U.S. Department
of Transportation
United States
Coast Guard

HEALTH PROMOTION MANUAL

COMDTINST M6200.1
CH-1

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U.S. Department of Transportation
United States Coast Guard

Commandant
United States Coast Guard

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Washington, DC 20593-0001
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COMDTNOTE 6200
11 February 2002

COMMANDANT NOTICE 6200 CANCELED: 10 Feb 03

Subj: CH-1 TO THE COAST GUARD HEALTH PROMOTION MANUAL, COMDTINST M6200.1

1. PURPOSE. This Notice publishes change one to the Coast Guard Health Promotion Manual, COMDTINST M6200.1.

2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of headquarters units, assistant commandants for directorates, Chief Counsel, and special staff offices at Headquarters shall ensure compliance with the provisions of this Notice. Internet release authorized.

3. DIRECTIVES AFFECTED: None.

4. SUMMARY OF CHANGES.

   a. The title of COMDTINST M6200.1 has been changed from the Wellness Manual to the Health Promotion Manual in accordance to ALCOAST 535/01.

   b. Tobacco use now includes the use of smokeless tobacco.

   c. The use of tobacco products (smoking and smokeless) is permitted only in designated tobacco use areas.

   d. Tobacco use is no longer authorized in Coast Guard owned bachelor living quarters.

5. PROCEDURE.

   a. All references to WKH-3 have been changed to WKW-1.

   b. Remove and insert the following pages:

DISTRIBUTION – SDL No. 139

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NON-STANDARD DISTRIBUTION: B:c MLCs (6 extra); B:r HS “A” School (10 extra)

COMMANDANT NOTICE 6200

Remove	Insert
Chapter 3	Chapter 3 CH-1

JOYCE M. JOHNSON
Director of Health and Safety

Encl: (1) CH-1 to the Coast Guard Health Promotion Manual, COMDTINST M6200.1

U.S. Department of Transportation
United States Coast Guard

Commandant
United States Coast Guard

2100 Second Street, S.W.
Washington, DC 20593-0001
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COMDTINST M6200.1
MAY 15, 1997

COMMANDANT INSTRUCTION M6200.1

Subj: COAST GUARD WELLNESS MANUAL

Ref: (a) Personnel Management Manual, COMDTINST M1000.6 (series)
(b) Reserve Administration and Training Manual, COMDTINST M1001.27 (series)
(c) Allowable Weight Standards for the Health and Well-Being of Coast Guard Military Personnel, COMDTINST M1020.8 (series)

1. PURPOSE. This instruction establishes a servicewide Coast Guard Wellness Program to optimize mission performance of the Coast Guard through enhanced physical, psychological, and social well-being of our people.

2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of headquarters units, assistant commandants for directorates, Chief Counsel, and special staff offices at Headquarters shall ensure compliance with the provisions of this directive.

3. DIRECTIVES EFFECTED. This Manual cancels the following Commandant Instructions:
   a. COMDTINST 6100.5(series) of 28 July 1992;
   b. COMDTPUB P6100.13(series) of 22 September 1994;
   c. COMDTINST 6280.1(series) of 14 April 1990;
   d. COMDTINST 6280.2(series) of 7 August 1990;
   e. COMDTINST 6330.1(series) of 21 May 1990.

4. MAJOR CHANGES. Major changes to this program include: (1) starting a Coast Guard wide Wellness Program and defining responsibilities, (2) changing the Coast Guard Alcohol Abuse and Prevention program to the Coast Guard Addictions Treatment and Prevention program, (3) updating and including COMDTINST 6280.1 and COMDTINST 6280.2 and further restricting the use of tobacco products, (4) setting voluntary physical fitness goals for Coast Guard members and allowing time during work hours for physical fitness, (5) outlining the elements of the Coast

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NON-STANDARD DISTRIBUTION: B:c MLCs (6 extra); B:r HS “A” School (10 extra)

Guard's health risk appraisal (HRA) program, (6) setting responsibilities for nutrition and weight management education, and inserting COMDTPUB P6100.13, Nutrition and Weight Control pamphlet as an appendix, (7) establishing nutritional guidelines for menus and food quality for Coast Guard contracted and food service specialist staffed dining facilities, and (8) including COMDTINST 6100.5 Physical Fitness Award Program as an appendix.

5. REQUESTS FOR CHANGES. Units and individuals may recommend changes by writing via the chain of command to Commandant (G-WKH-3), U. S. Coast Guard Headquarters, 2100 Second St. S.W., Washington, D.C. 20593-0001

ALAN M. STEINMAN
Director of Health and Safety

RECORD OF CHANGES			
CHANGE NUMBER	DATE OF CHANGE	DATE ENTERED	BY WHOM ENTERED

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(2) Example Fitness Leader Designation Letter
(3) CDAR Referral & Follow-up Report
(4) USCG Inpatient Rehab Request Form
(5) USCG Outpatient Treatment Request Form
(6) Physical Activity Readiness Questionnaire

CHAPTER 1. GENERAL INFORMATION

A. INTRODUCTION. "**Health is a state of physical, psychological and social well being**," defines the World Health Organization. Therefore, a healthy individual focuses on the whole picture which entails positive routines in the three aforementioned areas, not just the physical portions like exercise and diet. People who strive for personal fitness and well-being resist disease better and reap a greater enjoyment out of life. These healthy individuals' strong energy and drive fit perfectly into the Coast Guard organization which is continually asked to do more with less resources.

1. PURPOSE. To optimize mission performance of the Coast Guard through enhanced physical, psychological and social well-being of our people. By **educating** and **promoting** wellness habits, the Wellness Program seeks to **encourage members to choose positive lifestyle** habits.

   a. Members Affected: Active duty, reservists, retirees, civilian employees, auxiliarists and family members may participate in all the wellness programs as members in the Coast Guard family. However, some addiction treatment programs limit participation.

   b. Mandatory: Chapters Two and Three of this Manual cover mandatory policy regarding alcohol abuse and tobacco usage. Establishment of a Wellness Program as outlined in Chapter 1, section G (Responsibilities), is mandatory at the unit level except for afloat and administratively limited units. However, afloat units not administratively limited shall designate a unit Wellness Representative (WR). The Clinical Medicine and Wellness Programs division defines an *administratively limited unit* as one without an assigned yeoman.

   c. Highly Encouraged: Chapters Four through Seven and the appendices cover voluntary yet highly encouraged programs. The information provided is intended to increase awareness and provide opportunities for healthier lifestyle choices. Participation by an individual in non-mandatory programs is entirely voluntary, because only a personal commitment to wellness will produce positive and permanent lifestyle changes.

B. DISCUSSION.

1. Approximately fifty percent of all deaths and illnesses in the U.S. relate directly to unhealthy lifestyle habits: tobacco use, poor diet, lack of exercise, abuse of alcohol and drugs, and unmanaged stress. People who make positive changes in their behavior and lifestyle can reduce their health risks. Traditional medicine focuses on the treatment of illness and injury; wellness programs focus on the prevention of illness and injury.

2. The Department of Health and Human Services, recognizing the critical need to reduce the incidence and costs of unhealthy lifestyles in the United States, established a set of health promotion goals for the nation: *Healthy People 2000*. Established goals include the areas of nutrition, physical fitness, tobacco cessation, responsible alcohol use, personal safety, mental health, stress management, educating people about their current lifestyle risks, and reducing

the occurrence of cancer, heart disease, high blood pressure and stroke. The Coast Guard Wellness Program adopts these goals and will establish voluntary health promotion initiatives to achieve them.

3. Wellness programs in the civilian sector have demonstrated significant benefits through increased productivity, decreased absenteeism and decreased health care costs. Community health promotion efforts and those in industrial settings have both proven effective. The Department of Defense has pursued an active health promotion program for several years, and each of the other branches of the Armed Forces has established individual wellness programs. Existing wellness programs in the Coast Guard, established in the maintenance and logistics commands (MLC), area offices, district offices and individual commands, have already proven successful. The servicewide Wellness Program described in this Instruction will coordinate, augment and support these existing health promotion initiatives.

4. The Coast Guard Office of Readiness and Reserve started a wellness program in 1990 for Reserve personnel, entitled "Fit for Duty, Fit for Life." COMDTINST 6100.3 (series) and COMDTPUB 6100.2 describe the reserve program. Subsequent updates of COMDTINST 6100.3 expanded the “Fit for Duty, Fit for Life” program to all Coast Guard Personnel. The servicewide Wellness Program defined by this Manual incorporates parts of the “Fit for Duty, Fit for Life” program.

C. ESSENTIAL ELEMENTS. People who strive for total health must not only exercise and eat right but feed their mind and inner self. However, concentrating on improving in one area will positively affect the other dimensions. A complete wellness program touches upon all of the following:

1. Nutrition and weight management;
2. Physical fitness;
3. Tobacco cessation and avoidance;
4. Avoidance of alcohol abuse and drug abuse;
5. Control of cardiovascular risk factors;
6. Prevention of chronic disease;
7. Women’s health issues;
8. Men’s health issues;
9. Stress management;
10. Sexually transmitted diseases;
11. Occupational and environmental health and injury control;
12. Health risk appraisal.

D. WELLNESS PROGRAMS: The Coast Guard Wellness Program will use a three part process to increase the effectiveness of its prevention initiatives: (1) **Education**; (2) **Promotion**; and (3) **Choice**. Through education, Coast Guard members will learn the various elements of a healthy lifestyle and then be able to compare their current habit patterns with healthier alternatives. Following-up education with active promotions of wellness alternatives will encourage members and beneficiaries to slowly make a shift towards healthier lifestyles. To choose a positive lifestyle, members must have options to pursue and resources to utilize. By increasing the availability of healthier choices in Coast Guard dining facilities, improving exercise facilities, and offering clinical preventive services (i.e., tobacco cessation, weight-management, stress-management and health risk appraising); the Coast Guard commands will provide the opportunity for members to make positive lifestyle choices.

1. Promotion at Training Facilities and Schools. Indoctrinating members about wellness upon their entrance into the Coast Guard opens the mind for wellness education throughout their careers. Accession points like the Recruit Training Center, Officer Candidate School (OCS), and the Coast Guard Academy (CGA) include wellness training in their curricula and constantly update and expand the use of wellness material. Leadership development facilities like the Chief Petty Officers' Academy and Leadership School are targeted due to the mid-career personnel they reach. Introduction of wellness topics at recruit training and reinforcement during "A" and "C" schools, is especially important. The curricula at Food Service Specialist (FS) "A" and "C" schools already incorporates nutritional information, and the Coast Guard Food Quality Standards reflect current healthy dietary information for use in Coast Guard dining facilities.

2. Health Risk Appraisals (HRA). Utilizing Health Risk Appraisal questionnaires, Coast Guard medical facilities can provide essential information and preventive education for active duty members, dependents and retired personnel. Family acceptance of a healthy lifestyle change is critical to the success of the Coast Guard Wellness Program. This procedure is an effective measure to both monitor lifestyle habits and educate personnel on healthier alternatives.

   a. HRA for Beneficiaries. COMDT (G-WKW-1) provides a confidential HRA to any Coast Guard beneficiary interested in learning about the level of risk associated with their current lifestyle habits. The HRA is a self-administered questionnaire designed to evaluate lifestyle habits and recommend healthy alternatives to unhealthy behaviors. Medical personnel may use the HRA as an assessment tool in addressing specific areas of risk, such as excess body-fat, blood pressure, cholesterol, dietary habits, tobacco use, and alcohol consumption.

3. Wellness Bulletins. COMDT (G-WKW-1) publishes the biweekly Wellness Bulletins containing timely information on a variety of topics dealing with nutrition, health, fitness and psyche. The Wellness Bulletins are distributed servicewide through electronic mail to the Integrated Support Commands (ISC), MLCs and Headquarters for subsequent distribution to individual units. Units can print these Wellness Bulletins for individual members or incorporate all or part of them into local publications (e.g., Plan of the Week, newsletters, etc.).

4. Physical Fitness Award Program. A voluntary physical fitness award program exists for active duty personnel, reservists, auxiliarists, Coast Guard civilian employees, and families. The Physical Fitness Award Program described in **appendix A** of this Manual will help motivate personnel to pursue healthier habits by rewarding regular physical activity.

5. Heart at Work © (HAW) Program. The American Heart Association developed the "Heart at Work" program that provides examples, materials and simple plans for increasing health awareness in America. The HAW curriculum is the standard around which Coast Guard units can develop their wellness programs. This "off the shelf" package contains two parts; (1) a comprehensive Program Coordinator's guide and (2) "just add water" wellness activities designed to entertain and educate people. This kit enables even small units to manage a viable wellness program with minimal personnel support or cost. ISC Wellness Coordinators (WC) will provide training to unit Wellness Representatives (WR) in the use of the HAW material. Units needing these materials should contact their WC.

6. Addictions and Prevention Program. Chapter 2 of this Manual outlines the responsibilities and resources needed to prevent and treat addictions. The goal of the program is to reduce to a minimum the abuse of alcohol or other drugs within the Coast Guard.

7. Coast Guard Food Quality Guidelines. Diet and nutrition significantly affect the health and morale of Coast Guard personnel. Members need both nutritional information and choices so that they may make an informed decision about their diet. Chapter 7 of this Manual states the minimum recommendations at Coast Guard contracted and FS staffed dining facilities to improve food quality, enhance awareness about nutrition, and support the Coast Guard's wellness policies.

E. WELLNESS REPRESENTATIVE COURSE. G-WKW-1 oversees a standardized Coast Guard specific Wellness Representative Training Course. The course provides a comprehensive overview of important health promotion/wellness issues facing today's Coast Guard, and equips those attending to deliver effective health promotion training at their units. Attendees are given a ready-made comprehensive wellness program for use at their unit that includes: information on the background and development of health promotion, wellness marketing ideas, program measurement plans, and pre-made lesson training modules.

1. Objectives. Graduates will learn how to gain leadership support and be able to:

   a. Design a unit health promotion/wellness program with the approval of the command;

   b. Perform Health Risk Appraisals (HRA) and need assessments at their units with the supervision of a WC;

   c. Assist unit members in creating plans for any of the wellness essential elements.

2. Attendee Requirements. Commanding Officers should send their present or future Wellness Representative to this training as long as they conform to the qualifications outlined in section H of this chapter.

3. Reference Material. Materials are provided in hard copy and on computer disk for immediate start-up. Other resources include:

a. The USCG Wellness Start-Up Kit;

b. Shipboard fitness manual and fitness training modules;

c. Assorted reference material and supplies.

4. Application. Every Wellness Coordinator conducts the exportable training within their ISC region. Contact your WC for location and times of the Wellness Representative Training Course.

F. HEALTH AND FITNESS LEADER COURSE. G-WKW-1 manages a standardized Coast Guard specific Health and Fitness Leader training course. The course mixes classroom lectures with practical fitness labs designed to teach students how to build unit fitness programs and design personal training and nutrition routines. This five day course supersedes the old Wellness Program Specialist Training once offered at The Coopers Institute for Aerobic Research. Completion of the Health and Fitness Leader Course (or the old Cooper Institute Course) certifies that individual as a Coast Guard Fitness Leader (FL) with an enlisted qualification code.

1. Objectives. After graduating from the course the student will be designated as a Fitness Leader (FL) and should be able to:

a. Perform Health Risk Appraisals (HRA) at their units with minimal supervision from a WC;

b. Help individuals create fitness routines to reach their personal goals of weight loss, strength gain, or endurance enhancement;

c. Assist unit members in creating a nutrition plan.

2. Attendee Requirements. Commanding Officers may send either the designated WR (preferred) or another interested individual to this training but they must conform to the qualifications outlined in section H of this chapter. The student should have an up-to-date basic cardiopulmonary resuscitation (CPR) certification, however, the 4 hour CPR class will be offered at night during the week of the class.

3. Reference Books. The Commandant (G-WKW-1) provides four reference books to personnel who attend the Health and Fitness Leaders Course.

a. *The New Wellness Encyclopedia*, published by the editors of the University of California, Berkeley Wellness Letter, is a comprehensive family resource for safeguarding health and preventing illness.

b. *Health and Fitness Excellence*, by Robert K. Cooper, Ph.D., details seven steps to achieve peak physical and mental health.

c. *The Balancing Act, Nutrition and Weight Guide*, by Georgia G. Kostas, M.P.H., R.D., covers weight management in a complete and user friendly method.

d. *Personal Trainer Manual*, published by the American Council on Exercise, is a comprehensive resource for creating personal physical fitness routines.

4. Application. Send a Short-Term Resident Training Request (Form CG-5223) to the regional Wellness Coordinator who then will forward it to G-WKW-1. Funding for the classes resources is provided by G-WKW-1, while the unit covers the students travel and lodging expenses.

G. RESPONSIBILITIES.

1. Commandant (G-WKW-1) Clinical Medicine and Wellness Programs Division, of the Directorate of Health and Safety (G-WK), serves as the program manager for the Coast Guard Wellness Program. G-WKW-1 shall:

   a. Establish servicewide wellness initiatives to achieve the preventive medicine and health promotion objectives outlined in *Healthy People 2000*;

   b. Provide professional oversight for wellness initiatives, ensuring the scientific validity of each of the program elements;

   c. Identify training and educational opportunities for WCs. Provide funding, as available, to facilitate utilization of these opportunities;

   d. Serve as consultant on preventive medicine and health promotion topics to Coast Guard medical personnel and WCs;

   e. Publish biweekly Wellness Bulletins for servicewide distribution;

   f. Ensure provision of nutritional education programs for use in Coast Guard dining facilities (FS and contractor staffed), both ashore and afloat;

   g. Provide expertise to the FS Program Manager in devising initiatives to improve the nutritional quality of food served in Coast Guard dining facilities;

   h. Provide nutritional consultation to commands with contracted dining facilities;

   i. Devise educational and promotional initiatives to decrease the use of tobacco, alcohol and other addictive behaviors among Coast Guard members and beneficiaries;

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

   k. Develop initiatives to manage stress, with the specific goals of decreasing alcohol and drug abuse, the need for psychiatric intervention, the rate of suicide attempts, and family violence;

   l. Serve as liaison to Department of Defense and Department of Health and Human Services inter-agency wellness committees and to the President's Council on Physical Fitness;

   m. Run the Coast Guard's Physical Fitness Award Program as outlined in appendix A.

2. Wellness Coordinators (WC). Every ISC has one or more health care or fitness professionals serving as a Wellness Coordinator (WC) who are subject matter experts in the various wellness fields. WCs shall:

a. Serve as ISC Work-Life Staff liaison with COMDT (G-WKW-1) and assist in implementing Coast Guard wide wellness initiatives for all Coast Guard members and beneficiaries within their area of responsibility (AOR);

b. Serve as professional consultant within their AOR for all elements of the wellness program;

c. Assist Commanding Officers and Officers in Charge within their AOR in establishing unit level wellness programs, including selection and training of unit WRs;

d. Provide guidance and oversight in the development and implementation of unit wellness programs and activities;

e. Provide Coast Guard standardized training in the use of the Heart at Work program materials and other local resources;

f. Prepare, procure and distribute educational and promotional wellness materials, including Wellness Bulletins, to all designated WRs. Establish and maintain an ISC publication and audiovisual library;

g. Contact all commands within AOR on an annual basis. WCs shall visit units whenever possible with the goal of assessing and improving the existing wellness program;

h. Liaison with all clinics within the ISC in support of wellness initiatives;

i. Conduct Health Risk Assessments (HRA) for all interested personnel and submit questionnaires to Commandant (G-WKW-1) or other designated processing site for processing within seven days of completion;

j. Initiate contact with and serve as liaison to community-based, Public Health Service and DoD program managers in the areas of wellness within their AOR.

3. Commanding Officers and Officers in Charge.

a. All commands, *except* administratively limited units (without yeoman), shall:

(1) Designate in writing a unit Wellness Representative (WR) and provide a copy of the designation letter (enclosure (1)) to the WC responsible for the unit;

b. All commands, *except* afloat and administratively limited units, shall:

(1) Establish a unit level wellness program;

(2) Provide all members time during normal working hours to participate in scheduled wellness activities on a voluntary basis;

(3) Provide all members a minimum of **three hours** per week during working hours, operations permitting, (excluding units operating on tropical hours) for voluntary participation in physical fitness enhancing activities. Such physical activities should improve upon at least one of the four components of fitness (body composition, flexibility, muscular strength and endurance or cardiorespiratory endurance) as outlined in **chapter 4** and **appendix B**;

(4) Afloat and administratively limited units are highly encouraged to implement items (1)-(3) above. For administratively limited units the requirements of this instruction will be met by the next larger unit in their chain of command;

c. All commands may designate a unit Fitness Leader (FL) and provide a copy of the designation letter (enclosure (2)) to the WC responsible for the unit;

d. Collocated units may combine efforts and resources so long as the needs of the individual units are being met;

e. Commanding officers of Integrated Support Commands, the Coast Guard Yard, training centers, bases, and the Superintendent of the Coast Guard Academy shall establish a wellness committee, inviting participation from all tenant and local commands.

