit quarterly electronic data

collection system reports to their SAPS.

- I. Rehabilitation Failure. A rehabilitation (treatment) failure occurs when a member does not complete an alcohol treatment program or aftercare plan due to noncompliance. (The drinking of alcohol alone does not constitute a rehabilitation failure. Consult an AOHCP or equivalent trained MO for advice). Non-compliance with treatment includes:
 1. Being discharged against medical advice (AMA).
 2. Being asked to leave the treatment facility, not actively participating in required activities or leaving treatment before designated treatment is complete.
 3. Having an alcohol incident during treatment or the aftercare program. In such cases, the member will be processed for separation in accordance with Reference (e).

- J. Paperwork and Records Management for Substance Abuse Cases.
 1. Confidentiality. All correspondence, health, and personnel records regarding alcohol problems are “For Official Use Only” and will be handled in accordance with HIPAA and all other applicable records management requirements.
 2. CDAR Documentation.
 - a. The CDAR will complete all documentation requirements as instructed by the SAPS in the CDAR Course. CDARs are expected to remain current on documentation requirements and keep abreast of all changes as directed by the SAPPS.
 - b. Any time a member needs to receive treatment for alcohol or substance misuse the CDAR will contact the SAPS or SAPPS and follow the requirements as outlined in this Chapter.
 - c. All data, including alcohol incident, self-referral, command referral, and subsequent case-related information will be entered into the electronic data collection system by the SAPS as directed by the SAPPS.
 - d. The CDAR, under no circumstances, will maintain separate case files or keep copies or electronic files of medical and personnel documents.
 - e. CDARs may maintain a password protected spreadsheet as an electronic reminder list to assist in appointment scheduling or to monitor a member’s progress through the various phases of alcohol abuse treatment and recovery.
 3. Administrative Documentation.

- a. **Personal Data Record (PDR) Entries.** The only documents authorized in a member's PDR, pertaining to an alcohol or drug incident, are the appropriate Performance and Discipline (P&D) Administrative Remarks, CG-3307 entries, located in Enclosure (6) of The Personnel and Pay Procedures Manual, PPCINST M1000. 2 (series). The CDAR, in coordination with the SAP and the command, will ensure that all entries made in the member's PDR completely and accurately document the circumstances of each incident and confirm that the member has been referred for medical evaluation. Documentation for a command or self referral will not be placed in the member's PDR.
- b. **Health Record Entries.** Any medical actions resulting from alcohol problems must be documented in the member's health record. The CDAR, SAPS, and health record custodian will ensure that entries are made in the member's health record on a Chronological Record of Medical Care, Form SF-600. Documentation will include, but is not limited to the appropriate reports or summaries for all medical actions taken. At a minimum, such documentation includes:
 - (1) Reason for referral, name of physician and facility evaluating the member, results and/or recommendations from alcohol screening, and SUD diagnosis (in accordance with DSM-V).
 - (2) Details of pre-treatment plan or intervention prior to separation from the CG.
 - (3) Details of outpatient or inpatient treatment (e.g., name of treatment facility, type of treatment, and dates of treatment), recommended aftercare program, and actual aftercare program instituted. If the treatment plan is not completed provide a detailed summary of the reason(s) why. Narrative summaries from the treatment facility will be obtained and filed in the member's health record.
 - (4) Aftercare interviews conducted and reports submitted to the SAPS. 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) Rehabilitation failure or refusal of treatment.
- c. **Record Keeping by the SAPS.** The SAPS will maintain a secure electronic file, in the electronic data collection system, on all members for whom alcohol rehabilitation (outpatient or inpatient) has been requested and when alcohol incidents have occurred, as directed by Commandant (CG-1111). This process will be identified and clarified by the SAPM.

DEFINITIONS, COMMONLY USED TERMINOLOGY, AND RESOURCES

The following definitions are for use within the Substance Abuse Prevention and Treatment 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. Aftercare or Support Plan. A monitored program of continued care, immediately following completion of a formal inpatient or outpatient treatment program for SUD. Aftercare plans are usually generated by the discharging facility or physician while a support plan is generated by the Command/CDAR or individuals overseeing the member's recovery.
3. 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. The website is <http://www.al-anon.alateen.org/>
4. 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 SUDs, to cope with the troubles brought about by alcoholism, to make a new life, and to set goals for themselves. The website is <http://www.al-anon.alateen.org/>.
5. Alcohol Use Disorder. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by 11 criteria occurring within a 12 month period. This diagnosis is made by a trained professional.
6. Alcoholic. A dated reference to individuals who misuse alcohol.
7. 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 SUDs. The website is <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.
8. 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. Underage drinking by itself is considered an alcohol incident.
9. 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.

