

U.S. Department of  
Homeland Security

United States  
Coast Guard



---

# **Coast Guard Substance Abuse Prevention and Treatment Manual**

---

**COMDTINST M6320.5  
MAY 2018**

PAGE INTENTIONALLY LEFT BLANK



COMDTINST M6320.5  
28 MAY 2018

COMMANDANT INSTRUCTION M6320.5

Subj: COAST GUARD SUBSTANCE ABUSE PREVENTION AND TREATMENT  
MANUAL

Ref: (a) Military Drug and Alcohol Policy, COMDTINST M1000.10 (series)  
(b) Coast Guard Medical Manual, COMDTINST M6000.1 (series)  
(c) Military Separations Manual, COMDTINST M1000.4 (series)

- PURPOSE.** This Manual establishes policy, assigns responsibilities, and provides guidelines on substance abuse prevention, treatment, 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), and Health Services personnel.
- ACTION.** All Coast Guard unit commanders, commanding officers, officers-in-charge, deputy/assistant commandants, and chiefs of headquarters staff elements must comply with the provisions of this Manual. Internet release is authorized.
- DIRECTIVES AFFECTED.** Coast Guard Health Promotion Manual, COMDTINST M6200.1D, has issued a Commandant Change Notice to reflect the contents of this Manual.
- DISCUSSION.** Substance abuse, regardless of its causative factor (alcohol, prescriptive drugs, over-the-counter products or illicit compounds), is a threat to readiness, optimal performance, member health and safety, and to unit morale. This Manual allows commands to identify training opportunities to understand responsible low-risk guidelines, establish an effective Command Prevention Program provides treatment and referral options, and understand how to reduce stigma and increase help-seeking behaviors. To increase education and intervention opportunities, chief warrant officers and lieutenant commanders, who are

DISTRIBUTION – SDL No. 168

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	
A	X	X	X	X	X	X	X		X	X		X	X	X	X	X	X		X		X						
B		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
C	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
D	X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
E	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X	X			X	X			
F																	X	X	X								
G		X	X	X	X																						
H																											

NON-STANDARD DISTRIBUTION:

not in supervisory roles, can now volunteer to become Command Drug and Alcohol Representatives (CDARs). Leadership cadres must develop a command climate that encourages abstaining and reinforces responsible alcohol use, self- and command-referrals, as well as bystander intervention to curb binge and high-intensity drinking episodes (10 or more drinks). To facilitate this cultural shift, the Command Drug and Alcohol Representative Tactics, Techniques, and Procedures (TTP) was promulgated to provide the most current state of the science and training to effect cultural change.

5. DISCLAIMER. This guidance is not a substitute for applicable legal requirements, nor is it itself a rule. It is intended to provide guidance for Coast Guard personnel and is not intended to nor does it impose legally-binding requirements on any party outside the Coast Guard.
6. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS.
  - a. The development of this Manual and the general policies contained within it have been thoroughly reviewed by the originating office in conjunction with the Office of Environmental Management, Commandant (CG-47). This Manual is categorically excluded under current Department of Homeland Security (DHS) categorical exclusion (CATEX) A3 from further environmental analysis in accordance with "Implementation of the National Environmental Policy Act (NEPA)," DHS Instruction Manual 023-01-001-01 (series).
  - b. This Manual will not have any of the following: significant cumulative impacts on the human environment; substantial controversy or substantial change to 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 policy in this Manual must be individually evaluated for compliance with the NEPA, DHS, and Coast Guard NEPA policy, and compliance with all other applicable environmental mandates.
7. DISTRIBUTION. No paper distribution will be made of this Manual. An electronic version will be located on the following Commandant (CG-612) web sites.  
Internet: [www.dcms.uscg.mil/directives/](http://www.dcms.uscg.mil/directives/), and  
CGPortal: <https://cg.portal.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 no further records scheduling requirements, in accordance with Federal Records Act, 44 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 requirements.

9. FORMS/REPORTS. The forms referenced in this Manual are available in USCG Electronic Forms on the Standard Workstation or on the Internet at <https://dcms.uscg.afpims.mil/Our-Organization/Assistant-Commandant-for-C4IT-CG-6/The-Office-of-Information-Management-CG-61/>; and CG Portal at <https://cgportal2.uscg.mil/library/forms/SitePages/Home.aspx>.
10. REQUEST 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.