4. Unit Wellness Representative. WRs are not subject matter experts in health promotion but after training they will have sufficient knowledge and skills to plan and implement a comprehensive work-site wellness program. WRs shall perform, at a minimum, requirements (a) through (d) below. Requirements (e) through (s) are in order of precedence and are highly encouraged upon direction from the command.

a. Meet all the qualifications outlined in **section H** of this chapter;

b. Be designated in writing by the command and provide a copy of the designation letter (enclosure (1)) to the WC responsible for the unit.;

c. Complete the Wellness Representative training when possible as provided by the ISC Wellness Coordinator;

d. Make available Wellness Bulletins to unit personnel (electronically or hard copy, as appropriate);

e. Act as an advisor to the command on wellness programs and act as unit liaison to the ISC Wellness Coordinator;

f. Develop and implement unit level wellness programs with material (Heart At Work, Ship Training Modules) and guidelines provided by the WC;

g. Establish a wellness committee to coordinate unit participation in health promotion, nutrition, fitness and stress management activities. Suggested membership includes WR, FL, collateral duty addictions representative (CDAR), FSO (designated FS), HS and other interested individuals;

h. Assess and maintain a wellness resource library using the guidelines set forth by the WC;

i. Work with unit HS and CDAR to organize tobacco use cessation programs for personnel utilizing resources provided by the WC and/or those available within the community (i.e., American Cancer Society);

j. Assist the unit CDAR in encouraging the responsible use of alcohol and other addictive substances;

k. Provide weight management resources and support to members not in compliance with current Coast Guard weight standards and policies (reference c);

l. For units with a Coast Guard Dining Facility, work with the FSs or contracted food service providers to integrate the nutritional information set forth in this instruction;

m. Assess the needs and interests of unit members. Communicate desires of members to unit morale committee for financial support of programs;

n. Prepare and manage an annual budget for those items authorized for procurement utilizing appropriated funds and submit in accordance with command policies;

o. Identify and utilize community and DoD resources for wellness activities. Maintain a local data base for use in enhancing the unit wellness program (appendix E contains some needed numbers);

p. Encourage family member participation in unit wellness activities and programs, as appropriate;

q. Assist Coast Guard health care providers with health promotion activities;

r. Work with the unit supply officer, Coast Guard Exchange Representative or the contracted vendor to include healthy choice options in all vending machine operations;

s. Assist the WC with measurement and evaluation of the wellness program and special projects as requested with command approval.

5. Unit Fitness Leader (FL). A Coast Guard member successfully completing the Coast Guard Health and Fitness Leader Course earns the designation as Fitness Leader and shall:

   a. Meet all the qualifications outlined in **section H** of this chapter;

   b. Be designated in writing by the Command and provide a copy of the designation letter (enclosure (2)) to the WC responsible for the unit. Preferable, the Fitness Leader should also be the WR but another interested individual may be designated;

   c. Act as a liaison with the WC for physical fitness initiatives;

   d. Identify local resources (community and DoD) in support of fitness activities and maintain a current data base of these resources;

   e. Serve as the command physical fitness advisor as it relates to command sponsored fitness activities and the maintenance/procurement of exercise equipment;

   f. In conjunction with the unit WR, schedule fitness activities appropriate to all personnel;

   g. Assist individual members in developing and implementing a personal fitness program.

6. Collateral Duty Addictions Representative (CDAR) shall:

   a. Follow guidelines outlined in chapter 2 of this Manual;

   b. Work with unit WR to encourage the responsible use of alcohol and educate members about other addictive substances.

7. Unit Food Service Officer (FSO) shall:

   a. Coordinate nutritional programs with the unit WR when possible;

b. Strive to follow the nutritional recommendations set forth in chapters 6 and 7;

c. Promote good nutrition through posting of educational material in galley areas.

H. QUALIFICATIONS for unit Wellness Representative (WR) and Fitness Leader (FL):

1. Be free from tobacco products for a minimum of twelve months;
2. Be in compliance with the Commandant's policy on weight standards (reference c);
3. Possess good communication and leadership skills, including an approachable, empathic demeanor;
4. Be enthusiastic about wellness and committed to the principles of health promotion;
5. Be either a non-user or responsible user of alcohol;
6. Have a reasonable amount of time to work on unit wellness initiatives (recommend 3 hours per week);
7. Have two years remaining at a shore unit or one year remaining at an afloat unit;
8. Be a Petty Officer or above (exceptions made for small units);
9. Be on active duty. However, at the commanding officer's discretion, a reservist, auxiliarists or civilian employee may represent the unit if they meet the other qualifications;
10. Be aware of the responsibilities outlined in this instruction.

CHAPTER 2. ADDICTIONS TREATMENT AND PREVENTION PROGRAM

A. INTRODUCTION. The treatment of Coast Guard members who are substance abusers or dependent on alcohol or other drugs and the prevention of their abuse and dependency is provided in accordance with specific personnel policies as outlined in reference (a), COMDTINST M1000.6 (series) CG PERSMAN, Chapter 20 and reference (b), COMDTINST M1001.27 (series) CG RATMAN, Chapter 19. Requests for treatment must comply with both references as well as the procedures required in this Manual.

1. PURPOSE. This chapter sets policy and procedures for the Coast Guard Addictions Treatment and Prevention Programs (previously the Addictions program) and supersedes COMDTINST M6330.1, Alcohol Abuse Treatment and Prevention Program. Guidance on tobacco products use can be found in chapter three of this Manual.

2. BACKGROUND. The administration of the Addictions Program was transferred from Commandant (G-WP) to Commandant (G-WK). The personnel administration aspect of alcohol and drug abuse remains with Commandant (G-WP) and those policies and procedures can be found in reference (a). Additional policies and procedures for inactive reserve personnel can be found in reference (b).

B. DISCUSSION. The goal of this program is to reduce to a minimum the abuse of alcohol or other drugs within the Coast Guard. This will be accomplished through prevention education of our members and providers and by identifying members who are substance abusers, providing education for self-realization of their abuse and offering rehabilitation when needed.

1. Forms and Required Reports. Reports are required in accordance with sections G and J of this Manual and can be locally reproduced. Enclosure (3) is the CDAR Referral and Follow-up Report (form CG-5626) and enclosure (4) is the USCG Rehabilitation Treatment Request Form (form CG-5627).

C. DEFINITIONS AND COMMONLY USED TERMINOLOGY. The following definitions are for medical use within the Addictions 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. Addiction. A general reference to a compulsive or repetitive behavior in relationship to the use of various addictive substances (alcohol, caffeine, food, prescription or illicit drugs, etc.) or experiences (gambling, exercise, sex, etc.).

2. Addictions Prevention Specialist (APS). MLC personnel assigned to detached duty at major headquarters commands as full-time addictions prevention facilitators.

3. Addictions Program Administrator (APA). The CWO assigned to COMDT (G-WKW-1) who serves as the Coast Guard Addictions Program Administrator.

4. Addictions Program Representatives (APR). The CWO (MED) and the Health Services Technician assigned to each MLC for primary duty as Addictions Program Manager.

5. Aftercare. A required program of ongoing therapy for alcohol dependent members following formal inpatient/outpatient alcohol rehabilitation treatment.

6. Al-Anon. The Al-Anon family groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope to solve their common problems of fear, insecurity, lack of understanding of the alcoholic, and disordered personal lives resulting from alcoholism. Al-Anon is listed in the telephone directory. The Al-Anon Family Groups address is 1372 Broadway, New York, NY 10018, (800) 344-2666.

7. Ala-Teen. Ala-Teen is a fellowship of young people, 12 to 20 years of age, who are the offspring of alcoholics. They meet together to help themselves and each other to learn about alcoholism, to cope with the troubles brought about by alcoholism, to make a new life, and to set goals for themselves. Ala-Teen is listed in the telephone directory or information can be obtained through Al-Anon. The Ala-Teen address is the same as shown above for Al-Anon.

8. Alcohol Abuse. A maladaptive pattern of alcohol use that meets the following criteria as published in the Diagnostic and Statistical Manual, Fourth Edition (DSM), code number 305.0.

9. Alcohol Dependence. A diagnosis made by a physician or psychologist using the criteria as published in DSM, code number 303.9.

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

11. Alcoholics Anonymous (A.A.). is a fellowship of men and women who share their experiences, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism. A.A. is a worldwide organization of people who help each other stay sober and is listed in the white and/or yellow pages of almost any telephone directory under Alcoholics Anonymous. The A.A. World Services address is 475 Riverside Dr., New York, NY 10115, (212) 870-3400. 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.

12. Alcohol Incident. Any behavior, in which alcohol is determined 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.

13. Alcoholism. Same as alcohol dependence (section C-8).

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

    a. Members involved in alcohol related situations shall be counseled concerning their use of alcohol and informed of the conduct expected of members of the Coast Guard.

    b. Commanding Officers are strongly encouraged to consider whether screening and/or alcohol awareness training such as IMPACT is appropriate.

    c. Commanding Officers shall document such occurrences in the members Personal Data Record. Documentation of alcohol related situations provides commands with significant background information for determining whether any administrative or medical action is necessary.

15. Alcohol Treatment Facility (ATF). A U.S. Navy alcohol rehabilitation residential treatment department within or attached to a federal medical treatment facility.

16. Aeromedical Evacuation Coordination Center (AECC). This office assists in obtaining assignments in ATFs and ATFs operated by the military services if MLC APR and local APS/CDAR are unable to obtain bed assignment.

17. Collateral Duty Addictions Representative (CDAR). Unit members who serve as consultants and advisors to their parent command in the administration of the unit addictions program.

18. Continuum of Care. A medical model of care provided by U. S. Navy, DoD, or civilian substance abuse/dependency treatment facilities. Members recommended for abuse/dependency treatment will be referred to the appropriate level of treatment as determined by a Licensed Individual Practitioner (LIP) utilizing the Patient Placement Criteria (PPC). The members care requirements will be continually evaluated through out the multilevel treatment process ensuring individual needs are met.

19. Counseling and Assistance Center (CAAC). A Navy medical facility providing screening and evaluation, outpatient counseling, aftercare support, and individual and family referral services.

20. 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.

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

22. Drug and Alcohol Beneficiaries System II (DABSII). The DABSII tracking system is a confidential Coast Guard medical data base designed to assist MLC Addictions Program Representatives (APR) to track a members progress and status. This system measures the effectiveness of the Addictions Program in the areas of awareness, prevention and treatment.

23. Drug and Alcohol Counselor (DAC). An active duty Coast Guard member who has Navy Drug and Alcohol Counselor certification (NDAC) and is assigned to a DoD alcohol abuse treatment facility (ATF or TRISARF) to provide therapeutic counseling and education to members undergoing rehabilitative treatment.

24. Intoxication. A state of impaired mental and/or physical functioning resulting from the presence of alcohol or other intoxicants in the body.

25. Licensed Individual Practitioner (LIP). A qualified physician or licensed psychologist who can provide an appropriate diagnostic screening for substance abuse or dependency. To be qualified, the physician or psychologist must attend a formal addictions oriented training program provided by U.S. Navy, DoD or other MLC(kma) recognized addiction programs.

26. Outreach and Prevention Specialist (O&P). An active duty Coast Guard member who has Navy Drug and Alcohol Counselor certification (NDAC) and is assigned to the training branch of a DoD alcohol abuse treatment facility (ATF or TRISARF) to develop and provide prevention awareness education to Coast Guard and Naval Personnel.

27. Nicotine Addiction Cessation. The Coast Guard offers a limited number of nicotine cessation programs including community sponsored smoking/chewing tobacco cessation initiatives, as well as providing nicotine patches/chewing gum to assist members who are actively enrolled in one of these programs. Additional information concerning the use of tobacco products is contained in chapter 3 of this Manual.

28. Patient Placement Criteria. Personnel are evaluated for placement in the Continuum of Care, utilizing the following seven dimensions reflecting the severity of the individuals' problem:

    a. acute intoxication and/or withdrawal potential;

    b. biomedical conditions or complications;

    c. emotional and behavioral conditions;

    d. treatment acceptance/resistance;

    e. relapse potential;

    f. recovery environment; and

    g. operational commitments/patient availability to care.

29. Personal Responsibility, Values Education and Training (PREVENT). A U.S. Navy preventive educational program designed to allow participants to recognize potential hazards of substance abuse. Students in the 20-hour course are presented positive methods for personal health and well-being.

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

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

32. SAFE IMPACT Course. An intense, interactive preventive educational program taught by Navy and Coast Guard addictions program personnel designed for first time alcohol incident personnel or for personnel identified as high risk for substance abuse. While this course is not treatment, it is the first educational intervention toward the treatment continuum. This course is recommended for personnel convicted of a DWI offense, who do not meet the criteria for alcohol outpatient/inpatient programs.

33. Substance Abuse. The use of a substance (e.g., alcohol, caffeine, food, prescription or illicit drugs, etc.) by a member, which causes other (performance of duty, health, behavior, family, community) problems or place the member's safety at risk.

34. Substance Abuse Free Environment (SAFE). A prevention based program that provides uniform substance abuse training throughout the Coast Guard. SAFE offers awareness and prevention training at all levels over the course of a person's career. G-WKW-1 maintains and updates the SAFE program.

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

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

37. TRISARF. A U.S. Army alcohol rehabilitation facility located within the Tripler Army Medical Center in Honolulu, HI offers full alcohol rehabilitation services.

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

D. PROGRAM RESPONSIBILITIES.

1. Commandant (G-WKW-1) Responsible for the medical, training, and education policy aspects of the Addictions program. A CWO billet serves as the Addictions Program Administrator (APA) and liaison to the Department of Defense and other agencies. Specific duties of the APA include:

a. coordinating with Commander Coast Guard Personnel Command (opm) and/or (epm) and both MLC's (kma) to provide staffing for Coast Guard Drug and Alcohol Abuse Counselor billets in Navy alcohol treatment facilities, TRISARF, APRs, and APSs;

b. providing medical guidance in the development of alcohol training and education curricula for Coast Guard personnel;

c. ensuring that health care providers working in direct care, managerial, or supervisory roles over addictions program personnel have additional training in substance abuse related conditions;

d. develop, establish, maintain, and oversee training and educational requirements for CDAR training with assistance from Commandant (G-WKW-1);

e. supporting the MLC's in developing, establishing, and maintaining training and educational requirements concerning addictions program personnel with assistance from Commandant (G-WTT); and

f. providing oversight and supervision to personnel serving as DACs and O&P specialist.

2. Commanders, Maintenance and Logistics Commands (MLC(kma)). Responsible for coordinating the operation and administration of the Area Addictions program. The APRs shall:

a. develop a network of unit and regional CDARs. Provide CDARs initial training and assist them in the performance of their duties;

b. advise units in their respective area on matters pertaining to the Addictions Program;

c. provide oversight and supervision of full-time APSs, develop a network of unit CDARs and assist them in the performance of their duties;

d. advise commands on the availability of educational, treatment, and rehabilitation resources;

e. process requests for alcohol/drug rehabilitation, provide travel order numbers (TONO) for members requiring either outpatient or inpatient rehabilitation;

f. oversee the aftercare program and maintain a database of information as requested by G-WKH-3.

g. provide liaison with unit commanding officers, other military services, state and federal programs, and local civilian treatment facilities as required.

3. Commanding Officers and Officers in Charge shall:

a. designate a E6 or above (when possible), as CDAR (active duty units only) and provide G-WKW-1 a request for CDAR training with a copy of a designation letter, which will include authority for access to necessary files and records to perform their duties. Units collocated with a Group or ISC may designate the Group/ISCs' CDAR as their representative, when appropriate;

b. ensure the CDARs receive required Coast Guard CDAR training and additional local training to improve their effectiveness;

c. support the CDAR in the performance of assigned duties;

d. monitor and identify possible alcohol-related behavior such as unauthorized absences, tardiness, extended lunches, fights, accidents, or arrests. Commanding officers and OinCs shall ensure their unit CDAR submits the required CDAR Referral and Follow-up Report to the MLC APR;

e. document possible alcohol-related behavior for administrative purposes in accordance with reference (a) to facilitate the process of breaking through the individual's denial of any alcohol/drug problem;

f. take appropriate action in all instances of drunk driving as required by COMDTINST 5100.46 (series); and

g. promote responsible attitudes toward the use of alcoholic beverages, both on and off Coast Guard units, and establish local policies which discourage the use of alcohol during the work day (i.e. lunch). Guidelines for appropriate use of alcoholic beverages may be found in U.S. Coast Guard Regulations, COMDTINST M5000.3 (series), Section 9-2-14.

4. Addictions Prevention Specialist (APS): shall not be assigned CDAR duties so that they may fulfill their primary duties, which include:

   a. conducting and assisting other command CDARs (including Reserve units, when possible) in developing and conducting general alcohol awareness and SAFE awareness training programs;

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

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

      (2) an initial survey or screening test (i.e., SASSI 2 or M.A.S.T) to assist in identifying personnel at who are at risk for substance abuse; and

      (3) a prevention based educational program to reduce risk of future alcohol or other substance misuse for personnel identified as high risk for substance abuse.

5. CDAR shall:

   a. provide information and assistance to the command regarding substance abuse treatment and prevention;

   b. establish unit training plans for alcohol awareness and conduct semiannual training for all hands;

   c. work with unit Wellness Representative (WR) to implement and promote addiction prevention and nicotine cessation programs;

   d. prepare unit instructions concerning substance abuse;

   e. establish liaison with the regional APS, local federal screening/treatment facilities and civilian screening facilities, as appropriate;

f. provide initial screening using the screening form(s) required by the local screening facility for members identified as having possible alcohol related problems;

g. make necessary referrals, including diagnostic screenings by an alcohol screening facility, a physician, or a psychiatrist/licensed clinical psychologist, as appropriate;

h. shall ensure HIV-1 testing is performed prior to members being admitted to a U.S. Navy outpatient or inpatient treatment program;

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

j. assist and provide support for personnel undergoing or returning to duty from treatment;

k. coordinate implementation and monitor the mandatory pre-treatment and aftercare programs with the commanding officer;

l. ensure that health and service record entries and information are up-to-date;

m. submit a CDAR Referral and Follow-up Report, enclosure (3) to MLC APR for all members:

(1) interviewed by the unit CDAR;

(2) referred to an approved screening, prevention, educational or addictions treatment program;

(3) in the aftercare program;

(4) in aftercare being transferred to another unit or discharged.

E. ALCOHOL AWARENESS EDUCATION PROGRAMS.

1. General. Educational training programs will usually be provided by APSs, Wellness Coordinators, CDARs and available local community alcohol awareness resources. This awareness training is available to active duty, reservists, retirees, civilian employees, auxiliarists and family members. Presenting the information outlined in the following sub-paragraphs will aid in standardizing the alcohol awareness education programs throughout the Coast Guard.

2. Initial Orientation.

a. Cadets, officer candidates, and direct commission officers will be given orientation briefings by APSs on the Addictions Program and current policies.

b. All recruits will be briefed by MLC APSs, within seven weeks of reporting for training, concerning the Coast Guard policy on alcohol abuse and the availability of medical treatment.

c. All members will receive instructions in the following topics as part of their S.A.F.E. training:

(1) Awareness of the extent of substance abuse, its costs, and its effects on the Coast Guard, the member, and the member's family;

(2) Psychological and physiological effects of alcohol;

(3) Decision-making skills for alcohol use;

(4) Coast Guard policy on alcohol misuse; and

(5) Additional sources of information and guidance including:

(a) chaplains;

(b) Command Enlisted Advisors;

(c) Human relations offices;

(d) Medical personnel;

(e) Legal personnel;

(f) Family Advocacy Representatives;

(g) Family Program Administrators;

(h) District social workers;

(i) Alcoholics Anonymous (A.A.);

(j) Al-Anon;

(k) Ala-Teen, and;

(l) Other MLC (kma) approved support groups.

3. Senior Leadership Training Courses. APSs will provide leadership schools (i.e., CO/XO, OinC and CPOA) formal training to include, but not limited to the following areas:

a. Review of alcohol policies and procedures relating to the proper referral and assistance of members with alcohol or drug related abuse or dependency issues;

b. Setting appropriate atmosphere and policies which promote the responsible use of alcohol both onboard Coast Guard units and while on liberty;

c. Early signs of alcohol and drug abuse observable in the work place;

d. Documentation techniques and requirements; and

e. Role of the CDAR in the command's addictions program and the need for command support.

4. Substance Abuse Free Environment (SAFE). The goal of SAFE is to provide a uniform substance abuse training curriculum throughout the Coast Guard and to offer training at all levels over the course of a person's career. SAFE education conducted at active duty units should include auxiliarists, reservists, and civilian employees when possible. The safe program is presented in four training levels:

a. SAFE for Managers. This training will consist of a 2-hour session for personnel 0-5 and above (CO's, XO's, division officers), senior enlisted management positions (such as OinC's and CEA's) and civilian equivalents. Managers will focus on evaluation and assessment of their unit's addictions program. Training at this level will be required once during the manager's career.

b. SAFE for Supervisors. This training will consist of a 4-hour session for personnel E-6 through 0-4, and will include civilian equivalents and E-5s who serve in a supervisory capacity. Supervisors will cover various subjects including Coast Guard policies, identifying signs and symptoms of substance abuse, treatment levels and resources, referral procedures, and monitoring during aftercare. This training is designed to enhance the supervisor's ability to identify and deal with substance abuse problems in the workplace, and will be required once during the course of a career.

c. SAFE Awareness. This training will consist of a 2-hour session for personnel E-2 through E-5 and will provide a basic awareness of Coast Guard Addictions Program policies. Subjects covered will include signs and consequences of alcohol abuse, explanation of the term "alcohol incident" and how it can affect a member's career, and available treatment resources. Training at this level will be required once during the member's career.

d. SAFE Impact Training and Education. This training will normally target self-referrals and members charged with an alcohol incident, who do not meet the criteria for Alcohol Abuse (DSM code 305.0) or Alcohol Dependence (DSM code 303.9).

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

   a. alcohol abuse and its effect on members and their families;

   b. the identification of signs of alcohol abuse;

   c. Coast Guard policy on personnel having alcohol problems and individuals responsibilities; and

   d. alcohol treatment programs available to Coast Guard members.

6. Training Records. Unit and member training records should reflect alcohol awareness and/or supervisor training conducted at each unit documenting participants, subject of instruction, and date.

F. LEVELS OF TREATMENT: Continuum of Care Model.

1. Education. The first intervention level towards treatment in the Continuum of Care model is education. All personnel shall be familiar with Coast Guard policy regarding alcohol/drug use, abuse, and dependency. Any member involved in an alcohol incident or situation where treatment is not recommended should attend an alcohol awareness education program such as the 20-hour Navy PREVENT or Coast Guard SAFE Alcohol-IMPACT course, or a similar

community-sponsored program. Such programs normally require only local travel and charge minimal (or no) fees.