10. 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 must have a designated CDAR. CDARs are expected to manage substance abuse cases administratively and in a timely manner to minimize impact to their unit's mission(s).
11. Command Referral. A commanding officer or officer-in-charge may direct a member to be screened when substance abuse or dependency is suspected.
12. Continuum of Care. A medical model of care provided by the DoD and civilian substance abuse/dependency treatment facilities. Members recommended for treatment will be referred to the appropriate level of care as determined by a qualified screener utilizing the ASAM Patient Placement Criteria. The member's medical care requirements will be continually evaluated throughout the multilevel treatment process ensuring individual needs are met.
13. 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.
14. Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychiatric Association. A Manual used by medical 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 criteria.
15. Family Member. Includes married partners, CG or DoD registered same-sex domestic partners, minor dependents, and adult dependents.
16. Headquarters Substance Abuse Program Manager. The person assigned to Commandant (CG-1111) who manages policy, administration, and financial resources of the CG's SAP Program.
17. HSWL-SC Substance Abuse Prevention Program Supervisor (SAPPS). The CWO (MED) assigned to HSWL SC for primary duty as the SAPPS. The HSWL SC SAPPS provides guidance on substance abuse treatment resources and collects required CDAR report data and manages the Work-Life Information Management System (WIMS) for alcohol incidents.
18. 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 Manual, Article 111, and terms that are outlined by state and/or local laws.
19. Medical Officer. Physicians, physician assistants, and nurse practitioners (NP) who are members of the CG or Public Health Service detailed to the CG. Civilian medical practitioners (under contract to the CG or General Schedule employees) assigned to a CG medical treatment facility are considered medical officers to the limits defined by the language of their contract and/or job description.
20. 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, (ASAM criterion).
- 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.
21. Primary Care Manager (PCM). The Medical Officer or civilian TRICARE provider charged with managing healthcare, including the authorization of referrals for a prescribed area.
 22. Qualified Screener. An AOHCP or equivalently trained CG MO. Other licensed physicians or psychologists trained and privileged to provide diagnostic screening for SUDs. CG MOs may request drug and alcohol screening privileges to the Professional Review Committee through the normal privileging process. Attendance at the AOHCP or equivalent (e.g., Certified Addictions Counselor program), or documented professional experience and training in SUDs (last three years), are required for obtaining drug and alcohol screening privileges. The Professional Review Committee will evaluate non-AOHCP training and experience requests for SUD screening privileges.
 23. Recovering Alcoholic. A person whose SUD has been suppressed through abstinence and whose sobriety is maintained through a continuing personal program of recovery.
 24. Rehabilitation. Restoration to a normal or optimum state of health and constructive activity through medical treatment, physical and/or psychological therapy.
 25. Relapse. A return to an addictive drinking pattern.
 26. Responsible Alcohol Consumption. According to the National Institute of Alcohol Abuse and Alcoholism, responsible alcohol use is defined as no alcohol consumption under 21 years of age, and no driving under the influence of alcohol.
 27. Self-Referral. Members who, on their own accord, seek personal assistance for a perceived alcohol-related problem without occurrence of an alcohol incident.
 28. Slip. The short term minimal consumption of alcoholic beverages by someone diagnosed with severe SUD. In 12 Step terms, "Sobriety Loses Its Priority."
 29. Spouse. A person whose relationship to the sponsor leads to eligibility for TRICARE medical benefits.
 30. Standard Drink. A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). A 12 ounce beer, 8 ounces of malt liquor, 5 ounces of table wine or 1.5 ounces of 80 proof spirits (hard liquor).
 31. 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.

32. Substance Abuse Prevention Specialists (SAPS). HSWL SC personnel assigned to the Substance Abuse Prevention Program. Their primary purpose is to provide substance abuse prevention education, CDAR oversight and resource provision to Medical Officers for their assigned district.
33. Substance Use Disorder (SUD). Is a condition in which the use of one or more substances leads to a clinically significant impairment of distress.
34. Tobacco use / products. For the purpose of this policy, the terms “tobacco use” and “tobacco products” mean tobacco and nicotine products including electronic or e-cigarettes, smoking (e.g. cigarette, cigar, and pipe), smokeless tobacco products (e.g. spit, lug, leaf, snuff, dip, etc.) and all other nicotine delivery systems and products as defined by Commandant (CG-1111) and or the CDC.
35. Tolerance. Generally speaking, the amount of alcohol that a person consumes. The clinical definition is the resistance of the body to the pharmacological effects of alcohol or drugs, gradually increasing as use continue, and the body adapts to it.
36. Treatment. Includes inpatient/outpatient medical treatment, counseling, or other appropriate care administered to members in an effort to redirect life patterns and attitudes.
37. Twelve Step/Support Group Meetings. Support groups that meet to help individuals and/or their families cope with the various residual effects of alcohol misuse. The only twelve step or support group meetings authorized for CG members’ aftercare must be “abstinence-based”.
38. Withdrawal Symptoms. Characteristic reactions and behaviors resulting from abruptly stopping the use of alcohol or drugs that the body has become reliant 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, and hallucinations (“DTs”). Withdrawal symptoms from alcohol and various drugs can be fatal.