ERICA G. SCHWARTZ /s/  
Rear Admiral, U.S. Coast Guard  
Director of Health, Safety, and Work-Life

PAGE INTENTIONALLY LEFT BLANK



PAGE INTENTIONALLY LEFT BLANK

## Table of Contents

<b>CHAPTER 1</b>	<b>SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAP) PROGRAM .....</b>	<b>1-1</b>
A.	Introduction.....	1-1
B.	Overview.....	1-2
<b>CHAPTER 2</b>	<b>POLICY AND RESPONSIBILITIES.....</b>	<b>2-1</b>
A.	Policy.....	2-1
B.	Duties and Responsibilities.....	2-1
<b>CHAPTER 3</b>	<b>TRAINING AND REFERRALS .....</b>	<b>3-1</b>
A.	Introduction.....	3-1
B.	Requirements.....	3-1
C.	Medical Referrals, Screenings, and Action for Substance Abuse.....	3-3
<b>CHAPTER 4</b>	<b>TREATMENT AND SUPPORT PLANS .....</b>	<b>4-1</b>
A.	Treatment.....	4-1
B.	Support Plans for Substance Use Disorders.....	4-4
C.	Rehabilitation Failure.....	4-7
<b>CHAPTER 5</b>	<b>RECORDS MANAGEMENT.....</b>	<b>5-1</b>
A.	Paperwork and Records Management for Substance Use Disorder Cases.....	5-1
B.	Administrative Documentation.....	5-1
<b>CHAPTER 6</b>	<b>GLOSSARY.....</b>	<b>6-1</b>
A.	Definitions.....	6-1
B.	Acronyms.....	6-5

THIS PAGE INTENTIONALLY BLANK

## **Chapter 1 SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAP) PROGRAM**

### **A. Introduction.**

1. The policy in this Manual applies to all Coast Guard (CG) Active Duty (AD) personnel; including Reserve members while on AD orders 30 days or more. In accordance with Section 703 of the 2012 National Defense Authorization Act, 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 use disorders. Reservists no longer in an IDT or ADT drilling status will be afforded a Readiness Management Period (RMP) to allow for a command directed behavioral health support screening. Reservists are then responsible for any subsequent follow up care required as a result of the screening 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. Leadership is directed to prohibit substance abuse and limit use of substances to the lawful use of alcohol or medical provider-prescribed medication as instructed by Reference (a), Military Drug and Alcohol Policy. Substance abuse is the use of alcohol, prescription drugs, illicit drugs, over the counter compounds or any substance that is used to change mood or induce a “high” that causes cognitive, behavioral or physiological impairment problems. Of these compounds, alcohol is the most frequently abused substance by military personnel. 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 policy outlines the steps necessary for a command to appropriately address these situations and provide members with alcohol use (or prescription use) guidelines, treatment, and/or education they are entitled to, regardless of any personnel action associated with alcohol (or prescription) misuse or abuse. Substance use disorders 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).

Note: The term “Substance Use Disorders” (SUD) is used interchangeably with the term “substance abuse” when colloquial or clinical reference is implied.

- b. National Guidelines. The CG SAP Program strategy 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. Find detailed information on these guidelines at <http://niaaa.nih.gov/alcohol-health>. CG members are encouraged to either abstain or engage in low-risk alcohol consumption.
  - c. Medical Model. Substance abuse, which includes the abuse or dependence on alcohol or drugs, is a brain disease. Substance abuse and dependency are on 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. The CG uses the Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychiatric Association for diagnosing SUDs per Reference (b).
- B. Overview. This guidance provides commands and individuals with substance abuse prevention training and implementation strategies to prevent substance misuse and abuse. This program intends to:
1. Raise Awareness of Substance Abuse Issues. Help each member and command understand how to approach and handle substance misuse, abuse, and chemical dependence, which are referred to as SUDs.
  2. Encourage, Teach, and Support Low-Risk Guidelines for Alcohol Use. The SAP Program adopted a risk management model for alcohol consumption. NIAAA established low-risk drinking guidelines. 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; such as, when one is driving, using machinery, cleaning a weapon, pregnant, or on certain medications;
    - b. Consuming no more than one “standard alcoholic beverage” per hour;
    - c. Consuming 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 uses 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 clarify the physiological and absorption differences for males and females. For further clarification, please see: <https://www.rethinkingdrinking.niaaa.nih.gov/>.*

- d. Check with a Health Care Provider (HCPs) to ensure it is safe to consume alcohol with prescribed medication or diagnosed medical condition; and
  - e. Avoid any activity requiring strict focus and attention or coordination and balance, such as, cleaning a weapon, climbing a ladder, or operating machinery when consuming any amount of alcohol.
3. Provide Periodic Prevention Training. Provide members, cadets, recruits, and commands with prevention training, early problem identification skills, and resources for screening and treatment.
  4. Support Commands. Assist commands by providing the tools and procedures to address irresponsible alcohol use.
  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 of obtaining a “high,” which includes but is not limited to, herbals, gases, aerosols, and manufactured or yet-to-be manufactured designer drugs, such as, spice, bath salts, etc.
  6. Support Mission Readiness. Ensure that members are aware of how SUDs interfere with CG mission readiness and a safe work environment.
  7. Align with Other Policy. Administrative concerns are directed to Reference (a).