2. Outpatient Rehabilitation. Personnel recommended for outpatient treatment due to a diagnosis of alcohol abuse will normally be referred to outpatient care at a Navy CAAC or ATF. All U. S. Navy CAACs and ATFs are supervised by and work for their regional Navy medical treatment facility. Each facility follows a treatment model from the Continuum of Care. Treatment lengths vary depending on the individuals degree of need. Members returning to there commands may require local outpatient care, as determined by the treatment facility and the MLC(kma). The MLC APR must approve all requests prior to member's start of treatment.

    a. Pretreatment. Some members receiving a diagnosis of alcohol abuse may also require a pretreatment program when recommended by the screening facility. In these cases, the command shall immediately place the individual awaiting treatment into a pretreatment program to include: regular meetings with the CDAR or recovering member for support; Abstinence from consuming alcoholic beverages; and attendance twice a week to twelve step meetings (i.e., Alcoholics Anonymous (A.A.), Al-Anon, Adult Children of Alcoholics (ACOA), or other MLC approved support groups, etc.) if unit operations permit.

3. Intensive Outpatient/Partial Hospitalization Services (IOP). Personnel diagnosed as an alcohol abuser or alcohol dependent (DSM codes 305.0 and 303.9) and requiring a greater level of care than that provided at outpatient treatment will normally be referred to a more intensive outpatient/partial hospitalization program at a Navy ATF. IOP consists of daily classroom and counseling sessions on an outpatient basis. Members who are TAD will normally be berthed at the BEQ/BOQ nearest the MTF. The length of treatment will vary, depending on the individuals degree of need. The MLC APR must approve all requests prior to member's start of treatment.

    a. Pretreatment. Some members receiving a diagnosis of alcohol abuse may also require a pretreatment program when recommended by the screening facility. In these cases, the command shall immediately place the individual awaiting treatment into a pretreatment program to include: regular meetings with the CDAR or recovering member for support; Abstinence from consuming alcoholic beverages; and attendance twice a week to twelve step meetings (i.e., Alcoholics Anonymous (A.A.), Al-Anon, Adult Children of Alcoholics (ACOA), or other MLC approved support groups, etc.) if unit operations permit.

4. Inpatient Rehabilitation. Active duty Coast Guard personnel diagnosed as alcohol dependent (DSM code 303.9) will be primarily referred to ATF or equivalent treatment facilities when the member requires monitoring to abstain from the use of alcohol or other substances. Inpatient rehabilitation is an intensive residential treatment program that provides treatment and berthing on site. Treatment lengths will vary. Members are evaluated on a weekly basis, and referred on to the IOP or outpatient program as appropriate. The MLC APR must approve all requests prior to member's start of treatment. Alcohol dependent members who

have other primary diagnosis which would undermine or interfere with their treatment for alcoholism may require a referral to an ATF which has additional on-site treatment facilities.

a. Pretreatment. If a member is diagnosed as alcohol dependent, the command shall immediately place the individual on a pretreatment program. This will include: detoxification, if needed; meetings with the CDAR or other recovering unit members for support; and attendance at Alcoholics Anonymous (A.A.) meetings or other MLC approved support groups at least twice weekly if unit operations permit.

5. Aftercare. The aftercare program is an essential part of the rehabilitation process for alcohol dependent members returning from inpatient or outpatient treatment. The aftercare program provides follow-up to support and maintain a member's recovery. Details of the aftercare procedures are listed in section J of this chapter.

6. Emergency Care. In a genuine alcohol emergency, admit the member into detoxification (normally 3 to 7 days) at the nearest United States Military Treatment Facility (USMTF) or local civilian hospital (as in any other medical emergency).

7. Inactive Duty Reservists. Except for emergency care as defined in COMDINST M6000.1C, Coast Guard Medical Manual inactive duty reservists are generally not entitled to rehabilitation treatment at government expense. Reserve alcohol treatment policies are addressed in reference (b).

G. PROCEDURES.

1. CDAR Referral and Follow-up Reports. Anytime a member is referred to the unit CDAR, the CDAR shall fill out the appropriate section of the CDAR Referral and Follow-up Report enclosure (3), and submit the completed report to their respective MLC(kma). This report is required each time a member is interviewed, screened, attends a treatment program, or is seen by the CDAR for their quarterly aftercare follow-up.

2. Self-Referral. Members who self-refer shall be screened in accordance with paragraph 8 of this section. A member who is determined to require treatment for substance abuse or dependency shall comply with treatment recommendations. Self referral is **not** considered an alcohol incident. However, self-referring members requiring treatment who refuse the recommended treatment will be processed in accordance with paragraph G-3 below.

3. Refusal of Treatment. Members diagnosed as alcohol abusive or alcohol dependent (DSM codes 305.0 or 303.9) who refuse treatment will normally be separated from the Coast Guard in accordance with reference (a).

4. Preexisting Condition. A diagnoses as alcohol dependent or alcohol abuser physically disqualifies individuals who are within 180 days of enlistment. This represents a pre-existing medical condition according to section 3-D, Medical Manual, COMDTINST M6000.1 (series) and the unit commanding officers shall process these members IAW reference (a).

5. Alcohol Incident. When a member is involved in an alcohol incident, the CDAR must be notified as soon as possible.

6. Driving While Intoxicated/Driving Under the Influence(DWI/DUI). Members charged with such offenses shall be referred for alcohol screening since a high correlation exists between these charges and alcohol-related diagnoses. Comply with the requirements of COMDTINST 5100.46 (series), Driving Under the Influence of Intoxicants.

7. Family Violence and Family Advocacy Cases. Members who are involved in family violence cases where alcohol use is suspected will be referred for an alcohol screening. Referrals are required due to the high correlation of alcohol misuse in family violence cases. CDARs will report any suspected family abuse (verbal or physical) to the local Family Advocacy Representative.

8. Alcohol Screening. The CDAR shall schedule a screening at the local CAAC, USMTF, or other appropriate screening facility following an alcohol incident or in cases where alcohol abuse is suspected and ensure completion of the facilities required forms. Because physicians or psychologists are not assigned at all screening facilities, separate referral to a USMTF or contract physician/psychologist may be required for an alcohol dependence diagnosis.

   a. The member must report to the screening facility in the uniform of the day and have in hand their:

      (1) Personal Data Record (PDR);

      (2) Health record;

      (3) completed prescreening questionnaire as required by the screening facility; and

      (4) a complete supervisor's evaluation.

   b. The command shall review the written evaluation and treatment recommendation provided by the screening facility. When recommended, the command shall request treatment in accordance with this section.

   c. Unit commanding officers are strongly encouraged to refer any member for alcohol screening when alcohol misuse is suspected; an alcohol incident is not required before this referral is made. Unit commanding officers are encouraged to refer their personnel to assist them address a potential alcohol problem early on.

9. Alcohol Rehabilitation Treatment Requests.

   a. Outpatient Treatment, IOP, and Inpatient Rehabilitation Treatment. The command must submit a Treatment Request form (enclosure 4) by mail, message, or facsimile(FAX) for authorization of treatment. These requests must include:

      (1) an alcohol/drug abuse or alcohol/drug dependency determination by a Navy CAAC or equivalent screening facility;

(2) a medical diagnosis by a physician or licensed clinical psychologist based on DSM criteria and a brief explanation of the diagnosis, including any secondary diagnosis;

(3) a copy of an SF-600 indicating that an HIV-1 screening was performed. The confidentiality of the patients who test positive for HIV-1 is to be respected and safeguarded; and

(4) pertinent information from supporting documents such as Page 7 entries, marks for the last three years, evaluations by the CAAC, a qualified physician, licensed clinical psychologist, and supervisor, and health record entries.

b. Civilian facilities. In some isolated cases as determined by the MLC APR, use of civilian facilities may be appropriate. Pre-authorization must be obtained from MLC(kma) for this nonfederal medical care.

10. Coast Guard Medical Officers. Coast Guard Medical Officers are encouraged within their capabilities, to provide alcohol screenings. Each clinic shall designate a Medical Officer to attend a professional development training program to ensure they are qualified in diagnosing alcohol/drug abuse & dependency. The U. S. Navy Addictions Orientation for Health Care Providers (AOHCP) course is the preferred course to meet this requirement. This course is available at most Navy Alcohol Treatment Facilities (ATFs) and funded by COMDT (G-WKH-3). A training module, *On Alcoholism and Alcohol Abuse*, is also provided as a part of the Professional Proficiency Review Program.

H. AUTHORIZATION FOR TREATMENT.

1. Pre-authorization.

a. Before a member can start outpatient, IOP, or inpatient alcohol rehabilitation, a written authorization must be obtained from the appropriate MLC APR. The APR will evaluate all requests for alcohol rehabilitation treatment and issue written authorization with funding data for the appropriate care. Pending such authorization, the command must place the member in a pretreatment program (section F-4 of this chapter), and document by Page 7 entry (letter for officers) outlining the nature of the program, in writing, with acknowledgment by the member.

2. Length of Program.

a. The length of the member's rehabilitation treatment program will be determined by the CAAC or ATF once the member is accepted into a treatment program. MLC(kma) will solicit input from the member's commanding officer as the member nears completion of the treatment process. If the member returns to their unit in an outpatient status, the command must verify the member's compliance with all treatment aspects of the outpatient program (attendance at A.A. meetings and required counseling sessions) until the member completes the recommended program.

I. FUNDING FOR TREATMENT.

1. Education. Awareness training shall be funded by the member's command. This will normally involve only local travel and little or no course fee.

2. Outpatient.

   a. Outpatient treatment shall normally be accomplished at a Navy Counseling & Assistance Center (CAAC) or an Alcohol Treatment Facility (ATF). The costs of treatment at CAACs & ATFs is borne by the Navy under a Memorandum of Understanding. Any other source of treatment is subject to costly standard reimbursement rates. Exceptions will be made only for compelling reasons. Submit justification for exemptions to the appropriate MLC(kma).

      (1) Travel to and from outpatient treatment is funded by Commander MLC(kma). Submit TONO requests to the MLC(kma) in accordance with section G. Travel via privately owned vehicle to outpatient rehabilitation may be authorized by MLC. Forward copies of the member's liquidated travel claim to Commander MLC(kma) APR.

   b. Intensive Outpatient/Partial Hospitalization Services.

      (1) Inpatient/Outpatient & Inpatient residential treatment shall normally be accomplished at a Navy Alcohol Treatment Facility (ATF) approved by the MLC(kma). Any other source of treatment is subject to costly standard reimbursement rates. Exceptions will be made only for compelling reasons. Submit justification for exceptions to the appropriate MLC(kma).

      (2) Travel to and from inpatient ATFs is funded by Commander MLC(kma). Submit TONO requests to the MLC(kma) in accordance with section G. Travel via privately owned vehicle to inpatient rehabilitation is not recommended, but may be authorized by MLC. Forward copies of the member's liquidated travel claim to Commander MLC(kma) APR.

3. Treatment Involving Family Members.

   a. Outpatient or inpatient treatment of active duty members at a military treatment facility may involve non-active duty family members at the discretion of the treatment facility.

   b. Outpatient or inpatient treatment of active duty members at civilian facilities may involve non-active duty family members only if:

      (1) the facility allows family participation as part of the member's treatment without additional cost to the Coast Guard for their participation; or

      (2) the active duty member assumes responsibility for the additional cost for nonactive duty family member's participation.

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

J. AFTERCARE PROCEDURES.

1. Aftercare Plan. The CAAC or ATF staff shall provide a written aftercare plan during the terminal phase of the outpatient & inpatient rehabilitation program for members diagnosed as alcohol dependent. This will aid in the member's continuing recovery following completion of the formal counseling/rehabilitation program. Aftercare plans must be documented in the health record as per section K of this chapter, and in the service record per reference (a). Each command is responsible for implementing, documenting, and actively supporting aftercare programs. There may be some circumstances where operational commitments may force the unit commander to modify the implementation of the aftercare plan. This plan shall be individually tailored to the member's needs and must include, but is not limited to:

   a. abstinence from alcohol (per reference (a)). This is a legal administrative requirement for alcohol dependent members who desire continued service;

   b. contact with the CDAR on a weekly basis for 12 months;

   c. participation in Alcoholics Anonymous or a MLC (kma) approved support group, at least twice weekly (which may be increased, if required) for 12 months if operations permit. Al-Anon, Al-Ateen, and other MLC (kma) approved support groups are also recommended for family members to aid the member and the family in recovery from the effects of alcoholism;

   d. voluntary supervised disulfiram (Antabuse) therapy when prescribed by a physician.

2. Aftercare Report Status. Personnel who successfully complete the treatment phase of alcohol rehabilitation shall remain in an aftercare report status for twelve months if no further alcohol incidents occur.

3. Aftercare Reports. During recovery, the member, the CDAR, and the commanding officer (or representative) shall meet with the member quarterly to evaluate their progress during the twelve month aftercare period.

   a. Initial Report. Upon the member's return to the unit, the commanding officer shall forward a copy of the narrative summary of the rehabilitative treatment, the aftercare plan, and the initial aftercare report, enclosure (3), to MLC(kma) **ATTN: Addictions Program Representative Eyes Only**. A copy of the narrative summary should also be placed in the member's Health Record.

   b. Follow-up Reports. The command shall submit aftercare follow-up reports, enclosure (3) to MLC(kma) at 3, 6, 9, 12 months following completion of a rehabilitation program.

4. Rehabilitation Failure. A rehabilitation failure has occurred when a member does not complete an alcohol rehabilitation program or aftercare plan due to noncompliance, or has an alcohol incident during a rehabilitation or aftercare program. The member will normally be processed for separation in accordance with reference (a).

5. Second Aftercare Plan. Members with a confirmed diagnosis of alcohol dependence (a diagnosis made at a treatment facility and contained on the narrative summary prepared upon the member's discharge from the treatment facility) must abstain from alcohol use in order to maintain sobriety. When commanding officers/officers in charge observe that a recovering alcoholic (subsequent to successful completion of an aftercare program) is again consuming alcohol, the member will be referred to the CDAR and medical officer/physician for evaluation. The purpose of this evaluation is to reinstitute an aftercare program should it be confirmed that the member has relapsed. If relapse has occurred, an aftercare program will be reinstituted for a minimum of six (6) months. This program will be documented in both the member's service record (per reference (a)) and health record. An initial aftercare report and follow-up aftercare reports will be submitted every three (3) months as above, with the notation "Second Aftercare" in the upper right corner.

6. Outpatient Support Plan. Members who successfully complete an outpatient alcohol abuse treatment program **who are not diagnosed as alcohol dependent** are considered to have completed the necessary requirements for alcohol abuse treatment. Upon completing the following limited support program, the member should be able to use alcohol in a responsible and abuse-free manner (after the initial 90 days post-treatment). To assist these members in integrating the new skills acquired in treatment, their support plan should include:

   a. abstain from using alcoholic beverages for the first 90 days;

   b. meet with the CDAR on a weekly basis for 90 days;

   c. participate in a twelve step support program at least twice weekly, if operations permit, for 90 days.

K. RECORDS.

1. Use of Information. All correspondence and medical/service record entries regarding alcohol problems are, '**For Official Use Only**,' and will be marked as such. Medical and command personnel will take necessary steps to ensure that this information is not disclosed except within the Coast Guard, or between the Coast Guard and the other Armed Forces or those components of the Veterans Administration furnishing health care to veterans. See 42 CFR Part 2 for additional information.

2. Documentation.

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

      (1) Results/recommendations from alcohol screening for alcohol-related problems, the reason for referral, physician and facility evaluating the member, and diagnosis concerning alcohol dependence;

(2) Details of pretreatment program or intervention prior to discharge from the Coast Guard;

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

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

(5) Referral for reevaluation, revision of treatment or aftercare plan, or institution of a second aftercare plan; and

(6) A SF 600 entry when rehabilitation failure occurs.

b. Service Record entries will be made in accordance with reference (a).

3. Record Keeping.

a. Case files including, but not limited to medical diagnostic records and treatment summaries, or personnel action requests, will not be kept by APSs and CDARs on members in regards to alcohol-related problems. All medical and personnel documents will be filed in the appropriate record.

b. MLC APRs will maintain a tickler file system on all members for whom alcohol rehabilitation (inpatient and outpatient) has been requested. Store the information on file cards (3 by 5 inches) in locked filing cabinets and/or a computer data base protected by password with access limited to the APRs. This record may include identifying data (name, social security number, rate/rank, length of service, prior service, permanent duty status, sex, marital status), alcohol abuse history, type, location and dates of medical screening and alcohol rehabilitation treatment, particulars of aftercare plans, tracking of aftercare reports and final disposition.

c. CDARs may maintain a client list and a chronological file of message/rapid draft letter treatment requests. A chronological tickler file (appointment schedule) may be used to monitor a member's progress through the various phases of alcohol abuse treatment. Copies of medical and personnel record documents will not be maintained.

L. TRAINING FOR ADDICTIONS PROGRAM PERSONNEL.

1. Skills Required.

a. The MLC APRs are assigned to provide support and program guidance for their area. Management skills, record keeping, and an understanding of treatment resources are essential. Counseling skills are not needed. Program administrators shall not be designated as CDARs.

b. The APSs are tasked with education, area CDAR support, and aftercare program support. These duties require a knowledge of program administration, alcoholism, family systems, treatment, and recovery issues. APSs **shall not** be designated as CDARs to ensure they met their primary duties listed above.

c. CDARs are primarily a first level resource for commands. Some knowledge of alcoholism, administrative procedures, and aftercare support is necessary. Since initial referral does not involve therapeutic treatment, counseling training is not necessary.

d. Drug and Alcohol Counselors (DACs) are primary treatment counselors who are assigned to Navy and Army alcohol treatment facilities. Specific training in alcoholism therapy and counseling, a period of internship, and certification are required.

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

   a. Commandant (G-WTT) will fund prerequisite and recurrent training through annual funding. Quota allotments are then provided to Commandant (G-WKW-1). Requests for training, using Short Term Training Request (CG-5223), will be forwarded to Commandant (G-WKW-1).

   b. Unit funds will be utilized for elective seminars and training.

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

   a. MLC APR and APS training requirements.

      (1) Navy Addictions Orientation for Health Care Providers (AOHCP) or the CDAR course within six months of assuming duties;

      (2) Additional annual or recurrent training through other agencies and civilian programs, selecting courses specific to program management.

   b. DAC training requirements.

      (1) Navy Drug and Alcohol Counselor School prior to assignment to Navy treatment facility;
      Note: Coast Guard personnel who have received this or similar alcohol counselor training, are prohibited from acting as alcohol counselors unless assigned to a treatment facility as a DAC or have professional preceptor oversight by a certified treatment/screening facility.

(2) Additional annual or recurrent training through other agencies and civilian programs, selecting courses specific to program management.

c. CDAR. All CDARs will be required to attend the Coast Guard CDAR Course or similar training as training quotas become available. A special enlisted qualification code will be assigned to all persons receiving the CDAR assignment and the training outlined in the Enlisted Qualification Codes Manual, (COMDTINST M1414.9 (series)). CDARs of smaller units may request this training (on a space-available basis) or similar orientation from MLC(kma).

(1) Additional training will be provided for CDARs to include initial introduction to CDAR duties and ongoing training in treatment and policy revisions.

d. Additional Skills may be obtained through the sources listed below.

(1) The Instructor Training School, Training Center, Petaluma, CA. Apply through the unit training officer.

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

(3) Personal Responsibility and Values Education and Training (PREVENT) courses are available to Coast Guard members. MLC APRs, APSs, and CDARs are encouraged to attend these and the associated facilitator courses.

(4) Senior Petty Officer Leadership Management School (SPOLAM). Submit short term training requests to Commandant (G-PRF).

(5) Army, Navy, and Air Force correspondence courses.

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

CHAPTER 3. TOBACCO USE POLICY

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

B. DISCUSSION. The Coast Guard Health Promotion Program discourages the use of all tobacco products. The Surgeon General of the United States has determined that tobacco use is the single most preventable cause of illness, disability, and death in the U.S. Additionally, tobacco use (smoking and smokeless) detracts from a sharp military appearance when in view of the general public.

1. Readiness. Tobacco use (smoking and smokeless) impairs readiness by impairing physical fitness and increasing absenteeism, premature deaths, and health care costs. Controlling the use of tobacco products will enhance readiness and organizational efficiency by maximizing human resources.

2. Second-Hand Smoke. Environmental tobacco smoke (ETS), a combination of the smoke from a burning cigarette and the smoke exhaled by the smoker is a proven human carcinogen, containing over 4000 chemicals, at least 40 of which have been shown to cause cancer. Simple separation of smokers and non-smokers within the same airspace may reduce, but does not eliminate ETS exposure.

3. In the Home. Although ETS is harmful to all individuals, it poses greater health risks for infants, children, and the elderly and infirmed. It has also been shown to be especially harmful to the unborn fetus. ETS has been linked to decreased lung efficiency and function, increased frequency of SIDS and increased frequency and severity of childhood asthma, aggravation of sinusitis, rhinitis, cystic fibrosis, chronic respiratory problems such as cough and postnasal drip, increased incidence of colds and sore throats, and increased frequency and duration of ear infections in children. In children under the age of two, ETS exposure enhances the likelihood of bronchitis and pneumonia.

Smoking during pregnancy and exposure to second hand smoke have been associated with miscarriage, stillbirth, premature birth, low birth weight, and health problems associated with low birth weight, and a higher incidence of crib death. Children of mothers who smoked during and after pregnancy are more likely to suffer behavioral problems such as hyperactivity. Modest impairment in school performance has also been documented. Children of smokers are much more likely to become smokers themselves. Over 1,000,000 young people start smoking each year.

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

C. POLICY. It is the Commandant's policy to both discourage the use of all forms of tobacco products and to protect nonusers from exposure to ETS and unsanitary conditions created by the use of spit tobacco. Where conflicts arise between the rights of non-tobacco users and tobacco users, the rights of the non-tobacco user shall prevail. Failure to comply with this policy may lead to administrative action.