EXERCISE GUIDELINES

1. Health-related 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. A well-balanced exercise program should include activities that address all of the health-related components of fitness. Aerobic activities develop cardiorespiratory endurance and burn calories to aid in achieving a healthy body composition. Muscle-strengthening activities develop muscular strength and endurance and assist with the development of a healthy body composition. Activities such as stretching and yoga help improve flexibility. Physical activity guidelines for adults are presented below.
2. Aerobic Activities.
 - a. According to the CDC, adults should perform 2 hours and 30 minutes (150 minutes) per week of moderate-intensity aerobic activity.
 - b. Aerobic activity should be performed for at least 10 minutes at a time and spread throughout the week.
 - c. For greater health benefits, 5 hours (300 minutes) per week at a moderate-intensity level or 2 hours and 30 minutes (150 minutes) at a vigorous-intensity level or an equivalent mix of both is recommended.
 - d. The American College of Sports Medicine states that moderate-intensity physical activity between 150-250 minutes per week is effective in preventing weight gain, but will provide only modest weight loss. Physical activity greater than 250 minutes per week is recommended for weight loss and the prevention of weight gain.
 - (1) Examples of moderate-intensity physical activities.
 - (a) Walking briskly (about 3 miles per hour or faster but not race walking).
 - (b) Water aerobics.
 - (c) Bicycling, riding less than 10 mph.
 - (d) Tennis (doubles).
 - (e) Ballroom dancing.
 - (f) General gardening.

(2) Examples of vigorous-intensity physical activities.

- (a) Race walking, jogging, and running.
- (b) Bicycling 10 mph or faster.
- (c) Swimming laps.
- (d) Aerobic dancing.
- (e) Jumping rope.
- (f) Heavy gardening (continuous digging or hoeing with heart rate increases).
- (g) Hiking uphill or with a heavy backpack.

(3) Muscle-Strengthening Activities.

- (a) Muscle-strengthening activities should be performed on 2 or more days per week.
- (b) Muscle-strengthening activities do not count toward the aerobic activity total.
- (c) All major muscle groups should be worked. These are the legs, hips, back, abdomen, chest, shoulders, and arms.
- (d) Exercises for each muscle group should be repeated 8 to 12 times per set. As exercises become easier, increase the weight or do another set.
- (e) Examples: Lifting weights, working with resistance bands, or doing exercises that use body weight for resistance (e.g., push-ups, sit-ups, etc.).

(4) Flexibility.

- (a) Each time you perform aerobic or strength-training activities, take an extra 10 minutes to stretch the major muscle groups.
- (b) Hold stretches for 10 to 30 seconds and repeat each stretch 3 to 4 times.

FITNESS ASSESSMENT PROTOCOLS AND PROCEDURES

1. Purpose. These protocols should be used to administer all fitness tests and assessments throughout the CG including the Deployable Special Forces, Law Enforcement Teams, Maritime Law Enforcement Academy and other training schools where fitness tests are required. Protocols are taken from the Cooper Institute's Physical Fitness Assessments and Norms, for Adults and Law Enforcement 2009.
2. Safety. There is a natural risk of injury for all personnel participating in physical activity, even those related to improving health. The environment and the characteristics of the participants also contribute to the overall injury risk. The command representative conducting the test should seek the advice of medical or Unit Safety Officer for information concerning these risks and how to minimize the possibility of injury. To reduce the potential for injury, commands are responsible to ensure member's level of physical fitness, including acclimatization to environment and what is appropriate for any physical demands required operationally.
 - a. Support Personnel. The command will ensure at least one Cardio Pulmonary Resuscitation (CPR)-certified monitor, is present for every 25 members participating in a test. Monitors cannot be test participants and do not have to be members of the medical staff.
 - b. Medical Emergency Assistance. A safety plan must be in place for summoning emergency assistance. At a minimum, the plan must include telephone numbers and procedures for summoning aid, clear directions for emergency response personnel to avoid confusion and ensure prompt arrival. Include guidance for contacting base security personnel to assist with rapid access of emergency personnel to test site. Cellular phones, walkie-talkies, and other two-way communication devices are acceptable. When a swim test is conducted, at least one certified lifeguard must be present.
3. Test Site Selection and/or Certification. The command will select the most level 1.5-mile course available. The course will be free of steep inclines and declines, surface irregularities, and sharp turns. Verify or measure course distance with measuring wheel 7 (Usually available from recreation services). A bike odometer may only be used if measuring wheel is not available. Do not use automobile, motorcycle odometers, or GPS devices.
4. Weather Safety Concerns. The fitness testing must not to be conducted under harsh environmental conditions. Specifically, the test should not be conducted outdoors when wind chill is 20 degrees Fahrenheit or lower, or when hot weather "black flag" conditions exist (wet bulb globe temperature [WBGT]) of 90 degrees Fahrenheit or higher.
5. Physical Activity Readiness Questions (PAR-Q). Prior to the testing, personnel must review the PAR-Q located on the Commandant (CG-111) Physical Fitness web site: <http://www.dcms.uscg.mil/Health-Promotion-Resources/Physical-Fitness-Program/>