THIS PAGE INTENTIONALLY BLANK

## Chapter 2 POLICY AND RESPONSIBILITIES

### A. Policy.

1. Commanding Officers will institute a substance abuse prevention plan that leverages all unit leaders. Guidelines to develop 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 (a). Commands will use Reference (a) and this policy to appropriately document and handle alcohol-related issues at their unit.

### B. Duties and Responsibilities.

1. Commandant (CG-1111). Commandant (CG-1111) is responsible for SAP Program medical training, education, and evaluation policies.
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 Health Safety and Work-Life Service Center (HSWL SC) to provide staffing for CG Substance Abuse Prevention Specialist (SAPS) billets.
  - b. Coordinate with FORCECOM in assessing, developing and executing substance abuse training and education curricula for CG personnel.
  - c. Ensure CG Medical Officers involved in evaluating, screening, or diagnosing substance abuse patients are afforded the opportunity to receive the CG Addiction 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 Substance Abuse Prevention Program (SAPP).
  - f. Establish and oversee performance standards for SAPPS and prevention specialists.
  - 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.



- n. Oversee SAPSs compliance 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; and
  - r. Advocate for the needs of the SAPSs and the SAP Program.
4. Substance Abuse Prevention Specialist (SAPS). The SAPS 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 must:
- 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 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 Paragraph 6 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. Ensure timely, complete, and accurate CDAR data entry into the electronic data collection system for all alcohol incidents and referrals within the assigned AOR;
  - h. Provide guidance and quality assurance to CDARS for reporting substance related issues, as directed by the SAPPs and SAPM;

- i. When stationed at Training Center Cape May or the 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; and
    - (4) Educational courses to fulfill basic alcohol education requirements, as outlined by the SAPM.
  - j. Conduct substance abuse prevention training;
  - k. Complete the AOHCP SAPS course;
  - l. Complete annual HIPAA training related to substance abuse patient records;
  - m. Ensure CDARs complete annual HIPAA training; and
  - n. Promote education and awareness activities intended to prevent or reduce problematic gambling.
5. Commanding Officers and Officers-in-Charge (CO/OIC) must:
- 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; and/or
    - (3) Commands with 50 or greater members will designate, at a minimum, one primary and one alternate CDAR.

- b. Ensure members designated as a CDAR:
  - (1) Must be an E-5 to E-8, chief warrant officer of any specialty, or an officer (O-1 to O-4); members must not be in any supervisory role;
  - (2) Must not be a member of the command cadre (CO, XO, etc.) or at the department head level;
  - (3) Should be mature, reliable, and fully understand the sensitive nature of this role; and
  - (4) Should understand that he/she works as an extension of the command and as a resource for the member.
- c. Place the CDAR on all unit check-in/out lists and collateral duty lists;
- d. Ensure selected CDARS attend the CDAR course prior to accepting the appointment;
- e. Ensure unit CDAR submits updates to the SAPS, as directed;
- f. Ensure the CDAR completes the required steps to complete and accurately document all substance abuse incidents in accordance with this Manual, 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); and
  - (4) Assist with implementation, oversight, and monitoring of aftercare.
- g. Promote responsible attitudes toward the use of alcohol, both on and off CG facilities. Guidelines for appropriate alcohol use may be found at the NIAAA web site: <http://rethinkingdrinking.niaaa.nih.gov/>;
- h. Ensure a unit Alcohol Abuse Prevention Plan is developed, implemented, and updated yearly. SAPSs are available to assist and encouraged to use their services;
- i. Ensure that the CDAR participates in one or more of the following unit committees: safety, morale, or health promotion;
- j. Ensure members are afforded treatment and educational opportunities;
- k. Use all available CG approved resources (e.g., the [National Center for Telehealth & Technology \(T2\)](#), 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;