1. Workplace:

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

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

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

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

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

f. A section of the weather deck on afloat units may be designated as a tobacco use area (smoking and smokeless). In the event that weather conditions or operational requirements do not make the space available, an indoor space may be assigned provided the designated space vents directly to the external atmosphere. The safety officer/engineer will assist the command in determining the space aboard a ship that does not re-circulate tobacco odors/smoke. The following spaces will not be

designated tobacco use areas (smoking and smokeless) even if they meet ventilation requirements: work spaces, watch stations, berthing areas, lounges, messing areas, exercise areas, medical spaces, areas where computers and electronic gear/equipment is used or stored, engine rooms' fuel storage section, or any other areas not considered safe. All tobacco use is prohibited during drills, special sea details, mooring stations, and other all-hands evolutions.

g. Tobacco products (smoking and smokeless) may only be used during regularly scheduled breaks available to all crewmembers, which includes breaks during formal training. Tobacco use shall not be encouraged by allowing those who use tobacco breaks from their work schedule in addition to those regularly scheduled.

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

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

j. The expenditure of appropriated funds for structural and nonstructural changes to construct a designated smoking area with separate ventilation to the outside is not encouraged.

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

2. Lodging, dormitories, and housing:

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

b. Tobacco use (smoking and smokeless) is not allowed in Coast Guard owned bachelor living quarters.

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

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

4. Sales of tobacco products:

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

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

c. The sale of tobacco products to anyone under the age of 18 years is prohibited.

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

D. RESPONSIBILITIES.

1. Commanding Officers and Officers in Charge shall:

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

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

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

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

e. Consider non-compliance with the tobacco policy in members' performance evaluations.

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

g. Include the unit Health Promotion Coordinator in the check-in for new members reporting to the unit.

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

a. Maintain a supply of educational material on the risks of tobacco use and also on cessation programs.

b. Provide information on tobacco use cessation programs to all active duty members, eligible beneficiaries, attached commands, and independent units within AOR.

c. Have medical and dental providers inquire about the member's tobacco use history during medical and dental examinations. Furnish pertinent professional advice to every tobacco user using the guidelines in the Smoking Cessation Clinical Practice Guidelines (AHCPR pub 96-0692) published by the U.S. Department of Health and Human Services.

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

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

f. In conjunction with Regional Health Promotion Managers, determine acceptable tobacco cessation programs incorporating cognitive and behavioral change strategies on the use of nicotine replacement therapy when appropriate. Establish monitoring requirements for conducting these cessation programs to obtain authorized prescriptions of cessation aids as approved by the Office of Health and Safety.

3. Regional Health Promotion Managers shall:

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

b. Provide awareness training on detrimental effects of tobacco use and assist units establishing tobacco awareness training.

c. Assist units obtaining resources and/or conducting quality tobacco cessation programs or arrange counseling on tobacco cessation to local command and units in AOR.

d. In conjunction with Coast Guard Clinic Staff and Unit Health Services Technicians, determine acceptable tobacco cessation programs incorporating cognitive and behavioral change strategies on the use of nicotine replacement therapy when appropriate. Establish monitoring requirements for conducting these cessation programs to obtain authorized prescriptions of cessation aids as approved by the Office of Health and Safety.

e. Evaluate the effectiveness of tobacco use cessation programs through follow up surveys administered to participants six months and twelve months after tobacco use has stopped.

4. Unit Health Promotion Coordinators shall:

a. Assist the command enforcing this policy.

b. Maintain supplies of tobacco use educational material and a resource list for services and materials.

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

d. Assist the Regional Health Promotion Manager in evaluating the effectiveness of tobacco use cessation programs conducting follow up surveys.

e. Brief members reporting in to unit on this policy and resources available for cessation.

CHAPTER 4. PHYSICAL FITNESS PROGRAM

A. INTRODUCTION. Coast Guard personnel have a duty and an obligation to be ready to respond to situations affecting public safety and/or national security. Such situations vary infinitely. A healthier and more fit member has a greater chance of successfully responding to any emergency or routine task.

1. PURPOSE. This chapter contains the elements necessary to assess the physical ability of, and establish a physical fitness program for Coast Guard members (active duty, reservists, auxiliarists, and civilians) and beneficiaries.

   a. Highly Encouraged. This Chapter sets no requirements but includes highly encouraged recommendations for physical fitness. Mandatory physical fitness policy is outlined in Chapter 1, section G.3 and requires many units to provide members time for voluntary physical fitness when operations permit.

2. BACKGROUND.

   a. One of the cornerstones of wellness is the concept of self-responsibility. Each individual, rather than the medical community, is ultimately responsible for their own health and well-being. Individual participation in physical fitness activities is strictly voluntary. This servicewide program is designed to facilitate and encourage greater participation by Coast Guard personnel in medically sound fitness activities.

   b. In 1990, following a three-year national study involving thousands of health professionals, the U.S. Public Health Service published a set of national health promotion and disease prevention objectives. This report, named *Healthy People 2000*, recognizes the need for people to develop healthier habits to improve their quality of life. The top health promotion priority according to *Healthy People 2000* is, "physical activity and fitness," because of its profound effect on overall health and the other wellness aspects. Physical fitness levels in the U.S. are declining. Research shows that less fit people die more frequently from all causes. Lack of activity is now recognized as a major risk factor for heart disease, equal in importance to cigarette smoking, high blood pressure and elevated blood cholesterol. More people are at risk for heart disease due to physical inactivity than due to any other single risk factor. Inactivity also increases the risk of obesity, hypertension, diabetes, osteoporosis, and depression. Being physically fit improves physical and mental health, stamina, productivity, appearance, self-esteem and overall quality of life.

   c. Physiologically, a physically fit person can go from rest to intense activity, can sustain that activity and recover from it much better than an unfit person. In emergency situations, unfit people are risks to themselves and anyone they are working with. A few daily jobs in the Coast Guard are physically demanding and require a high level of physical fitness for mission success. Most are not. To be **Always Ready** for those infrequent emergencies, a regular physical training program is strongly advised for all Coast Guard members.

B. DISCUSSION.

1. Few Americans engage in regular physical activity despite the potential benefits. Fewer than 10% of U.S. adults exercise for 20 minutes or more three or more days per week at an intensity sufficient to improve cardiorespiratory endurance. The encouraging news is; health can be dramatically improved with even less activity than this. Recent research shows that even very mild activity, such as easy walking, gardening, or taking the stairs at work, when done cumulatively for 30 minutes a day on most days, is enough to positively influence important health parameters such as blood pressure, blood cholesterol, triglycerides, blood sugar regulation, and body composition. To become truly fit, you need more intense activity. But even if you choose not to participate in vigorous activities, your body greatly benefits from some movement in the daily routine.

2. There are four components of fitness that must be present to become truly physically fit: (1) **body composition**, (2) **flexibility**, (3) **muscular strength** and **muscular endurance,** and (4) **cardiorespiratory endurance**. Appendix B of this Manual describes in detail what type of activities develop each of the components and how they work together.

3. Physical activity is important for people of any age, and most can start a physical fitness program without any special medical clearance as long as they participate in a program of regular medical examination. However, before you start, take the time to answer the short list of questions in enclosure (5), the Physical Activity Readiness Questionnaire (PARQ). If you answer, **yes**, to any of the questions consult with your physician before beginning an exercise program.

4. Members are strongly encouraged to begin or continue a regular exercise program based on guidelines provided in the *Personalized Aerobics Lifestyle System (PALS)* health risk appraisal feedback booklet. Ask the unit WR or Wellness Coordinator to administer a PALS HRA.

C. RESPONSIBILITIES. This section contains fitness specific responsibilities in addition to those contained in chapter 1, section G of this Manual.

1. Commandant (G-WKW-1) Clinical Medicine & Wellness Programs Division, shall:

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

   b. Establish curriculum and provide instruction and course materials for unit Fitness Leader exportable training;

   c. Track trained Fitness Leaders;

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

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

a. When possible, enroll a qualified (chapter 1-H) MEMBER in the Coast Guard Health and Fitness Leader Course to serve as a fitness advocate and resource for unit personnel and dependents;

b. As operational schedules allow, empower and encourage the unit WR and FL to implement innovative and effective unit physical fitness programming;

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

3. Wellness Representative and/or Fitness Leader are highly encouraged to:

a. Schedule appropriate fitness related activities and events for unit members and beneficiaries;

b. Be innovative and flexible in promoting physical fitness. A few potential tools that can be used include: all-hands training, awards programs, on-duty workout time, mentoring of newly assigned personnel, and physical readiness related remarks in enlisted and officer performance evaluations;

c. Promote the Coast Guard Physical Fitness Award Program located in **appendix A** of this Manual which encourages all personnel and family members to begin a regular exercise program. Participants can earn Physical Fitness Awards by participating in over 68 fitness/sports activities (Coast Guard highly recommended activities are marked with an asterisk);

d. Use **appendix B** when creating an exercise program. This section covers important guidelines and components of a fitness routine.

CHAPTER 5. HEALTH RISK APPRAISALS

A. INTRODUCTION. Commandant (G-WK) has established the need for a major study to quickly and efficiently analyze and assess organizational goals, problems, and activities regarding the overall physical health and wellness of the Coast Guard. This process is established by the use of a periodic health risk appraisal (HRA) program for all Coast Guard members and beneficiaries.

1. PURPOSE. The HRA is a self-administered questionnaire designed to evaluate lifestyle habits and provide suggestions to modify risky behaviors. A physical fitness assessment can also be administered as part of the HRA to evaluate current fitness levels and make recommendations for improvement.

2. BACKGROUND.

a. The HRA will assist Coast Guard members (active, reservists, civilians, and auxiliarists) and beneficiaries in identifying unhealthy patterns by quantifying their current lifestyle on a wellness scale. Additionally, it will assist Coast Guard medical personnel in addressing specific areas of risk for Coast Guard members and beneficiaries. Ultimately, the information gathered will provide a raw data base (e.g., body weight, blood pressure, cholesterol, dietary habits, tobacco use, tobacco cessation, etc.) for measuring the overall health of the Coast Guard and the progress of the Coast Guard's Wellness Program.

b. A variety of organizational benefits are derived from implementation of an HRA program. The HRA will generate the necessary information to impact preventive health issues through an emphasis on modifiable risk factors in individual lifestyles. The data can be compiled into a group format which can then be used to identify and track common risk factors within work groups and the organization as a whole. The HRA is designed to gather data and provide individual feedback in an easy to use and inexpensive format. Individual benefits from personalized feedback on lifestyle habits include recommendations for modification within areas of increased risk.

c. HRAs are intended to be used with individuals who are free from chronic illnesses such as cancer or heart disease. The data collected does not constitute a complete medical history, nor is it a substitute for a medical exam. HRAs do not predict an individual's medical future, chances of death or most likely cause of death; and can not diagnose disease. However, the instrument will provide the individual with an evaluation of the risk associated with their current lifestyle practices.

d. **Appendix B** of this Manual gives short descriptions of the physical fitness tests administered as part of the HRA. The tests measure the four components of health-related fitness including: (1) body composition, (2) flexibility, (3) muscular strength and muscular endurance, and (4) cardiorespiratory endurance.

B. DISCUSSION. An essential element of the valid implementation of an organizational HRA is the adherence to established organizational and industry ethical standards. The HRA selected for use by the Coast Guard meets the following ethical standards:

1. The HRA is based on an established scientific data base. In this instance, the Coast Guard HRA uses the health standards established over twenty years of medical treatment by the Cooper Clinic in Dallas, Texas and converted to HRA use by the Cooper Institute for Aerobic Research in Dallas, Texas.

2. The Coast Guard HRA is appropriate to our population. The HRA developed by the Cooper Institute is designed to service a population ranging in age from 15 to 69. The questionnaire and feedback materials utilize simple terminology and set achievable goals for behavior changes.

3. All information collected by the HRA is confidential. This information will be used in the following limited applications: (1) preparation of individual sealed reports returned to the participant, (2) development of anonymous group reports for organizational needs, and (3) limited research application to improve health care delivery and job site safety. The information **will not** be used for any other administrative or disciplinary purposes. The collected information will be held in a secure, limited access data base at Coast Guard Headquarters under the direct control of the office Chief, Clinical Medicine and Wellness Programs Division.

4. The HRA is designed in an easy to use format for both participant and administrator. Personal feedback takes two forms, qualitative and quantitative. Organizational feedback can be adapted to meet the specific needs of the particular information request. All participant feedback documents should be provided in an environment which provides facilitated feedback either by an HRA administrator or through the use of an approved video feedback tool. HRA administrators will be available in person or by phone, to answer questions which may be generated by the HRA and its reports.

5. The HRA is not considered a substitute for a complete medical exam and does not substitute for or supersede any existing organizational policies for medical examinations. All information collected is treated as medical data and as such is fully confidential. The Wellness Program Manager will develop and administer the training program for all regional administrators of the HRA. Data processing and production of all reports will be conducted by the Wellness Program Manager at Coast Guard Headquarters or a designated processing site. This policy will ensure that all confidentiality aspects of the HRA are maintained. Participants will be required to sign an Informed Consent document.

6. All assessments associated with the HRA will be conducted in a manner that respects the privacy of the information collected.

C. <u>IMPLEMENTATION</u>.

1. The Personalized Aerobics Lifestyle System (PALS) as developed by the Cooper Institute for Aerobics Research is the only HRA authorized for use in the Coast Guard. The PALS HRA is available to Coast Guard members and beneficiaries through their ISC Wellness Coordinators. As implementation of this program progresses, HRA will also be available through Coast Guard health care facilities.

2. All recruits, officer candidates and cadets will complete the HRA at the time of accession (during recruit training, officer candidate school, or swab summer) into the Coast Guard. All other Coast Guard members and beneficiaries may complete an HRA by requesting one through the unit WR. Ultimately, the HRA will beomce part of the physical exam process. Command-wide HRA events may be scheduled through the ISC Wellness Coordinator. WCs will serve as the HRA administrator for their areas of responsibility. All Coast Guard members, employees and beneficiaries are encouraged to complete an HRA on a voluntary and confidential basis.

3. HRA materials will be ordered and distributed through Commandant (G-WKW-1). Completed HRA questionnaires will be forwarded to Coast Guard Headquarters or a specifically designated regional processing site. To maintain confidentiality of the information, all processing will be conducted by Commandant (G-WKW-1) or the designated processing site. Due to the confidential nature of the data being gathered and processed, no other Coast Guard entities are authorized to purchase this or similar software packages for local use. Expanded distribution of the software package will be authorized by Commandant (G-WKW-1) on an as needed basis.

4. Sealed feedback booklets will be returned to the member's command for distribution. Wellness Coordinators or unit WRs may schedule group or individual sessions for review of the feedback material and conduct question and answer sessions. Videos to assist in facilitating these meetings are available from Commandant (G-WKW-1) or the WCs.

5. Any member receiving a feedback booklet which is unsealed or has a broken seal shall report the same to their Wellness Coordinator and Commandant (G-WKW-1) so that these entities can ensure that no breach of confidentiality has occurred.

6. **Appendix D** is the manual for conducting the PALS HRA. This manual contains the guidelines for confidentiality during physical assessments, explanations of the physical assessments, and guidelines for conducting the HRA.

CHAPTER 6. NUTRITION AND WEIGHT MANAGEMENT

A. INTRODUCTION. As a uniformed service, appearance in uniform and fitness for duty are critical elements of mission accomplishment. A key factor in both of these issues is weight management. Current research suggests that the only way to lose or maintain weight is through a combination of healthy eating and physical activity.

1. PURPOSE. The weight loss solutions outlined in this chapter and appendix C helps members meet or exceed the standards set in reference (c) COMDTINST M1020.8 (series), Allowable Weight Standards for the Health and Well-Being of Coast Guard Military Personnel. The personnel administration aspect of the weight program remains with Commandant (G-WP) and those polices and procedures can be found in reference (c).

B. DISCUSSION.

1. Modern society has developed a **diet** mindset. Large portions of the American population are dieting at any given time creating a multibillion dollar industry. However, there is little evidence to suggest that diets alone will result in permanent weight loss or successful weight maintenance. This is largely a result of the diet mentality which holds that if you deprive yourself for a limited period of time to reach a specific goal, you can then go back to your previous eating habits. In most instances, individuals practicing this style of living end up weighing more than when they began the cycle.

2. **Appendix C**, Losing Body Fat the Easy Way, contains guidelines for developing healthy eating habits and learning the art of weight maintenance. Learning and practicing these healthy habits is the key to getting off the diet roller coaster and successfully losing and maintaining your weight.

C. RESPONSIBILITIES.

1. All Health and Fitness Leader class graduates shall, upon request, provide members with information on weight management planning and techniques as described in *The Balancing Act*. Members requiring professional counseling shall be referred to medical for further assistance.

2. Wellness Representatives should develop a list of local sources for weight management and nutritional counseling. Members requesting assistance beyond the scope of the WR's training should be referred to these local information sources (if no cost) or referred to medical. The Employee Assistance Program makes available one form of no cost weight loss counseling.

3. WRs should provide all members indicating a desire to lose or maintain their weight a copy of **appendix C** to assist them in their weight management planning.

4. ISC Wellness Coordinators may provide counseling and training to both members and units upon request by a designated WR.

5. Members exceeding the maximum allowable weight or percent body fat for their age and gender shall be referred to the ISC WC for counseling and assistance in meeting and maintaining their prescribed weight loss goals. All members in this category shall be provided a copy of **appendix C** to this manual in addition to any other materials deemed appropriate by the WC.

6. WCs and unit WRs should coordinate programs and activities with all CGDFs to insure that all members have access to healthy, nutritionally sound food choices on a daily basis. Food Quality Guidelines, located in **chapter 7** of this Manual, provides guidance for improving the nutritional quality of food served in CGDFs.

7. Unit level wellness training plans are highly encouraged to include a minimum of one nutrition or weight management training session quarterly.

CHAPTER 7. MENU AND FOOD QUALITY GUIDELINES

A. INTRODUCTION. Diet and nutrition have significant affects on the health and morale of Coast Guard personnel. Coast Guard dining facilities must provide nutritious meals to support the operational demands of the unit and meet the dietary needs of Coast Guard personnel. In addition, dining facilities should provide nutritional information to their customers to assist them in making informed decisions on their diet and in making beneficial changes to their eating habits.

1. PURPOSE. This chapter makes recommendations to promote health and well-being by improving food quality and nutrition awareness at Coast Guard contracted and food service specialist (FS) staffed dining facilities.

   a. Highly Encouraged: This chapter highly encourages using the recommendations but does not set requirements or act as a checklist for compliance purposes. The guidelines were designed to aid in planning Coast Guard Dining Facility's (CGDF) menus in the **promotion of healthy food choices**.

B. DISCUSSION.

1. Quality food and customer service contribute substantially to the maintenance of high morale, well-being, and a healthy lifestyle of Coast Guard personnel. Keeping that in mind, the food quality guidelines are based on good nutrition principles and focus on the **balancing** of menu items. Using these guidelines will not increase the FS workload. Planning a proper menu which incorporates nutritional adequacy does not necessarily entail increasing the number of menu items.

2. This chapter is not meant to coincide with the menu development requirements listed in the Food Service Practical Handbook, COMDTINST P4061.4 and Armed Forces Recipe Service (AFRS), NAVSUP Publication 7. The following menu planning guidance should continue to be consulted to ensure nutritional and dining facility operating allowance adequacy:

   a. Subsistence Manual, COMDTINST M4061.3 (series);

   b. Food Service Practical Handbook, COMDTINST P4061.4 (series);

   c. Food Service Sanitation Manual, M6240.4 (series);

   d. Armed Forces Recipe Service (AFRS), NAVSUP Publication 7 and Index.

C. DIETARY GUIDELINES FOR AMERICANS.

1. General. These guidelines, developed for healthy Americans by the U. S. Department of Agriculture and the development of the Food Guide Pyramid, are based on what we know today about the relationship of diet to good health. Nutrition initiatives are supported by all aspects of daily planning. It is recommended that menu drafters and interested patrons include the following guidelines and information when preparing the weekly menu:

a. Eat a Variety of Foods. To ensure variety, select foods from the menu from each of the major food groups: fruits and vegetables; breads, cereals, rice and pasta; milk and dairy products such as cheese, yogurt, and low fat cheese; and meats, fish, poultry, eggs, and dry beans and peas. Serve different foods from within these groups, and take advantage of the wide variety of the revised AFRS recipes and foods, especially seafood, poultry, fruits and vegetables when they are available.

b. Maintain Healthy Weight. These guidelines and an appropriate exercise program will contribute to a healthy lifestyle and contribute to ensure Coast Guard members are within the Commandants policy on Allowable Weight Standards (reference c).

c. Choose a Diet Low in Fat, Saturated Fat, and Cholesterol. Reducing dietary fat is an especially good idea for those limiting calories. A diet low in fat makes it easier to include the variety of foods needed for nutrients without exceeding calorie needs. Fat contains over twice the calories of an equal amount of carbohydrates or protein. Eat foods with adequate starch and fiber. Emphasis should be placed on fiber-rich foods such as grain products, vegetables, and mature legumes. A source for dietary information on AFRS food items is the Fat, Cholesterol, and Calorie List for General Messes published by the Naval Supply Systems Command, NAVSUP Publication 580, Stock No. 0530-LP-189-5100. Forward requests to:

Commanding Officer
Naval Publications and Forms Directorate
Naval Aviation Supply Office
Tabor Avenue
Philadelphia, PA 19111-5098

d. Choose a diet with plenty of vegetables, fruits, and grain products. Vegetables, fruits, and grain products (such as bread, cereal, rice, and pasta) are parts of the varied diet suggested in the first guideline. They are emphasized here for their carbohydrate and dietary fiber content.

e. Use sugars in moderation. Sugars and most foods that contain them in large amounts supply calories but are limited in essential nutrients. Thus, they should be used in moderation by most healthy people and sparingly by people with low calorie needs. For very active people with high energy needs, sugars may be a useful source of calories.

f. Use salt and sodium in moderation.