6. . If they have a "yes" or "I don't know" answer, it is strongly advised that they receive clearance from their medical provider to participate in physical fitness. Personnel recovering from a recent illness or reporting a decline in health (e.g. tightness or discomfort in the chest, arms, or neck associated with activity or exercise) are not to be tested and will be referred to their medical provider for evaluation and medical clearance.
7. Warm-Up. The command representative must lead participants in a five to ten minute dynamic warm-up exercise session prior to the start of the tests. The warm up session is not designed to tire members.
8. Hydration. Adequate fluid intake is vital to safe participation in any physical exercise. Members are encouraged to drink water before and after physical activity, especially in hot weather.
9. Cool-down. At end of the physical activity, members are required to participate in a cool down period to allow the heart rate to decline gradually. Cool down should last at least five minutes. Without cool-down, members may become dizzy or light-headed.
10. Injury Reporting. If members are injured during any physical activity, either command-authorized or personal, they must report their injury to their supervisor and ensure they are Fit For Duty or have the appropriate duty status.
11. Fitness Norms. The norm charts included in this appendix are a representation of how individuals compare to others with regard to performance on the physical fitness tests. The Cooper Institute has one of the largest and most valid data bases in the world with respect to fitness norms. There are two types of norms that the CG uses for fitness testing:
 - a. Age and Gender Norms. Age and gender norms are a representation of how individuals in a specific age and gender group compare to one another with regard to performance on physical fitness tests. Age and gender norms are acceptable for use in all CG fitness tests unless specified by the specific unit Instruction.
 - b. Absolute Norms. Absolute norms are minimal scores or “cut-points” that have been determined in law enforcement validation studies as the fitness standard that must be attained by everyone regardless of age, gender, or handicapping conditions for the person to be considered fit for duty. Absolute norm tables are not depicted in this appendix but can be found in the Manuals that require absolute norm standards.
12. Procedure and Order of Testing. Following a standardized protocol for order of testing ensures that every fitness assessment is delivered fairly every time. In the case of mandatory fitness tests, where members are required to pass a battery of tests for selection, assignment or maintenance of a unit fitness standard, the member must pass all components of the fitness test at one time. If one component of the test is failed, the entire test battery must be repeated during re-assessment, not just the portion of the test

that was failed. According to the National Strength and Conditioning Association, a battery of fitness tests should occur in the following order:

- a. Non-Fatiguing Tests (height/weight measurements, body fat tests, vertical jump), then rest for two minutes.
- b. Muscular Strength (sit ups, 1 repetition maximum bench press), then rest for five to ten minutes.
- c. Speed (300 meter run), then rest for five to ten minutes.
- d. Muscular Endurance (push up), then rest for five to fifteen minutes.
- e. Cardiovascular Endurance (1.5 mile run), then cool down for five minutes.
- f. Flexibility.

13. Mile Run Test.

- a. Test Description. This is a test which measures cardiorespiratory fitness. 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. The 1.5 mile norms for men and women are based on the Physical Fitness Assessments and Norms for Adults and Law Enforcement. These tables do not represent the pass/fail norms for any specific CG qualification requirement.
- b. Required Equipment.
 - (1) Stop watch to time the run to the nearest second.
 - (2) An accurately measured, flat, 1.5 mile course or ¼ mile track (6 laps = 1.5 miles).
- c. Test Guidelines. The following are some guidelines to be followed in preparation for the 1.5 mile run test.
 - (1) Members should not eat a heavy meal or smoke for at least two to three hours prior to the test.
 - (2) Members should warm up and stretch thoroughly prior to the test.
 - (3) Members should practice pacing themselves prior to the test.
 - (4) Members may attempt to run too fast early in the run and become fatigued prematurely. Running partners may accompany members around the track to help pace them.

d. Test Administration.

- (1) 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 participant's warm-up and cool down after the run.
- (2) Participants should be dressed in clothes ready to exercise, preferably exercise shorts or pants and running shoes.
- (3) Instruct participants to:
 - (a) Warm up by walking at a moderate pace for two to five minutes.
 - (b) The participant runs 1.5 miles as fast as possible. If a 440 yard track is used, 6 laps must be completed using the inside lane (lane 1). If using a 400 meter track, an additional 15 yards must be run after the six laps are completed.
 - (c) During the administration of the test, the participants can be informed of their lap times. Finish times should be called out and recorded.
 - (d) Upon test completion, a mandatory cool down period is enforced. The participants should walk slowly for about five minutes immediately after the run to prevent pooling of blood in the lower extremities.
 - (e) If participants experience any pain or severe shortness of breath or other abnormal signs, they should walk or stop and seek medical attention if necessary.

14. Mile Treadmill Test.

- a. Test description. The 1.5 mile run event may be conducted on a treadmill at CO's discretion where appropriate facilities and equipment are reasonably available. Treadmill must have following features:
 - (1) Motor-driven running surface belt with emergency stop button.
 - (2) Adjustable speed displayed in miles per hour.
 - (3) Inclination adjustment.
 - (4) Odometer that accurately measures distance traveled in miles.