- l. Cultivate an environment where members can seek assistance for actual or perceived issues with substances (reduce stigma and increase help seeking behavior);
  - m. Ensure the CDAR provides copies of all documentation to the receiving command when members on an aftercare plan are transferring; and
  - n. 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 administering the unit's substance abuse program. CDAR is a collateral duty and is administrative and educational in nature. Each CDAR must:
- a. Contact the SAPPs within 24 hours of Commanding Officer notification of a potential substance-related issue;
  - b. Collaborate with the SAPPs to provide administrative support to the command regarding prevention strategies and treatment options;
  - c. Collaborate with the SAPPs to prepare the appropriate Administrative Remarks, Form CG-3307;
  - d. Schedule and document required unit substance abuse prevention training, as needed, and in accordance with directions provided by SAPPs;
  - e. Prepare and prominently display prevention awareness materials;
  - f. Collaborate with the SAPPs 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 administrative action;
  - g. Ensure that all documentation is complete before arranging treatment or training via the SAPPs;
  - h. Keep the command informed of the status of members undergoing treatment, including expected date of completion and/or return, prognosis, and personal needs (e.g., pay, orders, etc.);
  - i. Collaborate with the SAPPs to develop support and aftercare plans;
  - j. Monitor 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; and
    - (2) Transferred or separated from service while in aftercare.
  - l. Provide copies of all documentation to the receiving command when members on an aftercare plan are transferring;
  - m. Complete annual HIPAA training related to substance abuse patient records;
  - n. Provide Substance Abuse Prevention Training minimally one time per year, especially during “Alcohol Awareness Month;” and
  - o. Enact and annually review with the unit “Seven Steps to an Effective Command Prevention Program.”
7. CG Health Services Personnel:
- a. CG Health Services Personnel must:
    - (1) Facilitate substance abuse screening services when needed, in coordination with the SAPS or SAPPS. For ships underway, where an Independent Duty Health Services Technician (IDHS) is the senior medical authority, the IDHS should contact the Designated Medical Officer Assigned (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 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-MO or equivalent course and refresher;
    - (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;
    - (6) Follow the guidance and best practices established in the AOHCP course;
    - (7) Exercise clinical judgment for the evaluation, treatment and aftercare for CG members who are screened and treated for SUDs;

- (8) Use various prevention tools, such as, prevention education (e.g., Prime for Life or myPRIME), 12-Step meetings, and abstinence recommendations, and are encouraged to meet regularly with their Command, district SAPS, and the CDAR;
  - (9) Use psycho-educative tools at the [National Center for Telehealth & Technology \(T2\)](#);
  - (10) Communicate with commands by using the “Substance Abuse Screening Memo” templates established and taught in the AOHCP-MO course; and
  - (11) Complete all “Referrals for Care” for the patient and medical surveillance methodology (and case management) established in the AOHCP-MO course.
- b. Health Record Custodians (HRC) will assist the CDAR as needed to locate required information within the member’s health record. Health care providers and HRC’s will ensure entries are made on the Chronological Record of Medical Care, Form SF-600.
  - c. Provide needed feedback to SAPS to “flag” duty status in the electronic data collection system.
8. Member Responsibilities. Each member must:
- 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. Follow all treatment plans (treatment, aftercare, support) fully and completely as designed by the MO. Mandated 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; and
  - g. If arrested member must report to Command according to policy established by Discipline and Conduct, COMDTINST M1600.2 (series).

## Chapter 3 TRAINING AND REFERRALS

- A. Introduction. Commandant (CG-1111), in coordination with FORCECOM, is responsible to develop, implement, and evaluate substance abuse training and education programs. These trainings are tailored to meet the needs of CG and SAP personnel. Prime for Life (and its surrogates) is the designated training for all CG personnel.
- B. Requirements.
1. CG Personnel. The SAPS will provide the following training.
    - a. CG Academy and Leadership Development Center. Cadets, officer candidates, and direct commission officers will complete an orientation on substance abuse awareness and current policy.
    - b. Training Center Cape May. All recruits will complete training on drug and alcohol risk management, substance use disorder policy, and the availability of substance abuse treatment resources.
    - c. 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.
    - d. Substance Abuse Prevention Training. Substance abuse prevention training uses a universal, selective, and indicated model. Universal prevention training is directed towards the AD population with a focus 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 should be a target population. Additional training available includes:
      - (1) Substance Abuse Prevention (All Hands). This command-driven training is for all military personnel. This targeted, yet customized, prevention training addresses CG policy in addition to SUDs signs, symptoms, and consequences. The principle focus includes impact on readiness and morale. This training is conducted because of a commander’s concern for their unit. SAPS, CDARs, or command designee (e.g., Chiefs Mess) can conduct the training.