2. Cholesterol.

a. Cholesterol is a fat-like substance found in the body cells of humans and animals. Cholesterol is needed to form hormones, cell membranes, and other body substances. The body is able to make the cholesterol it needs for these functions. Cholesterol is not needed in the diet. Cholesterol is obtained directly from foods of animal origin and present in all animal tissues (meat, poultry, and fish), dairy products, and egg yolks.

Cholesterol is not found in foods of plant origin such as fruits, vegetables, grains, nuts, seeds, dry beans and peas. An important factor in elevating blood cholesterol is the saturated fat in the diet, some of which is converted into cholesterol in the body. Most saturated fat is obtained from foods of animal origin. Reducing the amount of dietary saturated fat is an important means of lowering blood cholesterol.

b. Fatty acids are the basic chemical units in fat. They may be either saturated, monounsaturated, or polyunsaturated. All dietary fats are made up of mixtures of these fatty acid types.

(1) Saturated fatty acids are found in largest proportions in fats of animal origin. These include the fats in milk, cream, cheese, butter, meat, and poultry.

(2) Monounsaturated fatty acids are found in fats of both plant and animal origin. Olive oil and peanut oil are the most common examples of fat with mostly monounsaturated fatty acids. Also, most margarines and hydrogenated vegetable shortenings tend to be high in monounsaturated fatty acids.

(3) Polyunsaturated fatty acids are found in largest proportions in fats of plant origin. Sunflower, corn, soybean, cottonseed, and safflower oils are vegetable fats that usually contain a high proportion of polyunsaturated fatty acids.

Note: All fats, whether they contain mainly saturated fatty acids, monounsaturated fatty acids, or polyunsaturated fatty acids, provide the same number of calories.

D. <u>COAST GUARD FOOD QUALITY GUIDELINES</u>. The keys to planning and serving meals that are lower in fat and cholesterol are based on moderation. The idea is **NOT** to eliminate high-fat, high-cholesterol foods on your menu. Instead, **BALANCE** high-fat foods with other foods that contain LESS fat and cholesterol. CGDFs should provide: whole grain cereals at breakfast; less sugar coated cereals; provide one or more choices of dried fruits, such as dates, raisins, currants, etc. at breakfast; whole grain bread at each meal; fresh or canned fruit at each meal; a citrus fruit juice at each meal; serve fewer frosted cakes, cook with less fat and oil, especially saturated fats; stringent portion control; minimize purchases of pre-packaged cooked meals (e.g., pizza, TV dinners, pot pies; high fat snack items, etc.); and more emphasis on healthy eating alternatives.

1. Menu combinations offered at each meal shall continue to provide variety and contrast in texture, flavor, and color. The Food Guide Pyramid indicates that we should eat a variety of foods, maintain healthy weight, choose a diet with plenty of vegetables, fruit and grains, choose a diet low in fat, saturated fat, and cholesterol, use salt and sodium only in moderation, and to eat sweets sparingly.

2. Performing a food preference customer survey quarterly within the command can identify patron nutritional desires and satisfaction, as well as producing recommendations to improve product quality and increase patronage. Changes may be considered by the unit commanding officer and implemented as appropriate.

3. In order to provide variety and reduce saturated fat, fish and poultry should be integrated throughout the menu cycle.

4. Menus should be evaluated for too many:
   a. deep fat fried items;
   b. sautéed/fried menu items;
   c. sauced and/or gravy items.

5. Evaluate the menu for reduced calorie alternatives to those who choose low fat alternatives.
   a. Provide at least one or two low fat, low calorie salad dressings;
   b. Serve low fat 2% and/or skim milk;
   c. Provide an alternative entree that is not fried;
   d. Provide an entree without a gravy;
   e. Provide a low calorie, acceptable vegetable choice (look at preparation method);
   f. Provide a low calorie dessert choice (fruit, low fat yogurt, sherbert, smaller portions, gelatin, etc.);
   g. Provide an egg entree at breakfast prepared without added fat;
   h. Offer both butter or margarine at each meal.

6. A non-fried entree shall be offered as an alternate choice when a fried entree is featured.

7. Low fat 2% milk will be the primary milk. Whole milk, skim milk, butter milk, and chocolate milk may also be made available as an alternate dairy beverage choice.

8. Menus should be planned, whenever feasible, to include an alternate entree without gravy when the main entree incorporates a gravy.

9. Menus should offer a hot low calorie vegetable prepared without added butter or fat.

10. Avoid having more than one deep fat fried entree daily. (Exceptions are menus that offer multiple entrees).

11. When serving a meat entree high in fat such as sausage, spareribs, corned beef, pastrami or knockwurst, try making the meal healthier by:
    a. finding a low-fat version instead;
    b. creating a lower fat entree as an alternate choice such as roasted meat, fish or poultry; or
    c. ensuring overall low total fat content when including all meal items.

12. Select entrees that can be baked or roasted to the maximum extent possible.

13. Low calorie meals should include all the basic menu components without the high calorie extras.

14. Seasonal fruits and vegetables should be incorporated into the menu to the maximum extent possible in order to provide nutrient dense, lower calorie choices.

15. Avoid serving meals with too many high sodium foods, (e.g., knockwurst and sauerkraut with a vegetable prepared with bacon or sausage). After serving high sodium food such as ham, corned beef or other cured meats, serve a lower sodium food such as fresh meat/fish/poultry at the next meal. Balance high sodium main dishes, with lower sodium side dishes.

16. Avoid reliance on snack foods such as potato chips for the speedline starch choice as the sandwich accompaniment.

17. Include a variety of fresh vegetables on relish trays or salad bars to the maximum extent practicable.

18. Substitute mozzarella, when possible, when recipes call for cheese because mozzarella has only 1% milkfat.

E. FOOD COMBINATIONS, VARIETY, AND INNOVATION.

1. Analyze the menu to see if the meal combinations served are acceptable to most patrons.

2. Evaluate the menu to see if preparation methods are varied in the same meal, same day, throughout the menu cycle. Example, are the potatoes always mashed? Are the components of the menu similar in color?

3. Utilize the menu planning tools listed in the Food Service Practical Handbook, COMDTINST P4061.4 (e.g., Acceptance Factors, Food Preference Ratings, Meal Attendance Predictions, Frequency Charts, Food Usage Record, and the Cycle Menu Planning System).

4. Make effective use of the AFRS, NAVSUP Publication 7 or locally approved and recorded recipes for all food preparation.

5. Texture. Avoid a meal containing all fried items or all mushy items.

6. Avoid too many similar flavors in the same meal. For example, corn should not be scheduled with a meal containing cornbread or cornbread dressing; or sweet potatoes with pumpkin or sweet potato pie.

7. Prepare food as close to serving as possible.

8. Avoid using bacon fat.

9. Excess fat shall be trimmed or skimmed from all foods.

10. Use accurate deep fat frying temperatures to prevent excessive fat absorption.

F. MENU PATTERNS.

1. Breakfast Meals. Breakfast meal patterns shall include, but not limited to, the following:

   Fresh fruit, citrus, if available
   Fruit juice, citrus
   Cereal, cooked or dry whole grain cereal with dried fruit
   Main entree: Eggs to order, breakfast meat, griddle cakes or French toast
   Potato or Potato substitute
   Bread, muffin, or bagel, jam, jelly, and spreads
   Beverages
   Condiments

2. Menu Items for Breakfast.

   a. Fruit and Juice. A choice of orange juice, another juice, and fresh fruit (if available, if not, canned) shall be offered daily. A good source of Vitamin C, such as citrus and/or juice should be served each breakfast. Some good sources of vitamin C include orange juice; oranges; grapefruit; grapefruit juice; tangerines; cantaloupe; cranberry juice; strawberries; tomato juice.

   b. Cereal. At least two different types of dry ready-to-eat cereals shall be offered. At least one selection shall be whole grain. One cooked cereal shall be offered.

   c. Dried Fruits. At least one offering of raisins, dates, currants, figs, apricots, etc., shall be offered as cereal toppings for cereals, cooked or uncooked.

   d. Eggs. No more than the portion size listed in the AFRS shall be offered to each patron for each meal daily.

   e. Breakfast Meats. No more than the portion size listed in the AFRS shall be offered to each patron for breakfast daily.

   f. Griddlecakes, French toast and/or waffles shall be offered daily.

   g. Potato and/or substitute, such as hominy or grits, shall be offered.

   h. Bread and Pastry. A whole grain and a white bread shall be offered daily. English muffins and/or bagels should be offered at least three times per week. Muffins, doughnuts, breakfast pastry, coffee cake, and/or popovers may also be offered.

   i. Condiments. Butter and margarine shall be offered. Syrup, a choice of at least two or more spreads (jam, jelly, peanut butter, etc.) shall be offered.

   j. Low fat milk, coffee, and tea shall be offered. Decaffeinated coffee and tea may be made available upon patron request.

3. Lunch and Supper. Lunch and supper meal patterns shall include the following:

   Soup

Meat entree
Sauce or gravy
Starches
Cooked Vegetable(s)
Salads
Breads/Butter-Margarine
Dessert(s)
Beverages
Condiments

4. Menu Items for Lunch and Supper.

   a. Soup and/or substitute. At least one soup, stew, chili, or substitute, without added fat, should be included at lunch and/or supper. During cold weather it is recommended one be provided for lunch, supper, brunch, and midnight rations (MIDRATES).

   b. Meat entree. If only one meat entree is provided, either lunch or supper should include a non-meat addition to the menu such as seasoned steamed legumes, peas, eggplant, or other vegetable dishes that are high in protein and easy to prepare.

   c. Sauce or gravy. When offered as an appropriate addition to the menu; gravies, sauces, or garnishes should accompany the entree(s) and/or vegetables as a side dish, to be made available upon patron request.

   d. Starches. Serve at least one course of potatoes, rice, pasta, or other tuberous vegetable. If the recipe does not specify adding fat or butter, allow the patron the choice of additional fat.

   e. Vegetables. Two different vegetables are recommend for both lunch and supper and cooked with no extra fat or meat added.

   f. Salads. A salad selection of at least one vegetable and one fruit salad should be offered at lunch and supper. Salad selection should provide eye appeal and an assortment of fresh vegetables, if available. A salad bar should have a variety of prepared vegetables for patrons to enjoy. A fruit salad should include a variety of fresh fruits, if available. If unavailable, canned fruit should be provided.

   g. Breads/butter-margarine. Whole grain and a white bread shall be offered daily. Dinner rolls and/or muffins or biscuits, cornbread, and crackers shall be offered at least three times per week. Butter and margarine shall be included at each meal.

   h. Dessert(s). Desserts should include a variety of choices of fruit and gelatin desserts listed in the AFRS.

   i. Beverages. Low fat 2% milk should be included at all meals. Skim milk and at least one fruit juice should also be made available. Coffee, tea, and hot chocolate should also be made available for each meal.

j. Condiments. The appropriate condiments should be provided for each meal to accompany the menu item.

APPENDIX A. PHYSICAL FITNESS AWARD PROGRAM

A. INTRODUCTION. This appendix outlines the voluntary physical fitness award program for active duty members, auxiliarists, reservists, civilian employees and Coast Guard families.

1. Background. Physical fitness is a major component of the Coast Guard's Wellness Program. The importance of being physically fit cannot be overstated. Physical fitness improves one's physical and mental health, stamina, efficiency, appearance, and longevity. Failure to maintain physical fitness by active duty personnel can have a negative effect on their promotion and retention opportunities. However, the Coast Guard neither has, nor plans to implement, a mandatory physical fitness program. The philosophy of the Wellness Program centers on **voluntary participation**, since convincing people to adopt and maintain a healthy lifestyle cannot be achieved or effectively enforced by regulation. Accordingly, the physical fitness goals of the Wellness Program are to:

   a. educate people on the importance of physical fitness;

   b. train people to use safe and effective means of maintaining physical fitness; and

   c. motivate people to make physical fitness an integral and permanent part of their lifestyle, and to take advantage of command-sponsored and other physical fitness options.

B. DISCUSSION.

1. This appendix contains the old COMDTINST 6100.5, Physical Fitness Award Program which formed from the reserve wellness program instruction COMDTINST 6100.3 (series) FIT FOR DUTY - FIT FOR LIFE. The Coast Guard Physical Fitness Award Program, in cooperation with the President's Council on Physical Fitness and Sports and the Amateur Athletic Union, uses the criteria and certification procedures established by the President's Council on Physical Fitness and Sports to award certificates to participants achieving certain levels of fitness participation. The goal of the Coast Guard Physical Fitness Award Program is to motivate people to make a commitment to fitness through active and regular participation in sports and fitness activities. Earning these awards signifies that individuals have put in the time and effort to meet the challenge of personal fitness.

2. Participants can earn the Physical Fitness Awards by participating in one or more authorized fitness/sports activities, as described below. All members and beneficiaries of the Coast Guard (active duty; reserve, civilian, auxiliary, and their families) are eligible. To earn the awards:

   a. Select the fitness/sports activity or activities in which you wish to participate.

   b. Maintain a record of participation on a copy of the fitness log provided as page A-7.

   c. Upon completion of participation requirements, select either of the following two award packages (allow 6-8 weeks for delivery):

(1) Two certificates of achievement suitable for framing; one from the Coast Guard and one from the President's Council on Physical Fitness and Sports. The processing fee for the two certificates is $2.25.

(2) Two certificates **plus** an award patch, a shoe pocket, a bag tag and a letter from the Chairperson, President's Council on Physical Fitness. The processing fee for this package is $6.00.

d. Active duty and reserve members shall submit their logs to their unit commanding officer for certification prior to application for awards.

e. Mail the fitness log and the appropriate processing fee to:

Presidential Sports Award
P.O. BOX 10,000
Lake Buena Vista, FL 32830-1000

C. RESPONSIBILITIES. Unit commanding officers shall:

1. Encourage maximum voluntary participation in the Coast Guard Physical Fitness Award Program.

2. Subject to the constraints of unit operational requirements and workload, permit a reasonable amount of time during the work week for participation in fitness activities.

3. Reinforce participation of active duty members by reviewing and signing their Personal Fitness Logs.

D. QUALIFYING SPORTS AND STANDARDS. The following fitness activities and accompanying qualifying criteria are exactly as stated by the Presidential Sports Award pamphlet. Many sports listed below, although popular, have little fitness benefit (e.g., bowling, softball, horseshoes, shooting, etc.). To improve overall physical fitness, the Coast Guard emphasizes aerobic or strength/endurance activities as marked with an asterisk (*) below. For maximum benefit, the criteria for each of the following activities should be fulfilled within a four-month period operations permitting.

1. ***Aerobic Dance**: Participate in a minimum of 50 hours of aerobics, aerobic dance, dance exercise, “jazzercise" or similar activity. No more than 1 hour per day and 4 hours per week may be credited to the total. The one hour of activity should include 5-10 minutes of warm-up, 20-30 minutes of aerobic dance activity, and 10-15 minutes of strengthening exercises, and 5-10 minutes of cool down.
2. **Archery**: Shoot a minimum of 3,000 arrows with no more than 90 arrows credited to the total per day. Minimum target distance is 15 yards. In field or roving archery, there should be 14 different targets, each at 15 or more yards.
3. ***Backpacking**: Backpack for a minimum of 50 hours with no more than 3 credited to the total per day. Weight of pack must be at least 10 percent of body weight.
4. **Badminton**: Play badminton a minimum of 50 hours with no more than 2 hours credited to the total per day. Play must include a minimum of 125 total games with no more than 5 games credited to the total per day.

5. **Baseball**: Play baseball and/or practice baseball skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in an organized league or part of an organized baseball competition.
6. ***Basketball**: Play basketball and/or practice basketball skills a minimum of 50 hours. No more than one hour in any one day may be credited to the total. At least 15 of the 50 hours must be in an organized league or part of an organized basketball competition.
7. **Baton Twirling**: Practice twirling skills and/or compete in baton twirling a minimum of 50 hours with no more than 2 hours credited to the total per day. Practice must include work in at least two of the recognized events (one baton, two baton, three baton, strut, dance twirl, group twirling). Participate in at least 3 organized competitions.
8. ***Bicycling**: Bicycle a minimum of 600 miles (more than five gears) or 400 miles (five or fewer gears). No more than 12 miles in any one day may be credited to the total (more than five gears) or no more than eight miles in any one day may be credited to the total (five or fewer gears). On a stationary bicycle, bicycle a minimum of 25 hours with no more than 30 minutes of bicycling within your target heart rate range credited to the total per day.
9. **Bowling**. Bowl a minimum of 150 games with no more than 6 games credited to the total per day. The total of 150 games must be bowled on not less than 34 different days.
10. ***Canoe-Kayak**: Paddle a minimum of 200 miles with no more than 7 miles credited to the total per day.
11. **Cheerleading**: Cheelead or practice cheerleading a minimum or 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be accumulated during organized games or competitions.
12. ***Cross Training**: Complete at least one half of the requirements for two different categories of this program simultaneously. Activities should develop cardiorespiratory endurance, muscle strength and endurance , and flexibility
13. ***Dance**: Dance a minimum of 50 hours in Ballroom, Square, Folk, Round, pattern, Clogging, Country Western, or Dance Combination with no more than 1½ hours credited to the total per day.
14. **Disc Sports**: Practice flying disc skills a minimum of 50 hours with no more than 2 hours credited to the total per day. Practice must include work in at least three of the recognized events: distance, accuracy, self-caught flight, double disc court, golf, freestyle, discathlon, ultimate, or guts.
15. ***Double Dutch**: Complete a minimum of 50 hours of Double Dutch activity (jumping between the ropes or turning the ropes) with no more than 1 hour credited to the total per day. Include at least one organized Double Dutch competition (categories are Speed, Compulsory, and Freestyle) as part of the 50 hour requirement.
16. **Equitation**: Ride horseback or train horses a minimum of 50 hours with no more than 1½ hours credited to the total per day.
17. ***Fencing**: Practice fencing skills a minimum of 50 hours with no more than 2 hours credited to the total per day. At least 30 of the 50 hours must be under the supervision of an instructor or during competition.
18. ***Field Hockey**: Play field hockey and/or practice field hockey skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in organized league or tournament play.
19. ***Figure Skating**: Skate a minimum of 50 hours with no more than 1½ hours credited to the total per day. Skating should include at least one of the following elements: a) figure-eight work (patch), b) free skating, c) ice dancing, or d) precision skating.
20. ***Football**: Play any form of football, including flag or touch football, and/or practice football skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in an organized league or part of an organized football competition.
21. **Golf**: Play a minimum of 100 hours with no more than 3 hours credited to the total per day At least 15 rounds (18 holes) must be played as part of the 100 hour requirement. <u>No motorized carts may be used</u>.
22. ***Gymnastics**: Practice gymnastic skills and/or compete in gymnastics a minimum of 50 hours with no more than 2 hours credited to the total per day. Practice must include work in at least one-half of the recognized events (two of four for women; three of six for men). Participate in at least four organized competitions.
23. ***Handball**: Play a minimum of 150 games. No more than four games in any one day may be credited to the total.

24. **Horseshoe Pitching**: Pitch horseshoes a minimum of 50 hours with no more than 2 hours credited to the total per day. Sanctioned league or tournament games may be used; 100 sanctioned games required. If a combination of practice time and official games are used, credit 30 minutes for each sanctioned game (more than 2 hours can be credited if participating in a sanctioned tournament).
25. ***Ice Hockey**: Play and/or practice ice hockey a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in an organized league or part of an organized ice hockey competition.
26. ***Ice Skating**: Skate a minimum of 50 hours with no more than 1½ hours credited to the total per day.
27. ***Jogging**: Jog a minimum of 125 miles with no more than 2½ miles credited to the total per day.
28. ***Judo**: Practice judo skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 30 or the 50 hours must be under the supervision of a qualified instructor.
29. ***Karate**: Practice karate skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 30 or the 50 hours must be under the supervision of a qualified instructor.
30. ***Lacrosse**: Play lacrosse and/or practice lacrosse skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in organized league or tournament play.
31. **Lawn Bowling**: Participate in a minimum of 40 games in either social intraclub, interclub, or Division events, with no more than 3 games credited to the total per day. These may be singles (18 points) or pairs, triples, fours, games of no less than 12 ends. These games must be played in no less than 45 days and within the maximum of 120 days.
32. ***Marathon**: Run a minimum of 40 miles per week for at least two months. Weekly mileage should not increase more than 10% over the previous week. A longer training run must be done at least every 10 days at a distance of at least 15 miles for two months once the mileage level is at 40 miles a week. At the end of four-month cycle, complete a TAC-sanctioned marathon of 26.2 miles.
33. ***Martial Arts**: For all martial arts other than Judo, Karate, and Tae Kwon Do. Practice martial art skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 30 or the 50 hours must be under the supervision of a qualified instructor.
34. **Orienteering**: Practice orienteering skills a minimum of 50 hours with no more than 2 hours credited to the total per day. Participate in at least 3 organized orienteering events and locate all checkpoints within the allotted time.
35. **Pistol**: Fire a minimum of 2,000 rounds with no more than 100 rounds credited to the total per day. Minimum target distances at 22 feet for air pistol, 50 feet to 50 yards for .22 rimfire pistol and 25-50 yards for centerfire pistol.
36. ***Racquetball**: Play a minimum of 50 hours with no more than 1½ credited to the total per day. Total must include at least 25 matches (2 of 3 games) of single and/or doubles.
37. **Rifle**: Fire a minimum of 2,000 rounds with no more than 100 rounds credited to the total per day. Minimum target distances are 33 feet for air rifle, 50 feet to 100 yards for .22 rimfire rifle, and 100 yards for centerfire rifle
38. ***Roller Skating**: Skate a minimum of 50 hours with no more than 1½ hours credited to the total per day.
39. ***Rope Skipping**: Skip a minimum of 25 hours with no more than 30 minutes credited to the total per day. Rope skipping can be done in single or double dutch ropes.
40. ***Rowing**: a) Boat--row a minimum of 50 miles with no more than 1½ miles credited to the total per day; or b) Wherry--row a minimum of 100 miles with no more than 3 miles credited to the total per day; or c) Shell--row a minimum of 120 miles with no more than 3½ miles credited to the total per day.
41. ***Rugby**: Play rugby, practice rugby skills or condition for rugby a minimum of 50 hours with no more than 2 hours of rugby or 1 hour of conditioning credited to the total per day. Conditioning may include participation in any of the eligible activities of this program, or to any exercise activities listed under the Sports/Fitness category.
42. ***Running**: Run a minimum of 200 miles. Run continuously at least 3 miles during each outing. No more than 5 miles in any one day may be credited to the total (longer runs are not discouraged, but miles counted toward the 200 mile total must be spread over at least 40 outings). Average time must be nine minutes or less per mile (27 minutes or less for three miles, 45 minutes or less for five miles, etc.). Exceptions to this time requirement due to injury or age must be noted.
43. **Sailing**: Sail a minimum of 50 hours (practice and competition) with no more than 2½ hours credited to the total per day.