- (5) Mile run and/or Walk Event may be conducted on a treadmill as follows:
- (a) Member straddle treadmill belt with treadmill inclination set at 1.0 percent. Neither the treadmill belt nor stopwatch is running.
 - (b) The tester will signal start and member will start the treadmill at desired speed. Member is required to step onto the belt as soon as it starts moving, i.e., not wait until the belt has reached its programmed speed. As soon as member starts running, the tester will start the official time using a stopwatch.
 - (c) The tester will announce the start and call time within two minute intervals until the member has traveled 1.5 miles.
 - (d) Treadmill speed may be adjusted to member's comfort anytime during test.
 - (e) Member may momentarily touch the treadmill's safety bar with fingertips or open palm for safety to recover balance. Member may not, however, grab or hold onto the bar for any reason other than to recover balance.
 - (f) Member is allowed to briefly pause the treadmill to retie a shoelace. No distance must be counted towards the member's score during the pause. The stopwatch, however, will continue to run.
 - (g) Time is recorded with a stopwatch to nearest second. Although most treadmills are equipped with an accurate time display; only the time recorded by stopwatch must be used for official scoring. This is done to account for the time to retie a shoelace.
- b. Treadmill Test conclusion. The treadmill event is ended when the member:
- (1) Stops running or walking other than to retie shoelace or to remove a foreign object from their shoe (for safety purposes). If this should occur the member must pause the machine.
 - (2) Completes 1.5 miles.
 - (3) Supports body weight by holding onto or leaning against the treadmill support bar other than to momentarily regain balance (treadmill test only).
 - (4) Changes treadmill inclination.

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	< 9:17	< 9:33	< 9:51	< 10:37	< 11:26
Excellent	9:18-10:09	9:34 – 10:46	9:52 – 11:15	10:28 – 12:08	11:27 – 13:23
Good	10:10-11:29	10:47 – 11:54	11:16 – 12:24	12:09 – 13:35	13:24– 15:04
Fair	11:30-12:38	11:55 – 12:58	12:25 – 13:50	13:36– 15:06	15:21 – 16:46
Poor	12:39-14:00	12:59 – 14:34	13:51 – 15:24	15:07 – 16:58	16:46 – 19:10
Very Poor	> 14:00	> 14:34	> 15:24	>16:58	>19:10

Table 3-1: 1.5 Mile Norms for Men (Minutes: Seconds)

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	<10:28	< 11:00	<11:33	<12:53	<14:05
Excellent	10:29 – 11:58	11:01 – 12:24	11:34 – 13:23	12:54 – 14:34	14:06– 16:33
Good	11:59 – 13:24	12:25 – 14:08	13:24 – 14:53	14:35 – 16:35	16:34 – 18:27
Fair	13:25 – 14:50	14:09 – 15:43	14:54 – 16:31	16:36 – 18:18	18:28–20:16
Poor	14:51– 16:46	15:43 – 17:38	16:32 – 18:37	18:19 – 20:44	20:16 – 22:52
Very Poor	>16:46	> 17:38	>18:37	>20:44	>22:52

Table 3-2: 1.5 Mile Norms for Women (Minutes: Seconds)

15. One Mile Walk Test.

- a. Test Administration. The purpose of this test is to estimate cardiorespiratory fitness level (VO₂ max).
- b. An accurately measured course of exactly one mile is necessary. A ¼ mile running track is ideal. A pulse rate monitor device is required for this test. Clients are instructed to walk one mile *as fast as possible*. Running or jogging is *not* allowed. *Immediately upon completion* of the one mile walk, the pulse rate should be recorded from the pulse rate monitor. Do *not* use a ten second pulse check, this will invalidate the test. After completing the test, the client should continue walking slowly for 5 minutes to cool down.
- c. Calculation of Estimated VO₂ max. Knowing the client’s weight (WT), age, sex, one mile walk time (T) and one mile walk heart rate (HR), a good estimate of VO₂ max can be obtained by using the following formula:

$$VO_2 \text{ max} = 132.853 - (0.0769 \times WT) - (0.3877 \times AGE) + (6.3150 \times SEX) - (3.2649 \times T) - (0.1565 \times HR)$$

WT = Weight in pounds AGE = Age in years SEX = 0 for female, 1 for male
T = Walk time in minutes and seconds, to the nearest tenth of a minute
(seconds divided by 60 = tenths of a minute)

HR = Heart rate in beats/minute at the end of the walk

Compare with norms for VO₂ max in this Section to determine percentile ranking and fitness category.

Source: Kline, et. Al. Estimation of VO₂ max from a one mile track walk. *Medicine and Science in Sports and Exercise* 19(3):253-259, 1987.

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	55.5	54.1	52.5	49.0	45.7
Excellent	55.4-51.1	54.0 – 48.3	52.4 – 46.4	48.9 – 43.3	45.6 – 39.6
Good	51.0-45.6	48.2 – 44.1	46.3 – 42.4	43.2 – 39.0	39.5– 35.6
Fair	45.5-41.7	44.0 – 40.7	42.3 – 38.4	38.9– 35.5	35.4 – 32.3
Poor	41.6-38.0	40.6 – 36.7	38.3 – 34.8	35.4 – 32.0	32.2 – 28.7
Very Poor	< 38.0	< 36.7	< 34.8	<32.0	<28.7