- (2) Leadership Consultation. This training is available for senior leadership, AD and civilian supervisors and managers. It provides immediate “Prevention Intervention” to address a rash of incidents or Command concern. 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 are also addressed. SAPS should conduct this training.
2. Substance Abuse Prevention Program Training Requirements.
  - a. SAPS. The SAPS position requires the following training, education, and experience.
    - (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 SAP. If certification is older than one year, the course must be repeated.
    - (3) Complete AOHCP SAPS within 6 months of assuming duties.
    - (4) Additional training through government or community agencies and civilian programs as required by the SAPM.
    - (5) Complete CG Instructor Development Course (IDC) within one year of assuming duties.
    - (6) Yearly SAPS directed meeting focusing on programmatic AOHCP needs, (e.g., case management).
  - 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 when prescribed by a MO (e.g., those who receive an alcohol incident) or when recommended by a CG MO.
  - b. Other courses may be considered, but require pre-approval of the SAPPs.
  - c. This course replaces the Navy’s IMPACT class, Brief Alcohol Screening and Intervention for College Students (BASIC), or its civilian equivalent.

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

1. Referral. The preferred method to address potential or suspected abuse is through a medical referral (e.g., Command, Self-Referral, or Incident: drug/alcohol). This method is a means of early intervention in the progression of substance misuse and abuse leading to a disorder. Commands need to declare the type of referral for which a member is being sent: Alcohol, Drug, or Command. If the command does not, the default will be a command referral. The result of the substance abuse screening (e.g., the diagnosis) should not be the determining factor of whether the referral was an incident.
  - a. Command Referral. Initiated by the command where there is no indication of a potential drug or alcohol incident.
    - (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. It is done out of concern for the member.
    - (2) 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 member's health and safety.
    - (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
  - b. Self-Referral. Initiated by the member to receive appropriate screening and referral treatment if necessary.
    - (1) A request must be made to a Chaplain, Command, CDAR, SAPS, or health care provider.
    - (2) There can be no credible evidence of involvement in an alcohol/drug incident.
    - (3) Members may self-refer for drug abuse; however, self-referral may result in a drug incident determination and administrative actions in accordance with Reference (a).
    - (4) A self-referral for alcohol related issues is not to be punitive.

- (5) A self-referral resulting in a diagnosis (e.g., current version of DSM of Mental Disorders) will result in administrative action if treatment is required and the member refuses, fails, or does not complete it. 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.
  - (6) A reservist not in an IDT or ADT status may self-refer. However, a Readiness Management Plan (RMP,) or next scheduled IDT or ADT, whichever occurs sooner, will be used to complete the initial meeting that may be required by the command. An additional RMP is allowed for the initial health support screening if it cannot be completed during the initial meeting with the command.
- c. Incident Referral (Drug or Alcohol). Initiated by the command in circumstances in which a drug or alcohol incident has been determined or is being contemplated.
- (1) Reference (a) provides a description of the criteria for an alcohol/drug incident. The following are examples of substance-related incidents that require medical screening:
    - (a) Driving or operating a motorized vehicle, aircraft, or vessel while impaired (e.g., Driving Under the Influence);
    - (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 Chapter 5 of this Manual. 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 PFL or on line version, myPRIME. Members receiving inpatient or outpatient treatment may be exempt at MO discretion.

2. Medical Screening.
  - a. This 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. Screening should be conducted by an AOHCP-MO or equivalently trained CG MO; however, TRICARE-approved Substance Abuse Rehabilitation Programs or DoD Military Treatment Facility (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 by an AOHCP-MO.
  - d. The MO will inform and communicate with the Command using the “Substance Abuse Screening Memo.”
  - e. The MO will also complete all other “Referrals for Care.”
3. The following actions are taken when a member is diagnosed with a SUD (alcohol or drug) and is awaiting treatment:
  - a. Commands must:
    - (1) Review the evaluation and treatment recommendations provided by the screening facility and treat the diagnosis as any other medical 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 must abstain from intoxicants (alcohol or drug) until further evaluation and recommendation from the treatment facility;
      - (b) Weekly, documented meetings with the CDAR; and
      - (c) Attending an abstinence-based, 12-step program or “at risk” program a minimum of twice a week.
  - b. CDAR must:
    - (1) Collaborate with the SAPS to prepare the appropriate Administrative Remarks, Form CG-3307, for incident referrals, as per Chapter 5 of this Manual.
    - (2) Monitor the member’s Pre-Treatment Plan with the Commanding Officer and provide updates to the SAPS.

- c. HCPs and Health Record Custodians (HRC) must 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 Criteria treatment level; and
  - (5) Pre-Treatment Plan.