44. **Scuba-Skin**: Skin or scuba dive, or train for diving, a minimum of 50 hours with no more than 3 hours of total diving time credited to the total per day. Total time must include at least 15 logged dives on 15 separate days under the Safe Diving Standards of one of the following groups: National Association of Skin Diving Schools, National Association of Underwater Instructors, the National YMCA, Professional Association of Diving Instructors, or the Underwater Society of America.
45. **Skeet-Trap**: Fire a minimum of 800 standard trap or skeet targets or sporting clays with no more than 50 targets credited to the total per day. All shooting events must be under safe, regulated conditions.
46. ***Skiing (Alpine)**: Ski or train for skiing a minimum of 50 hours with no more than 3 hours of actual skiing time or 30 minutes of training on a ski-training apparatus credited to the total per day.
47. ***Skiing (Nordic)**: Ski a minimum of 150 miles with no more than 10 miles credited to the total per day. Comparable mileage accumulated on a workout apparatus may be credited to the total.
48. ***Snowshoeing**: Snowshoe a minimum of 50 hours with no more than 4 hours per outing credited to the total per day.
49. ***Soccer**: Play soccer or practice soccer skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in an organized league or part of an organized soccer competition.
50. **Softball**: Play softball and/or practice softball skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in an organized league or part of an organized softball competition.
51. ***Sports / Fitness**: Participate in a minimum of 50 hours in exercise activities, or in a combination of exercise and sports activities with no more than 1 hour credited to the total per day. Exercise activities may consist of aerobic dance, aquadynamics, calisthenics, exercise or conditioning classes, fitness dancing, rope jumping, workouts on apparatus including stationary bicycles, rowing machines, treadmills, stair climbing machines, skiing machines or a combination of any or all of these activities. Sports activity may include participation in one or more of the sports in which the Presidential Sports Award is offered, or other sports such as Diving, Water Polo, etc.
52. ***Squash**: Play squash a minimum of 50 hours with no more than 1½ hours credited to the total per day. Total must include at least 25 matches (3 of 5 games) of singles and/or doubles.
53. ***Swimming**: Swim a minimum of 25 miles (44,000 yards) with no more than 3/4 mile (1320 yards) credited to the total per day.
54. ***T'ai Chi**: Participate in a minimum of 50 hours of T'ai Chi Chuan following the standards set forth by the American T'ai Chi Association. Credit no more than 1 hour per day and 5 hours per week to the total. It is recommended that 1 hour of activity include: 10-15 minutes of warm-up (including flexibility and strengthening), 20-30 minutes of T'ai Chi within your target heart-rate range, and a 15 minute cool down period.
55. **Table Tennis**: Play table tennis a minimum of 50 hours with no more than one and 1½ hours credited to the total per day. At least 10 of the 50 hours must be under the supervision of a qualified instructor.
56. ***Tae Kwon Do**: Practice tae kwon do skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 30 of the 50 hours must be under the supervision of a qualified instructor.
57. ***Tennis**: Play a minimum of 50 hours of tennis with no more than 1½ hours credited to the total per day. Total must include at least 25 sets of singles and/or doubles (tie-break rules may apply).
58. ***Track and Field**: Compete in and/or practice track and field events a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 10 of the 50 hours must be accumulated during organized meets.
59. ***Triathlon**: Run a minimum of 10 miles per week for at least two months. Participants must run a minimum of three days per week for at least two months. Bike a minimum of 35 miles per week for at least two months. Individuals must bike a minimum of two days per week. Swim a minimum of 1 mile per week for at least two months. Individuals must swim a minimum of two days per week. Add no more than 10% to the distances for each sport each week. The individual should be completing three times the distance in their training mileage per week than the sprint distance event in which they intend to compete up to one week prior to the event One week prior to the event, training would be reduced to 1 times the distance of the event the athlete intends to compete (called tapering). A minimum of one and maximum of two sports should be practiced at least four days per week. One to two days of rest each week is recommended for recovery time. At least one workout per week should include a swim/bike or bike/run workout that includes performing the sports back to back and include practicing the transition of going from one sport to another (called a "brick"). At the end of the 4 month period, compete in a triathlon Federation/USA sanctioned sprint distance event (approximately a ½ mile swim, 12 mile bike, and 3.1 mile run).
60. **Volkssports**: Train for, or participate in an organized volkssport or volksmarch events for a minimum of 50 hours

with no more than 2 hours credited to the total per day. Exercise activity may consist of running, walking, cycling, climbing, hiking, skiing, or any combination of similar activities that promote healthful physical activity. For longer duration events, additional hours may be credited toward earning other awards.

61. **Volleyball**: Play volleyball, practice volleyball skills, or condition for volleyball a minimum of 50 hours with no more than 2 hours of volleyball or 1 hour of conditioning credited to the total per day. Conditioning may include participation in any of the eligible activities of this program, or in any of the exercise activities listed under the Sports/Fitness category.
62. ***Endurance Walking**: Walk a minimum of 225 miles, combining training walks and endurance walks. Training walks must be a minimum of 1 hour in duration. At least three must be completed each week and the mileage should be credited to the 225 mile total. Endurance walks must be continuous for a least 5 miles. At least five of the outings must be 10 miles long and one must be 15 miles long during the time the 225 miles is being completed. No more than one 10 mile or 15 mile walk can be credited to the total each week.
63. ***Fitness Walking**: Walk a minimum of 125 miles with no more than 2 ½ miles credited to the total per day. Each walk must be continuous, without pauses for rest, and the pace must be at least 4 m.p.h. (15 minutes per mile).
64. ***Race Walking**: Race walk a minimum of 200 miles. Race walk continuously at least 3 miles during each outing. No more than 5 miles in any one day may be counted toward the total. The miles counted toward the 200 mile total must be spread over at least 40 outings. Average time must be 12 minutes or less per mile. Follow the basic rules of race walking - keep one foot on the ground at all times and keep the supporting leg straight as it comes under the body. At least two of the outings must be judged events.
65. ***Water Exercise**: Participate in a minimum of 50 hours of water exercise. Credit no more than 1 hour per day and 4 hours per week to the total. It is recommended that one hour of activity include a 5-10 minute warm up, 20-30 minutes of water exercise activity within your target heart rate range, 10-15 minutes of strengthening exercises and a 5-10 minute cool down.
66. ***Water Skiing**: Water ski a minimum of 50 hours with no more than 3 hours of total skiing activity credited to the total per day.
67. ***Weight Training**: Train with weights a minimum of 50 hours with no more than 1 hour credited to the total per day. A workout must include at least eight separate weight/strength training exercises. Workouts should be balanced so that each body part is exercised during each cycle (daily, weekly, etc.). Each exercise should be performed in multiple set, six to 15 times.
68. ***Wrestling**: Wrestle or practice wrestling skills a minimum of 50 hours with no more than 1 hour credited to the total per day. At least 15 of the 50 hours must be in an organized league or part of an organized wrestling competition.

U.S. COAST GUARD

FIT FOR DUTY - FIT FOR LIFE

Sports Award

Personal Fitness Log

Date	Performance Entry (Time, Distance, Games, Etc.)	Date	Performance Entry (Time, Distance, Games, Etc.)	Date	Performance Entry (Time, Distance, Games, Etc.)

I hereby affirm that I have fulfilled all of the requirements for the FIT FOR DUTY - FIT FOR LIFE Sports Award in the sport: _____

Name of Award Category

_____ Signature

_____ Commanding Officer certification

Fill in Below **(Please print name exactly as it should be typed on certificate)**

Name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

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Apt |__|__|__|__| City |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State |__|__|

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Would you like to receive an *additional* brochure? ____ Yes ____ No

Age (check one)

___ 6-13
___ 14-19
___ 20-29
___ 30-39
___ 40-49
___ 50-59
___ 60-69
___ 70-79
___ 80-up

Sex (check one)

___ Female
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Mail to: Presidential Sports Award/AAU
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APPENDIX B. FITNESS TERMINOLOGY

A. PHYSICAL FITNESS. The American Council on Exercise defines peak physical fitness as "the condition resulting from a lifestyle that leads to the development of an optimal level of cardiovascular endurance, muscular strength, and flexibility as well as the achievement and maintenance of ideal body weight." The ability to carry out daily tasks with vigor and alertness, without undue fatigue, and with ample energy remaining to enjoy leisure-time pursuits and to meet unforeseen emergencies. While we all have genetic limitations, each of physical fitness components can be influenced greatly, for better or worse, by our lifestyle choices. There are four components to health-related fitness: (1) **body composition**, (2) **flexibility**, (3) **muscular strength** and **muscular endurance**, and (4) **cardiorespiratory endurance**.

1. Fitness Assessment: To reach your optimal fitness level, a base measurement of one's current fitness level in the four areas is needed. A fitness assessment highlights which components could use improvement. The goal of the fitness programs, as with the Wellness Program, is to improve one's health and produce a more fulfilling and productive life. The Coast Guard uses a health risk assessment (HRA) packet named PALS (Personalized Aerobics Lifestyle System) which includes a physical fitness assessment section. People who may administer the fitness assessment section include members who have completed the CG Health and Fitness Leader Course and ISC Wellness Coordinators. Several tests measure the body's level of fitness in the four aforementioned areas. The following paragraphs summarize each test utilized. Chapter 5 and appendix D of this Manual provide more information and directions on administering the PALS HRA.

B. BODY COMPOSITION. Body composition is the relative amount of fat tissue to lean tissue (muscle, bone, fluids, etc.) in one's body. It is normally expressed in percent body fat (%BF) by weight. This is a more meaningful figure than total body weight, as total weight does not account for differences in lean mass among individuals. A 6'0", 210 lb. active football player may have a substantially different body composition than a 6'0", 210 lb. executive, yet they would be classified as equally overweight if a height/weight chart is the only criterion. In reality, neither, either or both of the above persons may be *overfat*, which is the important issue in terms of health.

1. Body Fat Ranges: Healthy U.S. males range from about 8% to 20% body fat, and healthy females vary between 14% to 26% fat. These are somewhat arbitrary figures, but fat levels above or below these ranges produce increases in health risks while physical work performance declines. Maximum body fat percentages allowed by the Coast Guard as outlined in COMDINST M1020.8(series) are as follows:

AGE	MALES	FEMALES
Less than 30	23%	33%
Less than 40	25%	35%
40 or Greater	27%	37%

These are liberal standards, as values greater than these definitely affect health adversely. Physically fit males typically carry about 5-18% fat and females about 12-25% fat. The

average American gains about one pound of scale weight per year from the age of 25 to 55 while unfortunately losing 1/4 to 1/2 pound of lean weight (primarily muscle and bone) each year. This calculates out to about 40 pounds of fat tissue by age 55 for the average person. Encouraging news however; this is not an inevitable consequence of aging! It is to a much greater extent the result of our lifestyles becoming less active while we continue to eat the same amount as when younger.

2. Fitness Assessment: The most accurate way to measure body composition is to analyze a cadaver. Not a good method you say? Fortunately, there exists many other methods of estimating body composition. Underwater weighing, skinfold thickness measurements, body circumferences, bioelectrical impedance, infrared reactance, x-ray techniques and others are used with varying degrees of accuracy. Some of these techniques require expensive equipment, intensive test administer training, or cause the subject difficulty. The Coast Guard Wellness Program uses the circumferential measurement technique for obtaining percent body fat which requires minimal training and a simple non-elastic tape measure. Members who attend the Coast Guard's Health and Fitness Leader Course receive training in performing the measurements. If you are participating in a fitness program, re-evaluate your body composition about once a month, being careful to use exactly the same technique each time. If you are gaining muscle tissue at the same rate you are losing fat tissue, your scale weight will not change, but body composition will. Simple formulas can calculate how much fat you are losing and muscle you are gaining.

3. Desired Body Weight Calculation: Knowing your weight and body composition enables you to set a realistic goal for a scale weight. You must first set a body composition objective. It can be based on health, appearance, or athletic performance concerns. Not everyone will have the same body composition goal. Consult the ISC WC or unit WR for goal-setting assistance. Desired weight computation assumes a constant amount of lean tissue mass. Changing your diet and/or exercise habits can change your lean body mass. If lean mass changes, as with a strength training program (gain in muscle mass) or crash dieting (loss of muscle mass), desired weight will shift. In these cases, percent body fat and desired weight must be recomputed periodically. Calculate lean body mass (LBM) and desired body weight (DBW) as follows:

    1) Determine percent body fat (%BF)
    2) Calculate fat weight: **Total wt. × %BF**
    3) Calculate lean body mass (LBM): **Total wt. - Fat wt.**
    4) Calculate desired body weight (DBW): **LBM / (1.00 - Desired %BF)**

    EXAMPLE: A 215 lbs. male with %BF 24% desires a %BF of 16.0%

    1) %BF = **24%**
    2) Fat weight = 215 × 0.24 = **51.6 lbs.**
    3) LBM = 215 - 51.6 = **163.4 lbs.**
    4) DBW = 163.4 / (1.00 - 0.16) = **195 lbs.**

4. Exercise Recommendation: Activities of *low to moderate intensity*, which are continuous, rhythmic, and use the largest muscle groups (primarily lower body) are most effective for reducing stores of body fat. Walking, running, cycling, cross-country skiing, swimming, stair stepping, rowing, and continuous games such as handball, racquetball, and basketball are excellent calorie-burning activities.

C. FLEXIBILITY. The ability of a joint to move freely through its full range of motion. Flexibility is dependent on a number of factors and is specific to each joint. That is, you may be very flexible at the shoulder and inflexible at the hip, or vice versa. Maintaining or improving flexibility aids mobility, increases resistance to muscle injury and soreness, prevents low-back and other spinal column problems, helps with postural alignment, and promotes graceful movement and enhanced motor skills. Many injuries and musculoskeletal problems, particularly back problems, may be related to a lack of flexibility. About 80% of all lower back problems in the U.S. are due to improper alignment of the spine and hip; a direct result of poor flexibility at the hip joint and poor strength of the abdominal and low back muscles. Most individuals lose flexibility as they age. As with body composition, this is more a problem of decreasing activity levels rather than increasing age. You can improve your flexibility at any age with a regular stretching program.

1. Fitness Assessment: No general test is available that measures total body flexibility. The PALS HRA measures the flexibility of the back because of the prevalence of lower back problems in our society and the Coast Guard. The sit-and-reach (trunk flexion) test is used to assess flexibility through the hip joint. Supplies needed include a yardstick, tape, and a 12" high and wide box.

2. Exercise Recommendation: To increase flexibility stretching exercises should be included in any exercise program. However, to be most effective the stretching exercises should be performed after a general warm-up preceding the activity or immediately following the cool-down, after completion of the exercise or activity. Static stretches (no bouncing) for all major muscle groups should be held for a minimum of 30 seconds to improve flexibility (Range of Motion).

D. MUSCULAR STRENGTH/ENDURANCE. Strength fitness includes both "absolute strength" and "dynamic strength." Absolute strength is the maximum amount of force a muscle or muscle group can exert in one effort. When measured, this amount is called a one repetition maximum (1RM). Dynamic strength, or muscular endurance, represents the endurance capacity of a muscle or muscle group, and is measured by determining how many consecutive submaximal contractions can be performed before momentary muscular failure.

1. Fitness Assessment: The PALS HRA includes two dynamic strength tests to measure the submaximal muscle effort. The push-up test evaluates upper body strength and a one minute sit-up test measures abdominal strength. During the push-up test, females may start in the modified position which allows the knees on the floor and feet crossed verses the straight leg. The subject may rest, but only in the proper up position. The test is terminated when the person can not perform any more or the one minute time limit ends, which ever occurs sooner. For the sit-up test; lie down with the knees bent at approximately 100^0 and the legs

slightly apart. Your heels should be approximately 12-18 inches from your buttocks and finger tips cupped behind the ears. The score equals the number of correctly performed repetitions in one minute when the elbows touch the knees then shoulder blades contact the floor and return to the up position.

2. Exercise Prescription: Strength training is a systematic method of progressively overloading the musculoskeletal system so that it adapts and grows stronger. Anything that creates a resistance can be used for strength training, for example: body weight, barbells, dumbbells, rubberized tubing, machines, etc.

   a. Any of these methods of strength training can be used to improve muscular strength, muscular endurance or both. For example, circuit training, which is a form of training that takes the participant through a series of exercise stations, with brief rest intervals between stations, emphasizes muscular endurance and cardiorespiratory conditioning. If a participants focus is to improve muscular strength it is recommended they perform 6-8 repetitions of 80-90% of their 1RM. Additionally, a system of exercises known as calisthenics can be utilized anywhere at anytime to improve muscular strength and endurance. Calisthenics do not rely upon special equipment but utilize one's body weight against gravity for resistance (e.g., push-ups, dips and sit-ups).

E. CARDIORESPIRATORY ENDURANCE (CRE). Cardiorespiratory fitness best describes the health and function of the heart, lungs and circulatory system and is related to CRE. CRE is the ability to continue activity or exercise for prolonged periods. You may also hear it commonly referred to as aerobic power, aerobic capacity or cardiovascular endurance. CRE is probably the single best indicator of your physical fitness level from a health standpoint because it reflects the function of your heart, lung and circulatory system. Seldom are you required to perform a maximal aerobic effort, but you are constantly performing aerobic work at a sub-maximal level in your daily life. The relative ease or difficulty of performing everyday tasks is determined by the percentage of VO_{2max} at which we are working (VO_{2max} is the highest volume of O_2 a person can utilize during exercise). For any given chore, the higher your VO_{2max} is, the lower the percentage of maximum at which you are working. Hence, the work is easier and you can perform it longer.

1. Fitness Assessment: The PALS includes a choice of two assessments of cardiorespiratory endurance depending on the participants base CRE level: a one mile walk (based on a submax HR response) or a 1.5 mile run (based on a maximal effort). Since the tests' results are dependent upon submaximal heart rate response to standardized exercise bouts, outside factors that could affect submaximal heart rate should be minimized. The tests should not be performed in overly hot or humid weather or immediately after performance of the push-up or sit-up assessments. Tobacco and caffeine should not be used for at least two hours prior to the tests, and you should have eaten at least two hours before testing.

2. Exercise Recommendations: Participants should engage in prolonged rhythmic activities such as: walking, swimming, jogging, in-line skating, cross country skiing, etc. The minimum requirement for these type of activities is 3-5x per week for 20-45 minutes at a moderate intensities.

F. COMPONENTS OF A PROPER WORKOUT.

1. Warm-up/Stretching

2. Strength/Aerobic work

3. Cool-down/Stretching

G. ENERGY PRODUCTION. The bodies cells produce energy utilizing two methods: (1) aerobic or (2) anaerobic. The body demands certain types of fuel (energy) depending on what activity is being performed.

1. Aerobic Exercise: Activities for which the dominant source of energy involves the use of oxygen. Aerobic exercise is characterized by continuous rhythmic movement using the large muscles of the body over an extended period of time. Aerobic exercise increases the body's demand for oxygen, thereby adding to the workload of the heart and lungs and elevating the heart rate. Among its many benefits, it strengthens the cardiovascular system and allows the body to burn fat for energy. Aerobic activities include, but are not limited to, brisk walking, running, swimming, cycling, cross-country skiing, stair climbing, jumping rope, rowing, and some competitive sports such as racquetball and basketball.

2. Anaerobic Exercise: Activities for which the dominant energy source requires no oxygen. Such activities are more intense than aerobic activities, and cannot be sustained for as long a period. Discomfort and/or momentary muscular failure occur as a result of increasing levels of lactic acid in the blood. Anaerobic activities include weight lifting, sprinting, or any other activity requiring brief high level intensity bursts.

H. SAFETY. There is a risk of injury with exercise, as with most daily activities. However, there are greater risks in being sedentary. All responsible personnel, and especially program participants, shall ensure proper safety precautions are observed at all times.

1. CPR: All members and dependents are encouraged to know and be certified in providing cardiopulmonary resuscitation (CPR or Basic Life Support). Certification courses are provided by the American Heart Association and American Red Cross. Unit medical personnel are encouraged to provide CPR training to members and dependents. All unit Wellness Representatives and Fitness Leaders should be CPR certified annually.

2. Heat: High heat and humidity can be extremely stressful when exercising, and can lead to serious or fatal injury. *Never* wear any clothing which serves to trap body heat, such as rubberized or plastic suits. Drink plenty of water or sport drink before, during and after prolonged activity. Do not take salt tablets unless prescribed by a physician. At higher temperatures, your heart rate will be faster for any given exercise pace, and the pace will be more difficult to maintain. Slow your pace accordingly. If the air temperature and humidity added together total 160 or more, or the temperature alone is over 90° F and you are not adapted to training in the heat, decrease your intensity or skip the workout.