Table 3-3: 1 Mile Walk Test Male Norms Max VO₂

Age (years)	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	49.6	47.4	45.3	46.1	41.0
Excellent	49.5 – 43.9	47.3 – 42.4	45.2 – 39.6	46.0 – 36.7	39.9– 36.7
Good	43.8 – 39.5	42.3 – 37.7	39.5 – 35.9	36.6 – 32.6	36.6 – 32.6
Fair	39.4 – 36.1.	37.6 – 34.2	35.8 – 32.8	32.5 – 29.9	32.5–29.9
Poor	36.0– 32.3	34.1 – 30.9	32.7– 29.4	29.8 – 26.8	29.8 – 26.8
Very Poor	<32.3	< 30.9	<29.4	<26.8	<26.8

Table 3-4: 1 Mile Walk Test Female Norms Max VO₂

	Men Under 40	Men Over 40	Women Under 40	Women Over 40
Excellent	13:00 or less	14:00 or less	13:30 or less	14:30 or less
Good	13:01-15:30	14:01-16:30	13:31-16:00	14:31-17:00
Average	15:31-18:00	16:31-19:00	16:01-18:30	17:01-19:30
Below Average	18:01-19:30	19:01-21:30	18:31-20:00	19:31-22:00
Low	19:31 or more	21:31 or more	20:01 or more	22:01 or more

Table 3-5: 1 Mile Walk Test Norms in Minutes

16. Push Up Test.

- a. Test Description. This test measures muscular endurance of the upper body (anterior deltoid, pectoralis major, and triceps). All fitness assessments should follow the protocol below for the push up test with these exceptions:

Enclosure (3) to COMDTINST M6200.1D

- (1) Some fitness assessments require a maximum push up test. Follow the same protocol as the one minute push up test but continue the test until fatigue or until proper form can no longer be maintained. No resting is allowed.
- (2) Some fitness assessments require female participants to use the maximum push-up test in the modified position. The modified push up is performed on the hands and knees with the back straight and hands slightly in front of the shoulders in the up position. Continue the test until fatigue or until proper form can no longer be maintained. No resting is allowed.

b. Required Equipment.

- (1) Gym mat or suitable flooring.
- (2) Stop watch or timing device.

c. Test Administration.

- (1) Have the member place his/her hands slightly wider than shoulder width apart, with fingers pointing forward. The administrator places one fist on the floor below the subject's chest. If a male is testing a female, a 3 inch sponge should be placed under the sternum to substitute for the fist.
- (2) Starting from the up position (elbows extended), the subject must keep the back straight at all times and lower the body to the floor until the chest touches the administrators fist.
- (3) Subject then returns to the starting position. This is one repetition.
- (4) Resting can only be done in the up position. Both hands must remain in contact with the floor at all times. Exception: Some fitness assessments do not allow any resting and does not have a time limit. The test is terminated when the participant can no longer maintain proper form or until fatigue.
- (5) The total number of correct pushups completed in one minute is recorded as the score.

<u>Men</u>	20 – 29 yrs	30 – 39yrs	40 – 49 yrs	50 – 59 yrs	60 + yrs
Superior	62+	52+	40 +	39 +	28 +
Excellent	47 – 61	39 – 51	30 – 39	25 – 38	23 – 27
Good	37 – 46	30 – 38	24 – 29	19 – 24	18 – 22
Fair	29 – 36	24 – 29	18 – 23	13 – 18	10 – 17
Poor	22 – 28	17 – 23	11 – 17	9 – 12	6 – 9
Very Poor	13 – 21	9 – 16	5 – 10	3 – 8	2 – 5

Table 3-6: Push Up Test Norms for Men 1 Minute Test

<u>Women</u>	20 – 29 yrs	30 – 39 yrs	40 – 49 yrs
Superior	42+	39+	20 +
Excellent	28-41	23-38	15-20
Good	21-27	15-22	13-14
Fair	15-20	11-14	9-12
Poor	10-14	8-10	6-8
Very Poor	3 – 9	1-7	0-5

Table 3-7: Push Up Test Norms for Women 1 Minute Test

** Coopers doesn't have full body push up norms for women over 50.

Women	20 – 29 yrs	30 – 39 yrs	40 – 49 yrs	50 – 59 yrs	60 + yrs
Superior	45 +	39 +	33 +	28 +	20 +
Excellent	36 – 44	31 – 38	24 – 32	21 – 27	15 -19
Good	30 – 35	24 – 30	18 – 23	17 – 20	12 – 14
Fair	23 – 29	19 – 23	13 – 17	12 – 16	5 – 11
Poor	17 – 22	11 -18	6 – 12	6 – 11	2 – 4
Very Poor	< 16	< 11	< 6	< 6	< 2

Table 3-8: Push Up Test Norms for Modified Push Up

17. Sit-Up Test.

- a. 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.

b. Required Equipment.

- (1) Gym mat or suitable flooring.
- (2) Stop watch or watch with a second hand.

c. Test Administration.

- (1) 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.
- (2) 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.
- (3) Instruct the subjects to:
 - (a) Lie on their back on a mat, knees bent at a 90 degree angle, feet shoulder width apart with heels on the floor and hands cupped behind the ears.
Exemption: Some health risk assessments require arms to be crossed in front of the body with fingertips on shoulders.
 - (b) A partner holds the feet down firmly.
 - (c) The subject then performs as many correct sit ups as possible in one minute.
 - (d) In the up position, the individual should touch elbows to knees and then return until the shoulder blades touch the floor.
 - (e) Breathing should be as normal as possible, making sure the subject does not hold their breath.
 - (f) Neck remains in the neutral position. Do not pull on the head or neck.