## Chapter 4 TREATMENT AND SUPPORT PLANS

### A. Treatment.

1. A CG MO must authorize all treatment.
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 member 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 Criterion. The following are the ASAM recommended levels:
  - a. Level 0.5 Substance Abuse Education: PFL or myPRIME.
    - (1) These evidence-based programs have shown to be clinically valuable in reducing high-risk choices and high-risk drinking. An on-line version of PFL or myPRIME is available when face-to-face classroom instruction is not accessible or feasible.
    - (2) The MO will prescribe PFL or myPRIME for personnel who do not require formal outpatient or inpatient treatment. The member is to arrange to attend a PFL class or obtain an entry code for myPRIME. If prescribed myPRIME, the member must obtain a myPRIME code within seven days of completing their medical visit.
    - (3) Members have 30 days to complete PFL or myPRIME if assigned to a land unit and 60 days if assigned to an afloat unit.
    - (4) The SAP will give the member one “reminder notice” if they do not complete the program after their scheduled medical visit (screening). The SAP will allow an additional 30 days to complete the educational program if needed. If the member does not complete the program within 30 days, the SAP will notify and inform the member’s command about the non-compliance. SAPs will then instruct the command to complete an Administrative Remarks, Form 3307, stating that the member “Failed to Comply with Substance Abuse Education Intervention” assigned by their MO.

- b. Level I Outpatient Treatment (OP).
  - (1) This treatment is prescribed for personnel diagnosed with Alcohol Use Disorder (DSM-5 code 305.00, mild; 303.90 moderate).
  - (2) Military Treatment Facilities (MTFs) or TRICARE facilities that offer this type of treatment should be used.
- c. Level II Intensive Outpatient/Partial Hospitalization (IOP).
  - (1) This treatment is prescribed for personnel requiring 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 should be used.
- d. Level III Residential/Inpatient.
  - (1) This treatment is prescribed for personnel diagnosed as having a SUD mild, moderate, or severe (DSM-V code 303.9).
  - (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.
- e. 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" 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 civilian facility should be utilized.
  - b. Vetted TRICARE civilian facilities may be used. Consult with your District SAPS for vetted civilian providers.
7. Treatment Grading. Treatment programs recommended by a MO, SAPPS, or an 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), Article 5.B.5., a member diagnosed within the first 180 days of CG service 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. COs/OICs will process these members in accordance with Reference (c). The CG is not obligated to offer treatment prior to separation. Commands should not offer treatment if said treatment would 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 the District SAPS first and foremost. The SAPS will guide and assist ensuring that all required documentation is completed; and
  - b. Contact SAPS for treatment facility approval and authorization prior to seeking SUD treatment.
10. Ensure that a CG Substance Abuse Screening form is provided to the SAPS or MO.
11. Refusal of Treatment. Members diagnosed with a SUD (DSM-5 codes beginning with 290 to 300 series, drug or alcohol) who refuse treatment will:
  - a. Sign Administrative Remarks, Form CG-3307, (P&D), in accordance with Paragraph 5.B.1 of this Manual;
  - b. Be processed for separation from the CG in accordance with Reference (c); and
  - 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, and (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 that the member must "abstain from alcohol." Other funding consideration are:

- a. Alcohol education (e.g., PFL) will be funded by the command when prescribed by CG screening. This will normally involve only local travel and little or no course fee. Commands may choose to have a member pay for PFL or myPRIME when ordered by a civilian authority.
- b. Local treatment through vetted TRICARE civilian facilities and MTFs reduces the cost of travel associated with medical care. The availability of local facilities that offer SUD 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.
- c. 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., suspended driver's license). Travel by privately owned vehicle to inpatient rehabilitation is not recommended and strongly discouraged.
- d. If medically required and approved by a MO, a spouse, which is a non-medical attendant, may be authorized to travel related to treatment. If not overseas, this travel would be accomplished using unit funds. Contact the HSWL SC for travel guidance.

B. 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 SAPPs so treatment milestones (or the lack of) can be recorded in the electronic data collection system.

1. Level II Support Plan. For members not diagnosed as "moderate or severe (DSM 5: abusive or dependent)," the plan should include:
  - a. Abstinence. Abstaining from using intoxicants (alcohol or drug) 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. The CDARs role is designed to be supportive, informative, and constructive.
  - c. Support Program. Participating in a 12-step, abstinence-based group support program at least twice weekly for 90 days.
  - d. CDAR Command Caseload Review. When possible, CDAR will schedule a quarterly meeting with the MO and the executive officer/executive petty officer to review current caseload.
  - 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 initial 90 days post-treatment). Use of the 0,1,2,3 model outlined earlier in this Manual is strongly recommended. Members diagnosed with a SUD will follow the aftercare/support plan established by the discharging treatment facility. Zero drinks is the only option for someone diagnosed with a severe SUD.
  - g. Immediate inclusion into prevention education (e.g. PFL 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, completing PFL or myPRIME prevention education, abstinence from alcohol or illicit drug consumption) may be subject to further administrative action, including separation.
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, treatment type, dates of treatment, and support requirements.