3. Cold: Cold conditions are usually not as serious as heat, but can present problems. In severe climates, you must prevent frostbite and hypothermia. Protect fingers, ears and nose. Be aware of the wind chill factor. Dress in layers to help trap air for insulation. Do not overdress so as to cause excessive sweating. The clothing layer next to the skin should wick away moisture, and the outer layer should be wind resistant. Wear a wool blend cap, as the head loses much heat. Eat adequately and drink plenty of fluids in cold weather to prevent dehydrated which affects heat regulation.

4. Clothing and Footwear: Wear comfortable, breathable clothing appropriate for climatic conditions. Poor or inappropriate shoes probably cause more injuries than any other equipment. Get the best pair you can afford, and buy shoes designed for your activity. If you run, buy a quality pair of running shoes rather than a court or cross-training shoe which has different features. Replace shoes when they start to get worn or the sole cushioning materials are breaking down. Many ankle, knee, hip and back injuries are caused by shoes that have outworn their useful life even if they still look good.

I. PHYSICAL FITNESS RESOURCES. The following texts contain excellent information on proper exercises techniques, avoiding and treatment of injuries, and healthy eating techniques: *Heart at Work*, *The Wellness Encyclopedia*, *ACE: Personal Trainer Manual*, and *Health and Fitness Excellence*. These texts are given to graduates of the Coast Guard's Health and Fitness Leader Course and make outstanding references. Further information about these texts can be found in chapter 1 of this Manual.

LOSING BODY FAT THE EASY WAY

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Section 1. <u>Introduction</u>:

So you've finally decided to get serious about losing weight, eh? Well, so have a whole lot of other people in the U.S. In fact, so strong is this impulse in our culture that an entire industry has evolved to *assist* you in losing weight. Unfortunately, what you mostly lose is your money. Although you may temporarily lose some weight, studies show that the majority of people who subscribe to various fad diets, patronize weight loss clinics, purchase expensive diet foods or spend time (and a whole lot of money) at fat farms, invariably regain most of their lost weight when they return to real life. And then they do it all over again the next year. This type of *yo-yo* dieting is not only ineffective, it actually hurts you. Each time you cycle the *yo-yo*, losing weight and gaining it back again, you make it harder the next time to succeed. This irregular dieting slows down your metabolism, meaning you burn fewer calories throughout the day than you did before you bought into the *yo-yo* syndrome.

It doesn't have to be that way. The goal is to permanently lose excess body-fat. But to do this, you have to be willing to alter your life-style. Nothing else will work! And although this sounds ominous (yes, you will have to learn how to eat different things and exercise more), it's really pretty simple and relatively painless. It only requires commitment on your part and a realization that it is going to take time, maybe even as long as a year to get where you want to be. But since it took you until now to get fatter than you'd like (or in some cases, fatter than regulations allow), and since you have to make a lifelong commitment to change your life-style in order to succeed, what's the hurry? In fact, if you adopt healthy food and exercise habits, you won't need to *diet* at all. In essence, if you habitually eat a low-fat balanced diet and if you habitually participate in aerobic exercise with a little added weight training, you will steadily lose body-fat without the need for magic foods, starvation diets, food deprivation, or any of the other extremes that weight-loss diets often prescribe. It'll all happen automatically.

Now, here's the most important thing you need to know about losing weight: your primary objective is to lose body fat, not simply to lose pounds. At the same time, you want to maintain or even increase your lean body mass: you don't want to lose your hard-earned muscles while you're losing fat. If you gauge your success solely by what your scale reads, you're making a big mistake. From the standpoints of both health and what you see in the mirror, your weight is not nearly as important as is how fat you are. The scale, of course, reads your total weight, which basically consists of fat plus lean body mass (e.g., muscle, blood, bone, skin, organs, etc.). Water is by far the largest component of both your total weight and your lean body mass (60% and 75%, respectively). So most of your daily (or even weekly) changes in total body weight, and therefore in what your scale reads, is really nothing more than changes in the water content of your body.

Water is not what you want to lose; fat is what you want to lose. So relying on your scale to tell you how much fat you've lost is highly inaccurate. Worse, thinking you've really accomplished something because you weigh two pounds less after a vigorous workout is silly. 99.5% of what you've lost is sweat (i.e. water), not fat. It takes quite a while to lose fat; it's not something you can measure or even notice over the course of a few days. Losing body-fat rather than bodywater is what your goal should be. For men, any bodyfat over about 23% is too much, and a body-fat over about 28-30% is obesity. For women, the corresponding figures are 28% and 33-35%. Your goal should be to achieve a body-fat of 15-18% for men and 18-21% for women.

For comparison, the upper limit of acceptable body fat for male U.S. Marines is 18%; most male world-class marathon runners have body-fats under 10%; professional football defensive and offensive backs are at about 10-12% (with linemen at 14-18%). World-class female distance runners have about 10-12% body fat (but for women, body-fats this low usually are associated with loss of menstrual periods, which increases the risk of osteoporosis). Unfortunately, body-fat increases naturally with age, and some of this body-fat is deposited internally (particularly in the gut for men and the hips for women), rather than under the skin where you can see it. The figures above are for men and women between 20-45 years of age.

Section 2. <u>Getting Started</u>:

There is no quick way to lose body fat, but there is a safe and effective way: simply decrease the number of fat calories you eat, don't replace them with calories of sugar, starch and protein, and perform some type of exercise every day. That's all there is to it. As you can see, it boils down to the old equation: if you burn up more calories than you take in, you'll lose fat. To accomplish this, however, you need to learn a few things about food and exercise. So let's start with food.

Food calories basically come from three sources: protein, carbohydrate (sugar and starch) and fat. Protein is essential for building muscle, making antibodies, repairing damaged tissue, and a host of other vital functions. Protein calories come from meat, poultry, fish, dairy products, grains, beans, and nuts. Carbohydrates are the primary energy source for every cell in the body. Carbohydrate calories come from the sugars and starches found in fruits and vegetables, milk, grains, beans and nuts. Fat deposits in the body are a reserve energy source and provide insulation against the cold. Fat calories in foods come from oils, meats (beef, pork, cold cuts, veal, breakfast meats, etc.) egg yolks, dairy products (except skim milk), nuts (including peanut butter, which is 80% fat), poultry skin, margarine, mayonnaise, coconuts, avocados and olives. A gram is the basic measure of food weight; there are 28.35 grams in each solid ounce, and 454 grams per pound. Each gram of protein and each gram of carbohydrate provides 4 calories of food energy. But, each gram of fat provides 9 calories! (I'm telling you all this because you should get used to reading food labels and calculating the percentage of your total calories coming from fat). So if you're going to cut down your food calories, you obviously get more bang for your effort by restricting fat calories. Furthermore, recent studies show that not all calories are equal in making body fat. Fat calories are more efficient at increasing your body-fat than are protein and carbohydrate calories, which is all the more reason to restrict your fat intake. Conversely, limiting fat calories is more effective in losing body-fat than is limiting protein or carbohydrate calories. From the above you can see that one pound of body-fat equals about 4000 calories (454 grams x 9 calories per gram). Ultimately, if you ingest 4000 fewer calories (particularly from fat) than you expend over the long run, you'll lose a pound of body-fat. The body's physiology and chemistry aren't nearly this simple, but it's a pretty good approximation.

If you're like most Americans, you eat 35-40% of your total calories as fat. That's too much! The American Heart Association recommends you eat no more than 30% of your total calories as fat. This will not only help you lose body-fat, but it will also help lower your cholesterol. So, if you're like most people, you have a lot of room in your diet to reduce your fat intake. The more fat you eliminate from your diet, the faster you will lose body-fat. Actually, even 30% of your calories from fat is too much - remember, that's the maximum recommended fat intake. If you want to lose body-fat, you need to eat much less fat than this.

The easiest way to reduce unnecessary fat calories is to stop using fat as a spice. Fat as a spice? Yes, many people use fat to change the taste (or texture) of other foods, just as they do salt, pepper or other spices. What else do you call it when you slather butter or margarine on toast or vegetables, or when you spread these fats, mayonnaise (which is 98% fat) or cream cheese (90% fat) on sandwiches? One tablespoon of butter, margarine or mayonnaise contains 60-100 calories of fat. The same is true of sour cream (90% fat).

If you simply stopped using these fats as spices, you could save several hundred calories per day, and many thousands of calories per month, just by this one simple alteration in your diet! Instead of butter or margarine on toast, eat it dry or use jelly, apple butter, or any other non-fat topping. Instead of mayonnaise on your sandwiches, or as a binder in tuna salad or chicken salad, use fat-free mayonnaise (it tastes the same) or yogurt with your favorite spices. Instead of butter or margarine on vegetables, use any other spice (and there are dozens available on the shelves of your supermarket - even salt-free spices and flavorings). For example, consider a baked potato. A large, plain baked potato is an excellent food - 100-125 calories, nearly all carbohydrate, virtually no fat, and a good source of vitamins and minerals. But most people find it pretty bland, so they like to spice it up (i.e. change its taste) by adding things like butter, sour cream, bacon bits or even all three together. When you glop on these fats, you convert the innocent, healthy, fat-free baked potato into a 400-500 calorie fat-bomb! Instead of spicing the baked potato with fat, try vinegar, lemon juice, catsup, soy sauce, teriyaki sauce, non-fat salad dressings (fat free ranch dressing with sprinkled dill is particularly tasty), or any other low-fat, low-calorie flavoring of your choice. Another relatively simple way to reduce your fat intake is to switch from regular milk (49% fat) or 2% milk (35% of total calories from fat) to 1% milk (24% fat) or skim milk (0% fat). If you drink two or three glasses of milk per day, you again can save several hundred calories with this simple change. One cup of regular milk contains about 9 grams of fat - about 81 fat calories out of a total of 166; one cup of 2% milk has about 5 grams of fat - 45 fat calories out of a total of 130; one cup of 1% milk has about 2.7 grams of fat - 24 fat calories out of a total of 100; and one cup of skim milk has no fat at all! - zero fat calories out of a total of 85. So by switching from regular milk to skim milk, you save 81 total calories (all fat) per cup.

But what's that you say? You like the taste of butter or margarine on your foods, and you think skim milk tastes like cloudy water? Well, that's the heart of the problem: if you're too fat, you got that way because of your life-style, which includes the foods you currently LIKE to eat. It's really not all that hard to get to like a different set of foods, foods that will be kinder to your waistline and hips. For example, if you wanted to beef-up the appearance and taste of skim milk, add some condensed skim milk (available in cans) You'll be adding only a few extra calories of protein and carbohydrate, but no additional fat calories.

To lose body fat successfully, that is, to lose it and keep it lost, you have to change what you like to eat. This is an essential part of the commitment to changing your life-style. If you don't do it, you will never get rid of your extra fat. Consider this, if you simply ate 500 fewer fat calories per day (that's five tablespoons of butter or margarine), you could probably lose one pound per week of fat (and probably more than one pound per week of total weight). It's easy to do.

Section 3. Food Table:

Here's a list of foods that are notoriously high in fat (and some, by comparison, which are low in fat), many of which are good targets for reduction or elimination from your diet:

FOOD	% CALORIES FROM FAT	FOOD	%CALORIES FROM FAT
Salad Dressings		**Lunch Bag "Desserts"**	
Blue Cheese	100%	Cookies, Fig Bar	15%
French	90-100%	" Sandwich w/cream	52%
Italian	90-100%	" Shortbread	45%
Mayonnaise (Real)	90-100%	" Soft Oatmeal	40%
Ranch	90-100%	Pecan Pie (1/8th pie)	36%
Thousand Island	75-95%	Apple	0%
(changing to fat free brings this to 0%)		Grapes	0%
		Peach	0%
Meats, Eggs, Fish		Raisins	0%
Beef, pot roast	36%		
Chicken, White w/o skin	25%	**Milk Products**	
Cod, fillet, broiled	9%	Cheese, Cottage, 4%	38%
Egg substitute	0%	Cheese, Mozzarella	68%
Egg yolk	75-95%	Cheese, Process. Soft	68%
Flounder, broiled	13%	Ice Cream, cook & cream	58%
Ham, roast	30-46%	Ice Cream bar (w/chocolate)	63%
Pork chop, center cut lean	41%	Ice Milk	27%
Salmon, Red	54%	Sherbert, (all flavors)	13%
Salmon in water	30%	Whipping Cream	100%
Turkey, Dark meat, w/skin	47%	Yogurt, low-fat w/fruit	11%
Veal Cutlet	21%	Yogurt, premium frozen van	21%
Nuts		**Snacks (1 oz.)**	
Cashews, honey roasted	64%	Popcorn, micro, singles	39%
Deluxe Mixed Nuts	85%	Pretzels	10%
Peanut Butter, Old Fashioned	73%		

Note: The food table doesn't give you total calories, which vary with the amount eaten. Also, carefully read all labels and compare. The amount of fat for similar products may vary by brand.

Using this list can help you lose body-fat. For example, note the difference between salad dressings and their fat free versions. Consider the difference in fat intake if you made omelets or scrambled eggs using one whole egg and two egg whites or egg substitute instead of 3 whole eggs. Or look at the percentage of fat you get when you eat that snack cake or cookie. Why not fruit? Look at the flounder or cod fillets. Each are packed with high quality protein.

Now look at the cheese and nuts on this list. These foods, popular for both snacking and condiments, provide a large fat-calorie load. Interestingly, both nuts and cheese enjoy a reputation as "health" foods (helped, in part, by advertising from dairy producers). But the high fat content of nearly all cheese, even those that advertise themselves as part-skim, makes them particularly unhelpful for people who are trying to lose body-fat. Since most cheeses have over 75% of their total calories in fat (cottage cheese is the notable exception, especially low-fat (1%) or non-fat cottage cheese), they are far from "health" foods. Eaten in moderation, cheese can be

part of a healthy diet; but its high saturated fat (i.e. butterfat) content makes cheese unhealthful for those concerned about heart disease or their waistline.

Our list of high fat foods also include many choices that are low in fat. Portion size is also a big consideration. How much fat you eat per day is cumulative. In other words, if you eat small portions of something containing fat throughout the day, although the fat count may be low, the total fat consumed adds to your daily total. One big step in losing body fat the easy way is finding the low/no-fat item that replaces the high fat one and keeping the total fat in your diet to a minimum.

Section 4. <u>Meal Planning</u>:

One of the most important meals during your day is breakfast, and it's also a meal where many people get a mess of their daily fat calories. So, here's what you need to do. Avoid the usual bacon, sausage and eggs - all are very high in fat. Also, don't spread butter or margarine on your toast - use jelly or apple butter instead. Cereals, either hot or cold, are your best bet, particularly if you add fresh fruit or raisins and if you use skim milk (or 1% milk). Again, if you don't currently like skim milk, I guarantee you'll get use to it after a few days. Otherwise, use condensed skim milk; it has the consistency and appearance of cream, but it is just concentrated skim milk. Add it to your normal skim milk to give it more body. Also you can use condensed skim milk as a whitener in your coffee instead of half-&-half or non-dairy creamer (both of which are very high in fat content). The condensed skim milk, which comes in cans, has no fat at all.

Pancakes, waffles and French toast are okay, so long as you don't slather them with butter or margarine. Just use plain syrup, jelly, or honey (in moderation, of course). What about omelets and scrambled eggs? Although this may sound weird, make your omelets and scrambled eggs using only egg whites (or 2-3 egg whites for each whole egg). Egg whites have zero fat and contain the highest quality protein you can eat. Aside from their color, the taste of the omelet or scrambled eggs is virtually the same, particularly if you add mushrooms, green peppers, bits of ham, onions or whatever (notice I didn't say cheese). Another way to make omelets is with artificial eggs (e.g., Egg Beaters, etc.). These are usually just egg whites with some coloration to make them look yellow-the taste is about the same as for regular eggs. In any event, they have zero fat. Or finally, you can use 2 egg whites and one whole egg. One more thing about breakfast: avoid croissants (45% fat), doughnuts (50-60% fat) and beignets (50% fat). Other sweet rolls and pastries are nearly as bad, but bagels are totally non-fat, as is toast without butter or margarine. If you want a dramatic demonstration on how much fat doughnuts contain, microwave one on a paper towel and watch what happens. You'll be amazed at how much oil comes bubbling out of that innocent appearing morsel! Commercial muffins are nearly always loaded with fat, so avoid them. Best is to make your own muffins using a low-fat recipe.

Here is some good news about breakfast pastries: there are now non-fat pastries and cakes available in stores that are pretty tasty. These truly have no fat, but they are high in calories and sugar, so eat them in moderation and watch out for the serving size listed on the box. It is

usually unrealistically small, meaning you'll probably eat a larger piece and therefore eat more calories than intended (unless you stick strictly to the serving size mentioned).

LOW-FAT COOKING TECHNIQUES:

Non-stick pots and pans enable you to use little or no added fat to brown meats, sauté vegetables, re-heating leftovers, and make golden brown, low-fat pancakes and omelets.

Instead of using that leftover bacon grease (which you shouldn't be eating anyway, either from the standpoint of a low-fat diet or from the standpoint of health!) or dollop of oil in your cooking, try the end of a stick of reduced calorie (diet) margarine or a pastry brush dipped in oil to smear on a light coating of fat. Or else, if you really need oil, spritz on a light coat of a vegetable oil spray.

Experiment with nonfat liquids, such as worchestershire sauce to sauté mushrooms, chicken broth or tomato juice to prepare vegetables or to poach poultry and fish.

Trim off all visible fat from meat while removing the skin from chicken before you cook it.

Broil meats, poultry, and fish instead of frying them. For stewing or soups, cook the meat ahead of time, let cool and skim off the accumulated fat before you go on.

In most recipes and dishes calling for sour cream, substitute plain low-fat yogurt or non-fat sour cream. You can also substitute skim milk for whole milk, condensed skim milk for regular evaporated milk.

Many no-oil (fat free) dressings and condiments are now available to dress up that salad, including mayonnaise for that low-fat potato or macaroni salad. These toppings are tasty and truly non-fat.

THE TRUTH ABOUT PART-SKIM CHEESES:

Ricotta and mozzarella are the most common part-skim cheeses, but are they low in fat? NO! Both are made from whole and skim milk. Look at the figures:

CHEESE	CALORIES	FAT (g)	CALORIES FROM FAT
Mozzarella, whole milk, 1 oz.	80	6	68%
Mozzarella, part-skim, 1 oz.	72	4.5	56%
Ricotta, whole milk, cup	216	16	67%
Ricotta, part-skim, cup	171	10	53%

You save a few calories and grams of fat with part-skim cheeses, however they are far from being low-fat choices. To be truly low-fat, a cheese must have 3 grams of fat or less. That

doesn't mean you can never use them. Small amounts of even the whole milk versions can be used with pasta and tomato sauce to yield a dish acceptably low in fat. Remember: the fat content of your whole meal (and of the whole day) is what's important, not just the content of one dish or ingredient. Check the label of any cheese marked part-skim, low-fat, or reduced fat so you can decide for yourself.

Section 5. Fast Food Traps:

Fast-food is usually fat food! Fast-food restaurants are notorious for high-fat, high calorie items. Obviously, if you're trying to lose fat, meals at these places are not in your best interest. The following table shows you why.

Type	Total Cals	% Fat Cals
McDonald's		
Hamburger	250	36%
Quarter Pounder	414	46%
McLean Deluxe	320	28%
(w/cheese)	370	34%
Big Mac	562	51%
Egg McMuffin	340	42%
Chicken McNuggets	323	59%
Burger King		
Breakfast Croissanwich	304	56%
Hamburger	275	39%
Whopper with cheese	711	54%
Whopper	628	52%
Chicken Tenders	204	44%
Taco Bell		
Taco	184	54%
Burrito Supreme	422	41%
Taco Salad w/ranch	1167	67%
Nachos Bellgrande	649	49%
Pizza Hut		
Thick Pizza Supreme	640	31%
Thin Pepperoni Pizza	430	36%

Type	Total Cals	% Fat Cals
Wendy's		
Hamburger	350	41%
Big Classic	470	48%
Chicken Breast Sandwch	340	69%
Arby's		
Sausage/egg croissant	500	58%
Roast Beef King	467	37%
Superstuff potato dlx.	648	53%
Kentucky Fried Chicken		
Brst, side, extra crsp	354	60%
Breast, orig. recipe	257	48%
Chicken Nuggets (ea.)	46	57%
Roy Rogers		
Bacon Cheeseburger	552	54%
Fried Chicken Breast	412	52%
Long John Silvers		
Fish and Fries 3 pcs.	853	51%
Seafood platter	976	53%
Seafood salad w/cracker	406	67%

Actually, many fast food restaurants are responding to the public's demand for low-fat items by serving new non-fat and low-fat items. McDonalds offers a non-fat apple muffin and a low-fat salad (chicken breast on a bed of lettuce). The McDonalds Chef Salad is not low-fat because of its use of ham and cheese.

Many fast-food restaurants have salad bars which typically have many low-fat and no-fat items available (e.g., any plain vegetable or fruit). Items to avoid on a salad bar (if you want to avoid the high-fat foods) are: shredded cheese, potato and macaroni salads (both usually made

with mayonnaise), olives, avocado, deviled or diced eggs (because of the yolks), anything marinated or soaking in oil (e.g., 3 bean salad, artichoke hearts, mushrooms, etc.), and tuna in oil.

Watch out for the salad dressings. Most salad dressings are nearly 100% fat, and worse, most salad bars like to use ladles that deliver 2-3 tablespoons of dressing. Each tablespoon of salad dressing is about 100 calories, so if you put a couple of ladles of salad dressing on your salad, you've added about 400-600 calories of fat to your otherwise healthy salad! Most people don't realize this fact; although you might think you've done your body a favor by eating from the salad bar (and in fact, even a huge plate of lettuce, tomatoes, cauliflower, broccoli, carrots, etc. usually is less than 150 calories), by adding 2 ladles of salad dressing you're adding 400-600 fat calories to your diet. Do you only use 2 ladles? Some people use three and four ladles! These folks are adding nearly 1000 calories, or more, to their innocent plate of veggies!