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60 – 69
Superior	62+	55+	51+	47+	43+	39+
Excellent	51 – 61	47 – 54	43 – 50	39 – 46	35 – 42	30 – 38
Good	47 – 50	42 – 46	39 – 42	34 – 38	28 – 34	22 – 29
Fair	41 – 46	38 – 41	35 – 38	29 – 33	24 – 27	19 – 21
Poor	36 – 40	33 – 37	30 – 34	24 – 28	19 – 23	15 – 18
Very Poor	<36	<33	<30	<24	<19	<15

Table 3-9: Sit-Up Norms for Men 1 Minute

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60 – 69
Superior	55 +	51 +	42 +	38 +	30+	28 +
Excellent	46 – 54	44 – 50	35 – 41	29 – 37	24 – 29	17 – 27
Good	36 – 45	38 – 43	29 – 34	24 – 28	20 – 23	11 – 16
Fair	32 – 35	32 – 37	25 – 28	20 – 23	14 – 19	6 – 10
Poor	28 – 31	24 – 31	20 – 24	14 – 19	10 – 13	3 – 5
Very Poor	< 28	< 24	<20	<14	<10	<3

Table 3-10: Sit-Up Norms for Women 1 Minute

18. Abdominal Curl Ups.

- a. 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.
- b. Required Equipment.
 - (1) Gym mat.
 - (2) Ruler.
 - (3) Small blocks for fingers to touch in order to signal person when they have moved hands 3 inches forward.
 - (4) Stop watch with second hand.
- c. Test Administration.
 - (1) Test subject should be screened for lower back pain. People suffering from back pain or uncontrolled high blood pressure should not do this test.
 - (2) Instruct subject to:
 - (a) Lie on their back on a mat with knees bent, feet shoulder width apart.
 - (b) Arms are fully extended by the sides, palms down with fingers extended. A piece of masking tape is placed perpendicular to the fingertips of each hand such that the fingertips are at the front edge of the tape. Another piece of tape is placed parallel to and three inches in front of the tape at the fingertips.
 - (c) While holding participant's feet, participant must move both hands along the floor a distance of three inches by flexing the trunk (fingertips are moving

from one piece of tape to the next). Upon returning to the floor (shoulder blades touching the floor), one repetition is counted.

- (d) Instruct the subject to do as many curl-ups in one minute as they can without undue strain and while breathing as normally as possible.

d. Test Scores for the Curl-up. The Cooper Institute does not have norms for the one minute curl up test, nor are there published norms derived from large population studies. The norms below are based on a study published in the Medicine and Science in Sports and Exercise, Volume 13, pages 54-59, 1981. The scores 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.

Age	18-29		30-39		40-49		50-59		60+	
Sex	F	M	F	M	F	M	F	M	F	M
Advanced	>45	>50	>40	>45	>35	>40	>30	>35	>25	>30
Intermediate	25-45	30-50	20-40	22-45	18-35	21-40	12-30	18-35	11-25	15-30
Beginner	<25	<30	<20	<22	<18	<21	<12	<18	<11	<15

Table 3-11: Test Scores for the Curl-up

Men	15 – 19 yrs	20 – 29 yrs	30 – 39 yrs	40 – 49 yrs	50 – 59 yrs	60 – 69 yrs
Excellent	60+	54+	45+	39+	33+	29+
Desirable	53 - < 60	46 - < 54	39 - < 45	33 - < 39	28 - < 33	21 - < 29
Needs Improving	48 - < 53	41 - < 46	34 - < 39	28 - < 33	23 - < 28	15 - < 21
Caution	< 48	< 41	< 34	< 28	< 23	< 15
Women	15 – 19 yrs	20 – 29 yrs	30 – 39 yrs	40 – 49 yrs	50 – 59 yrs	60 – 69 yrs
Excellent	53+	45+	36+	31+	24+	20+
Desirable	45 - < 53	39 - < 45	30 - < 36	25 - < 31	15 - < 24	15 - < 20
Needs Improving	40 - < 45	31 - < 39	25 - < 30	19 - < 25	6 - < 15	5 - < 15
Caution	< 40	< 31	< 25	< 19	< 6	< 5

Table 3-12: Portland State University Curl Up Norms

19. Flexibility: Sit and Reach Test.

- a. Test Description. This test measures flexibility of the hamstrings and low back. Flexibility is not considered a good predictor of overall fitness and is not recommended for inclusion in testing for qualification or selection to a specific team or assignment.
- b. Required Equipment.
 - (1) Gym mat.
 - (2) Flexibility box, or 12” high box and yardstick on box with 15” mark at the edge.
- c. Test Administration.
 - (1) Test subject should be screened for lower back impairment or pain. Persons suffering back pain should not do this test.
 - (2) Be sure participants are well instructed in the proper technique. Describe and if needed, demonstrate the correct technique as follows:
 - (3) 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.
 - (a) Remove shoes.
 - (b) The feet are placed squarely against the box with the feet no wider than eight inches apart. Toes are pointed directly toward the ceiling.
 - (c) The knees should remain extended throughout the test.
 - (d) The hands are placed one hand on top of the other, fingertips even.
 - (e) The yardstick is set on the box such that the 15” mark is flush with the edge of the box.
 - (f) The subject leans forward without lunging or bobbing and reaches as far down the yard stick as possible. The hands must stay together and even and the stretch must be held for one second. Neck should remain in the neutral position.
 - (g) Record the reach to the nearest ¼ inch.
 - (h) Three trials are allowed; the best of the three trials is recorded. Exhaling on the reach is recommended.