3. Aftercare Plan for SUD.

- a. Aftercare Plan. The MTF or TRICARE, or civilian treatment facility will provide a written aftercare plan during the terminal phase of the rehabilitation program.
- b. The command is responsible to implement, document, and actively support aftercare programs. There may be some circumstances where operational commitments force the unit commander to modify the aftercare plan implementation due to mission requirements. This plan will be individually tailored to the member's needs, mission requirements, and resources available. Clinical evidence demonstrates that recovery is not only possible but also probable if the following lifestyle changes are maintained and must include, but is not limited to:
  - (1) Adhere to zero drinks (abstinence) as the only low-risk option for a member with a severe SUD diagnosis;
  - (2) Ensure completion of Aftercare. The aftercare period (surveillance) for a severe SUD diagnosis is normally 12 to 18 months;
  - (3) Meet with the CDAR on a weekly basis for the first six months. The CDAR will then determine the frequency of meetings thereafter; and
  - (4) Participate in a 12-step or abstinence-based group support program at least twice weekly, operations permitting, for at least 12 months. Alcoholics Anonymous (AA) is the recommended 12-step program focusing on abstinence. The SAPS must approve other 12-step and support groups. Again, evidence has shown that treatment will get the member sober, but AA will keep the member sober.
  - (5) "Slips" and "relapses" are a condition of the SUD disease. Therefore, non-compliance with the abstinence portion of a member's treatment plan is not, in and of itself, a reason to award a drug or alcohol incident. However, behaviors associated with relapse, (e.g., 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, including determination that an incident has occurred.
- c. 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.

- d. PCM or MO meeting on a quarterly or as needed are helpful to recovery.
  - e. The voluntary use of alcohol-inhibiting drugs, such as Disulfiram (Antabuse) or Naltrexone is recommended when clinically supported.
  - f. 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; and
    - (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 CO/OIC (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, and must place a copy of the narrative summary in the member’s health record:
    - (1) Narrative summary of the rehabilitative treatment;
    - (2) Support plan or the aftercare plan; and
    - (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.
- C. Rehabilitation Failure. A rehabilitation (treatment) failure occurs when a member does not complete an alcohol treatment program or aftercare plan due to noncompliance. Drinking alcohol alone does not constitute a rehabilitation failure; consult an AOHCP-MO or equivalent trained MO for advice. Non-compliance with treatment includes:

COMDTINST M6320.5

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; and/or
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 (a).

## Chapter 5 RECORDS MANAGEMENT

### A. Paperwork and Records Management for Substance Use Disorder 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. At Commands discretion, CDAR shall prepare for the Commanding Officer’s signature e.g. P&D 3307 all documents outlined in the CDAR course;
  - b. 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;
  - c. 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;
  - d. The CDAR will provide and the SAPS will enter all data, including but not limited to alcohol incident, self-referral, command referral, and subsequent case-related information into the electronic data collection system, as directed by the SAPPS;
  - e. The CDAR, under no circumstances, will maintain separate case files or keep copies or electronic files of medical and personnel documents; never sign P&D 3307’s and,
  - f. 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.

### B. Administrative Documentation.

1. 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, Form CG-3307, entries located in the Personnel and Pay Procedures Manual, PPCINST M1000. 2 (series), Enclosure (6). 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.

2. Health Record Entries. Any medical actions resulting from alcohol problems must be documented in the member's health record. The CDAR, SAPS, and HRC 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:
  - a. 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);
  - b. Details of pre-treatment plan or intervention prior to separation from the CG;
  - c. Details of outpatient or inpatient treatment (e.g., name of treatment facility, treatment type, 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;
  - d. Aftercare interviews conducted and reports submitted to the SAPS. Appropriate notation when aftercare report status is completed;
  - e. Referral for re-evaluation, revision of treatment or aftercare plan, or institution of a second aftercare plan; and
  - f. Rehabilitation failure or refusal of treatment.
3. Record Keeping by the SAPS. The SAPS will maintain a secure electronic file, in the electronic data collection system, on all members who have been screened and for whom alcohol rehabilitation (outpatient or inpatient) has been requested, and when alcohol incidents have occurred, as directed by Commandant (CG-1111). The SAPM will identify and clarify this process.