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	>=23.4	>=23	>=22	>=21.3	>=20.5	>=20
Excellent	21.7-22.6	20.5-21.8	19.5-21	18.5-20	17.5-19	17.3-19
Good	19-21.4	18.5-20	17.5-19	16.3-18	15.5-17	14.5-16.5
Fair	16.5-18.7	16.5-18	15.5-17	14.3-16	13.3-15	12.5-14
Poor	13.2-16	14.4-16	13-15	12-14	10.5-12.5	10-12
Very Poor	<13.2	<14.4	<13	<12	<10.5	<10

Table 3-13: Sit and Reach Flexibility Norms for Men (inches)

Age (years)	<20	20 – 29	30 – 39	40 – 49	50 – 59	60+
Superior	>=24.3	>=24.5	>=24	>=22.8	>=23	>=23
Excellent	22.5-24.3	22.5-23.8	21.5-22.5	20.5-21.5	20.3-21.5	19-21.8
Good	21.5-22.3	20.5-22	20-21	19-20	18.5-20	17-18
Fair	20.5-21.3	19.3-20.3	18.3-19.5	17.3-18.5	16.8-18	15.5-17
Poor	18.5-20	17-19	16.5-17.8	15-17	14.8-16	13-15.2
Very Poor	<18.5	<17	<16.5	<15	<14.8	<13

Table 3-14: Sit and Reach Flexibility Norms for Women (inches)

20. Vertical Jump Test.

- a. Test Description. This test is a measure of jumping or explosive power.
- b. Required Equipment.
 - (1) Yardstick taped to a smooth wall, and
 - (2) Chalk dust or chalk for marking extension when jumping
- c. Test Administration.
 - (1) Subject stands with one side toward the wall and reaches up as high as possible to mark his/her standard reach.
 - (2) Subject jumps as high as possible and mark the spot on the wall above his/her standard reach mark. Prior to jump, one foot must remain stationary on the floor.
 - (3) Score is the total inches, to the nearest ½ inch.

(4) The best of three trials is the score.

Age (years)	20-29	30-39	40-49	50-59
Superior	>26.5	>25	>22	>21
Excellent	24-26.5	22-24.5	19-21.5	17-20.5
Good	21.5-23.5	20-21.5	17-18.5	15-16.5
Fair	20-21	18.6-19.5	15.5-16.5	13.5-14.5
Poor	17.5-19.5	16.5-18.5	14.0-15.0	12-13
Very Poor	< 17.0	<16.0	<13.5	<12

Table 3-15: Vertical Jump Test Norms Men

Age (years)	20-29	30-39	40-49
Superior	>18.5	>17.0	>13.5
Excellent	17.5-18.0	15-16.5	13-13.5
Good	16.0-17.0	13.5-14.5	11.5-12.5
Fair	14.0-15.5	12-13	9.5-11
Poor	12.5-13.5	11-12	7.5-9
Very Poor	< 12	<11	<7.5

Table 3-16: Vertical Jump Test Norms Women

21. 300 Meter Run Test.

- a. Test Description. This test is an assessment of anaerobic power.
- b. Required Equipment.
 - (1) 400 meter running track, or
 - (2) Any measure 300 meter flat surface that provides good traction
- c. Test Administration.
 - (1) Allow subject to warm up and stretch before beginning test.
 - (2) If using a 400 meter track, participant runs $\frac{3}{4}$ of one lap (inside lane) at maximum level of effort.
 - (3) Time used to complete distance is recorded in seconds.

- (4) Participant should walk for three to five minutes immediately following test to cool down.

Age (years)	20-29	30-39	40-49	50-59
Superior	<46	<46	<52	<58
Excellent	48-50	47-51	53-57	59-66.4
Good	51-54	52-55	58-64	67-74
Fair	55-59	56-59	65-72	75-83
Poor	60-66	60-68	73-83	84-95
Very Poor	>66	>68	>83	>95

Table 3-17: 300 Meter Run Norms Males

Age (years)	20-29	30-39	40-49
Superior	<54.3	<56.5	<65
Excellent	56-58.3	60-66	66-72
Good	59.7-61	66.5-71	72-79
Fair	62.7-71	72-79	80.5-94
Poor	74.5-78	80.5-86	101.8-110
Very Poor	>78	>86	>110

Table 3-18: 300 Meter Run Norms Females

**Coopers does not have 300 meter run norms for women over 50