## Chapter 6 GLOSSARY

- A. Definitions. 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. Aftercare or Support Plan. A monitored program of continued care, immediately following completion of a formal inpatient or outpatient treatment program for SUD. The discharging facility or physician usually generates aftercare plans while a support plan is generated by the Command/CDAR or individuals overseeing the member's recovery.
  2. 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://al-anon.org/>.
  3. 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/>.
  4. 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. A trained professional makes this diagnosis.
  5. 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.

6. Alcohol Incident (AI).

- a. Except as set forth in Paragraph 6.A.c. below, any behavior, in which the CO/OIC determines by a preponderance of evidence after considering the relevant facts (i.e., police reports, eyewitness statements, and member's statement if provided) that alcohol was a significant or causative factor that resulted in the member's loss of ability to perform assigned duties or is a violation of the UCMJ, Federal, State, or local laws. The military member need not be found guilty at court-martial, in civilian court, or be awarded non-judicial punishment for a behavior to be considered an alcohol incident.
- b. Except as set forth in Paragraph 6.c. below, the military member must actually consume alcohol for an alcohol incident to have occurred. Simply being present where alcohol is consumed does not constitute an AI.
- c. Any military member who provides alcohol to an underage military member must be awarded an AI, regardless of whether the alcohol is actually consumed by any member.
- d. The following events must all be considered an Alcohol Incident:
  - (1) Underage Drinking. Any of the following events represent an underage drinking event and thus an AI.
    - (a) Active Duty Not on Approved Leave and Reservists on Duty. The CG minimum drinking age is 21 for all military members, wherever located; this is established as a Lawful General Order. Failing to comply with this order is punishable under Article 92 and other appropriate Articles of the UCMJ.
    - (b) Active Duty on Leave and Reservists Not on Duty. While on authorized leave, CG members must comply with the minimum legal drinking age for the jurisdiction in which they are present or the policy contained in Enclosure (9) of Coast Guard Morale, Well-Being, and Recreation Manual, COMDTINST M1710.13 (series). In the absence of any local law, the minimum drinking age is 21 for all military members.
  - (2) Impairment While on Duty. All military members must be free from the residual effects of alcohol consumption and required to be free from all alcohol effects when reporting for duty, commencing duties, and/or expiration of liberty. Research shows impairment can occur in BAC as low as 0.02% but is significant at BAC of 0.04%.

7. 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.
8. 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 use disorder cases administratively and in a timely manner to minimize impact to their unit's mission(s).
9. 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.
10. 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 Manual, substance abuse-related diagnoses should be reported using criteria.
11. Primary Care Manager (PCM). The MO or TRICARE civilian provider charged with managing healthcare, including the authorization of referrals for a prescribed area.
12. 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.
13. Rehabilitation. Restoration to a normal or optimum state of health and constructive activity through medical treatment, physical and/or psychological therapy.
14. Relapse. A return to an addictive drinking pattern.
15. Slip. The short-term minimal consumption of alcoholic beverages by someone diagnosed with severe SUD. In 12-Step terms, "Sobriety Loses Its Priority."
16. Standard Drink. 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).

17. 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.
18. 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 MO for their assigned district.
19. Substance Use Disorder (SUD). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to SUDs, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. SUDs occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.
20. Treatment. Includes inpatient/outpatient medical treatment, counseling, or other appropriate care administered to members in an effort to redirect life patterns and attitudes.

B. Acronyms.

1. AOHCP-MO - Addiction Orientation for Health Care Provider-Medical Officer
2. ASAM - American Society of Addiction Medicine
3. CDAR - Command Drug and Alcohol Representative
4. DMOA - Designated Medical Officer Assigned
5. EHR - Electronic Health Record
6. HIPAA - Health Insurance Portability and Accountability Act
7. IDHS - Independent Duty Health Services Technician
8. MO - Medical Officer
9. MTF - Military Treatment Facility
10. NIAAA - National Institute of Alcohol Abuse and Alcoholism
11. P&D - Performance and Discipline
12. PCM - Primary Care Manager
13. PFL - Prime for Life
14. SAP - Substance Abuse Prevention and Treatment Program
15. SAPM - Substance Abuse Program Manager
16. SAPP - Substance Abuse Prevention Program
17. SAPPS - Substance Abuse Prevention Program Supervisor
18. SAPS - Substance Abuse Prevention Specialist
19. SUD - Substance Use Disorder

THIS PAGE INTENTIONALLY BLANK