The same is true for most of the packaged salad dressings provided by McDonalds and other fast-food restaurants (each package provides about 400 calories of dressing, nearly all of it fat). If you're on a low-fat diet, this is obviously a disaster. Hopefully the salad bar has low-fat or non-fat dressings available, which typically have less than 100 calories per ladle (McDonalds has a low-fat packaged Italian dressing). If low-fat or non-fat dressings are unavailable, use vinegar, lemon-juice, or just plain salt and pepper to season your salad. None of these alternatives have any fat. You can also use small amounts of the regular salad dressings and simply mix it well into your salad.

Most salad dressings spread very well, so by tossing your salad with a small amount of dressing, you can flavor it with the dressing while avoiding most of the fat.

Section 6. Essential Items To Remember About Losing Body Fat:

1) You must make a commitment to change your lifestyle (e.g., what you eat and how much you exercise); if you don't, you won't be able to permanently lose weight or body-fat.

2) Don't judge your success by what your scale reads; short-term changes in weight are mainly losses of body water, not fat. How you look in your mirror in the harsh light of reality is much more important than what your scale says. And even more relevant is the portion of your weight taken up by fat: your percent body-fat. Men should try to have less than 23% body-fat, and women should try to have less than 28% body-fat.

3) You never need to go on a fad diet. Most of these so-called *sure-thing* weight loss schemes, usually prominently advertised on the covers of magazines and newspapers at the checkout counters of supermarkets (you know the ones I mean) and touted by a movie star or soap opera personality, are nothing more than ways to lose water. Water doesn't count; body-fat does. If you simply decrease the amount of fat in your diet, you will automatically lose both weight and body-fat without even trying.

4) Losing body-fat takes time. It took you years to get your weight and body-fat where they are now; don't expect to shed them in a few weeks (or even months). A reasonable goal is pound of

body-fat per week, or 2-3 pounds of body-weight per month. Be patient; following a low-fat diet will work, but it will be slow. But if you've made the commitment to change your lifestyle, you've got the whole rest of your life. So what if it takes 6 months to lose 10-15 pounds, particularly if it's mainly body-fat?

5) Each gram of fat in your diet has 9 calories (compared to sugar, starch or protein, each of which has only 4 calories per gram). So limiting fat calories gives you more than twice the bang for your buck. Furthermore, fat in your food is much more easily converted to fat on your body than is either carbohydrates or protein. Try to limit your fat calories to less than 25% of your total dietary calories.

6) The easiest way to eliminate fat in your diet is to stop using fat as a spice. In other words, stop adding fat to your foods. This means stop using so much butter, margarine, mayonnaise, sour cream and cream cheese. Don't add margarine or butter to your bread or rolls, and don't put them on your vegetables. Don't add sour cream or butter to your baked potato. Use non-fat mayonnaise on your sandwiches and in your tuna, chicken or pasta salads.

7) Substitute low or no-fat alternatives for high fat foods: skim or 1% milk for whole or 2% milk; Yogurt instead of sour cream; non-fat ice cream or low-fat ice cream or yogurt instead of regular ice cream; non-fat salad dressings instead of regular salad dressings; poultry (without the skin) or fish instead of beef, pork, ham and lamb; cereal (with fruit), pancakes or waffles for breakfast instead of eggs, bacon or sausage; non-fat pastries instead of doughnuts, sweet rolls or croissants.

8) Reduce high fat foods in your diet: deep fried or french fried anything; cheeses (80% fat); nuts (80% fat); peanut butter (80% fat); doughnuts and pastries (50% fat); hot dogs, salami, bologna and other deli meats (70-80% fat); potato or corn chips (70-80% fat); whole milk (49% fat) and 2% milk (35% fat).

9) In fast-food restaurants, avoid hamburgers, cheeseburgers, super-burgers, super-colosso-burgers, fries, chicken nuggets, fried chicken, and high-fat pizza toppings (sausage, pepperoni and beef) on your pizza; go for the salad bar, the low-fat hamburger, the roast beef sandwich, or the chicken meat on lettuce salad. **Watch out** for salad dressings at the salad bar. Each ladle has 200-300 calories of 90-98% fat: just two ladles can dump nearly 600 calories of fat onto an otherwise low-fat salad! 600 fat calories is probably more than your entire day's supply of fat, just in salad dressing! If they offer a no-fat of low-fat dressing, use it.

INTRODUCTION TO PALS

PALS (Personalized Aerobics Lifestyle System) is a comprehensive program designed to help an individual achieve optimal physical and emotional health. It is based on an evaluation of fitness and activity levels, nutritional habits and other health and lifestyle factors.

The PALS report consists of six personalized profiles:

Wellness Profile: The Wellness Profile is designed to help an individual understand the relationship between lifestyle and health. Ten vital areas of lifestyle are evaluated and specific recommendations are made to help an individual improve in each area.

Exercise Activity Profile: The Exercise Activity Profile will help evaluate exercise habits in three important areas: aerobic, flexibility, and strength. A score for each will determine if an area needs improvement.

Fitness Profile: The Fitness Profile assesses your cardiovascular endurance, blood pressure, body composition, muscle strength and endurance, and flexibility. Scores are compared to a standard which has been set for age and sex groups. A safe personal exercise program is developed to help improve an individual's overall fitness level.

Nutrition Profile: The Nutrition Profile examines eating habits and diet. Four important areas of nutrition--fat and cholesterol, sodium, fiber, and variety and balance--are evaluated and recommendations on how to improve in each area are made.

Blood Test Profile (Optional): The Blood Test Profile analyzes blood components important to health. These include total cholesterol, MDL and LDL cholesterol, total/HDL ratio, glucose, and triglycerides. Current levels are assessed and compared to a desired range. Suggestions are given to decrease "high risk" levels to desired ranges.

Personal Well-Being: The Personal Well-Being Profile will help to evaluate an individual's general outlook on life, level of happiness and ability to manage stress. Where appropriate, suggestions are given to help make positive changes.

The premise of the PALS program is that people are primarily responsible for their own health. Lifestyle habits influence moods, energy levels, and possibly even longevity. The PALS program can help individuals create a better quality of life for themselves.

Obtaining the personalized PALS profiles begins with a test. No studying is required. A Lifestyle Inventory Questionnaire is completed before the fitness assessments are administered.

PALS goes beyond most fitness programs. It is personalized and considers health status and individual preferences. It is more comprehensive than most because it also includes nutrition, a blood analysis, a psychological profile, and other lifestyle habits which contribute to total well-being. This integrated health and fitness program helps individuals improve the quality of their lives by being healthier, happier and more productive.

COMPONENTS OF AN EFFECTIVE SCREENING ACTIVITY

Before beginning the fitness assessments, review this checklist that outlines components of an effective screening activity. It is important that you understand the scope of screening activities and that you have the capabilities and resources to conduct an effective screening. There are serious consequences to screenings that are conducted in a negligent manner.

SCREENING SITE/ENVIRONMENT

* easy access by entire population
* adequate space for registration, waiting, testing, counseling
* smooth flow of traffic
* privacy during testing results reporting, and counseling

PROMOTION/RECRUITMENT

* promotion activities that emphasize participation of the entire population
* voluntary

STAFFING

* adequate number of staff for expected flow rate
* properly trained for respective jobs; certified (if required)
* screening supervisor(s) on premises at all times
* professional appearance and conduct
* understand and respect confidentiality
* trained to deal with emergency situations (fainting, anxiety reactions, etc.)
* appreciate the importance of accurate reporting of results and documentation of screening center activity

PROCEDURES

* obtain informed consent and/or release form
* minimize waiting period
* testing protocols conducted in accordance with standards for population(s)

EQUIPMENT

* properly maintained and calibrated
* clean
* adequate supplies on hand

RESULTS REPORTING AND COUNSELING

* privacy maintained
* individualized review of results; recommendation for follow-up care as appropriate
* printed "take home" educational materials for all participants regardless of risk level. These materials should include information about the relationship of the screening factor to health risks, overview of ways to lower risk, and general recommendations for follow-up.

QUALITY CONTROL

* regular schedule for equipment calibration
* adequate supervision of staff procedures and calibration of equipment as recommended

FITNESS ASSESSMENT PLANNING CONSIDERATIONS

Below are considerations specific to fitness assessments.

DATE AND TIME
* Block out the appropriate time to assess # of employees (usually can comfortably test 8 people per hour).
* Will the assessment be done on company time or personal time? (Time away from work is usually one hour.)
* Do special arrangements need to be made for various shift workers? (Odd testing hours might need to be incorporated.)

TESTING STAFF
* Should be qualified fitness professionals/technicians.
* Supervisor should be certified through the American College of Sports Medicine (Exercise Test Technologist, Health/ Fitness Director or Health/Fitness Instructor).
* All technicians should have current CPR certification.
* All technicians should be good role models and good communicators.
* Numbers of both sexes should be on staff to assure that only female technicians measure female participants on the skinfold assessment.

SCHEDULING OF APPOINTMENT
* Devise an appointment sheet to facilitate scheduling.
* Keep the number of people helping with sign-up to a minimum (potential for scheduling errors increases).
* Only use one master schedule. Watch out for double scheduling!
* Give the participant an appointment reminder card/memo.

ORIENTATION MEETING
* A meeting to introduce everyone to the program is a wonderful way to generate interest. A PALS orientation video is available--"Maximizing Your Potential" (approximately 10 minutes).
* It is the perfect opportunity for an individual to sign-up.
* An appointment reminder, Lifestyle Inventory Questionnaire with instructions, and the pre-assessment instructions should be given to the individual before leaving.

SPACE CONSIDERATIONS
* Secure a space for the length of time that the assessments will take place.
* The area should be clean and orderly.
* Convenience and accessibility are major considerations.
* The area should be equipped with a telephone and should have water readily available.

SAFETY CONSIDERATIONS
* Emergency procedures should be practiced and posted.
* Emergency equipment should be readily available.

GROUP REVIEW SESSION
* After the results have been prepared, interpretation of the results by a professional is recommended. A PALS video for interpretation results is available (approximately 20 minutes).
* Groups of 25-50 can be scheduled for one session depending upon space available.

PREPARATION FOR SCREENING

An orientation video (approximately 10 minutes in length) is available to explain the PALS program and encourage individuals to complete the Lifestyle Inventory Questionnaire and participate in the fitness assessments.

After the orientation video, participants should be given an opportunity to make an appointment for a blood test (optional) and the fitness assessments.

The following instructions need to be given to each participant before the time of his/her fitness assessment:

- Bring a towel
- Wear exercise clothing and tennis/running shoes
- If you wear warm-up pants, wear gym shorts underneath
- WOMEN; No leotards or panty hose
- NO coffee, tea, or cola for 4-6 hours prior to screening
- NO tobacco for 2 hours prior to screening
- NO alcohol or heavy exercise for 24 hours prior to screening
- Eat light meals prior to screening
- Take prescribed medications as usual; bring name of medicine and dosage to the screening

A handout containing these instructions should be provided to all participants.

ADMINISTRATION OF THE FITNESS ASSESSMENTS

IMPORTANT:
A PALS training video is available and should be reviewed by fitness technicians prior to performing assessments.

INTRODUCTION/OVERVIEW

1. Welcome participants and make them feel comfortable.

2. Take a few minutes to give an introduction/overview of the assessments.

3. Check to make sure that the correct OPFAC number has been entered in the appropriate space on page 2.

4. Check input booklet for errors or incompletions. Use the Instructions for Completing the PALS Lifestyle Inventory to assist you in locating errors and incompletions.

5. Complete the medical information section on page 15 of the questionnaire and write the participant's name in the block at the top of page 16.

6. The social security number is required on page 2 of the questionnaire. This number is very useful when doing follow-up assessments. It is the most reliable method of tracking when doing epidemiological studies.

REQUIRED CONSENT/SCREENING FORMS

1. Obtain signatures in ink on the Informed Consent form. The form meets requirements of the Institutional Review Board for Research with Human Subjects at The Cooper Institute for Aerobics Research. Be sure that participants read and sign the form.

2. Administer the Physical Activity Readiness Questionnaire (PARQ) found in enclosure (5). If the answer is "No" to all the questions on the PARQ, proceed with the assessments. If there are any "**Yes**" responses, probe for additional information to determine that it is safe to perform the tests. The technician should use his/her best professional judgment, however, if there is any doubt, it is best not to perform the tests that are in question. Obtain a signature on the PARQ by the testing supervisor. If there are "**Yes**" responses, it is likely that the participant should be referred to his/her physician for medical clearance before certain assessments are conducted.

3. See pages D-9 & D-10 for a list of medications that would exclude a participant from performing specific assessments. For example, if the participant is taking a beta-blocker, he/she would be excluded from the cardiovascular test because this type of medication limits the heart rate response to exercise.

SUGGESTED SEQUENCE OF TESTS

Blood Test Profile (Optional)
Resting Blood Pressure
Resting Heart Rate
Height/Weight
Flexibility (Sit and Reach)
Body Composition
Waist-to-Hip Ratio
Cardiovascular Endurance
Abdominal Strength
Upper Body Strength

Conduct assessments according to the protocols taught during the Coast Guard Health & Fitness Leader Training. Because of the potential research studies that may evolve from this database, it is extremely important that the standard procedures are followed. It is also important to maintain and calibrate equipment often.

NOTE: In the case that one or more of the above tests are not taken, make sure that you fill in "test not taken" in the appropriate oval on page 16 of the questionnaire. Height, weight, resting blood pressure and resting heart rate are all **required tests**!

OPTIONAL TESTS

BLOOD PROFILE:

Providing a cholesterol screening is an important phase of the assessment process. It is optional, and can be offered by the finger-stick method or a venous blood draw.

If the finger-stick method is used to obtain a total cholesterol value only, the participant is not required to fast. If this method is used we suggest that it be the first assessment.

A venous blood draw requires fasting 10-12 hours prior to the screening to obtain accurate readings. Total cholesterol, MDL, LDL, triglyceride, and glucose levels will be measured. If this method is used, we strongly suggest that the blood draw is conducted prior to the fitness assessment so that the results will be available and counseling can be provided.

EXCLUSION CRITERIA FOR THE CARDIOVASCULAR ENDURANCE TESTS

1. History of heart disease, including heart attack, cardiac arrest, valvular disease, congestive heart failure, myocarditis or any other heart disease treated by a doctor.

2. Any history of chest pain diagnosed by a physician as angina pectoris.

3. Any known cardiac dysrhythmias or conduction defects.

4. History of stroke.

5. Use of medications for the heart or blood vessels during the last 3 months, including medicine for chest pain, dysrhythmias, congestive heart failure, or hypertension; specific medications warranting exclusion:

   A. Alpha blockers
   B. Beta blockers
   C. Calcium channel blockers
   D. Nitrates
   E. Combined alpha and beta blockers
   F. Centrally acting adrenogenic inhibitors
   G. Non-adrenogenic peripheral vasodilators

   If there is any question about a drug, the test should be postponed pending clearance by the participant's physician. A list of medications that will preclude administration of the cardiovascular endurance test is provided at the end of this appendix.

6. Any acute infectious disease (colds, flu, virus, etc.)

7. Neuromuscular, musculoskeletal, or orthopedic disorders that would make the test uncomfortable or dangerous.

8. Renal, hepatic, or other metabolic insufficiency.

9. Resting blood pressure greater than 160 mmHg systolic or 100 mmHg diastolic.

10. The participant does not want to take the test for any reason.

11. The test supervisor can also exclude based on professional judgment.

INDIVIDUAL REVIEW SESSION

* Welcome participants to the final station in the assessment process.

* Ask the participant about:

    1. Their reaction to the assessment process
    2. Any specific questions
    3. Any comments

* Carefully review all pages of the Lifestyle Inventory Questionnaire. Mark "test not taken" as appropriate on page 16.

* Let the participant look at the example report while you check their booklet.

* Review the ASSESSMENT DATA SHEET.

* Handout cholesterol fact sheet and any other educational material and explain (if applicable).

* Schedule the participant for a group review session.

* Ask for any additional questions. Reinforce the importance of attendance at the group review session.

* Express appreciation for participation.

GROUP REVIEW SESSION

A PALS Video entitled "Understanding Your Health Profile Report" is available for the group review session. The video is approximately 20 minutes long.

IMPORTANT:

* Distribute the sealed Health Profile Reports and allow individuals 5-10 minutes to look over their reports before starting the video.

* After viewing the video, health and fitness experts should be available to answer questions.

* Provide a name and phone# for individuals to contact for private follow-up.

* Distribute any education materials or information about health promotion program activities.

Instructions for Completing
PERSONALIZED AEROBICS LIFESTYLE SYSTEM
Lifestyle Inventory Questionnaire

General Instructions:

The PERSONALIZED AEROBICS LIFESTYLE SYSTEM is based on your responses to the Lifestyle Inventory Questionnaire. It is only as complete and accurate as the responses you provide on the questionnaire. The following information is provided to assist you in completing the questionnaire:

* Refer to the marking examples on page 1 of the questionnaire.
* Only use a No. 2 pencil on the booklet.
* Read each question carefully and mark your answer in the appropriate oval.
* Make a heavy dark mark that fills the oval completely.
* Erase completely any response that you change.
* Do not write on the booklet except in the space provided. Keep the booklet free from wrinkles, and stray marks.
* Do not fold the booklet.

Special Considerations:

Give special attention to the items listed below. Read the questions carefully and follow the tips to avoid making errors.

ITEM	TIPS TO AVOID ERRORS
Page 2, Program code	Your OPFAC number is _____. Fill in the number AND the corresponding ovals.
Page 2, Name	Fill in information in the blocks AND corresponding ovals. When completing ovals, be careful not to confuse "O" and "Q".
Page 4, Section 1, Question 1	Mark only the HIGHEST number.
Page 4, Section II, Question 6	Provide ONE response for each condition.
Page 4, Section II, Question 7	Provide ONE response for EACH illness or condition. "No" is a response.
Page 5, Section II, Question 15	If you answer "No", be sure to skip questions 16, 17 and 18 and go to Section III, Question 1.
Page 5, Section II, Question 17	Provide ONE response for EACH medication. Answer this question only if you are currently taking medication.
Page 7, Section V, Question 13	Mark only ONE location.
Page 7, Section V, Question 14	Mark only ONE type of injury.
Page 7, Section VI, Question 1	Mark ONE response for EACH food item.
Page 8, Section VI, Question 2	Mark ONE "frequency of consumption" and "low sodium" (if applicable) for each food item. Complete these items VERY carefully.
Page 9-11, Section VII, A,B&C	Mark an answer for each question.
WOMEN ONLY	
Page 11, Section VIII, Question 1	If you respond "No" to question 1, be sure to go to question 4.

Depending upon your answer to certain questions, you may be directed to go ahead (skip some questions). You may be directed to go ahead at:
Section II, Questions 11, 13, 15
Section III, Questions 2, 3, 7, 8
Section IV, Question 3
Section V, Questions 1, 4, 11, 16, 17

FINAL CHECK

Please look over your entire Lifestyle Inventory Questionnaire one more time. Make sure you have responded to all questions, your responses are accurate, and your marks are clear and dark. DO NOT BEND OR FOLD THE BOOKLET. If there are errors, your questionnaire booklet will be returned to you for correction before your report can be generated.

Thank you again for participating in the PALS program.

CARDIOVASCULAR MEDICATIONS WHICH WILL PRECLUDE ADMINISTRATION OF TESTING

GENERIC NAME	BRAND NAME
BETA BLOCKERS	
1. Acebutolol	Sectral
2. Atenolol	Tenormin, Tenoretic
3. Metoprolol	Lopressor
4. Nadolol	Corgard
5. Pindolol	Visken
6. Propranolol	Inderal
7. Timolol	Blocarden
8. Transicor, Slow Transicor	
9. Labetalol	Trandate, Normodyne
10. Perbutol	Levitol
11. Betaxol	Kerlone
ANTI-ARRHYTHMIC AGENTS	
1. Amiodarone	Cordarone
2. Quinidine	Quinidex, Quinaglute
3. Procainamide	Pronestyl, Procan SR
5. Tocainide	Tonocard
6. Mexiletine	Mexitil
7. Encainide	Enkaid
8. Flecainide	Tambocor
9. Disopyramide	Norpace
10. Ethmozine	Moricizine
11. Bretylium	Bretylol
12. Propafenone	Rythmol
13. Moricizine	Ethomozine
14. Esmolol	Brevibloc
NITRATES AND NITROGLYCERIN	
1. Isosorbide dinitrate	Isordil
2. Nitroglycerin	Nitrostat
3. Nitroglycerin ointment	Nitrol ointment
4. Nitroglycerin patches	Transderm Nitro, Nitro-Dur, Nitrodisc
DIGITALIS	
1. Digoxin	Lanoxin

*** Note: This list represents most of the current cardiovascular medications but new ones may be added.**

CARDIOVASCULAR MEDICATIONS WHICH HAVE A MINOR BUT SIGNIFICANT EFFECT ON THE HEART RATE

If these medications are being taken, the tests may still be administered after asking why the medication was prescribed. Medications to control hypertension allows testing but if is prescribed for a heart condition of any kind, do not administer the tests.

GENERIC NAME	BRAND NAME
CALCIUM CHANNEL BLOCKERS	
I. Verapamil	Calan, Isoptin
2. Diltiazem	Cardizem
3. Nifedipine	Procardia, Adalat
4. Nicardipine	Cardene
5. Nitrendipine	Baypress
6. Felodipine	Plendil
7. AmlodipineNorvasc	7. 1 + 5
PERIPHERAL VASODILATORS	
1. Hydralazine	Apresoline
2. Minoxidil	Loniten
ADRENERGIC BLOCKER	
1. Prazosin	Minipress
2. Terazosin	Hytrin
3. Doxazosin	Cardura
ANTI-DRENERGIC AGENTS	
1. Clonidine	Catapres
2. Guanabenz	Wytensin
3. Guanethidine	Ismelin
4. Guanfacine	Tenex
5. Methyldopa	Aldomet
6. Reserpine	Serapasil

GENERIC NAME	BRAND NAME
DIURETICS	
I. Hydrocholorthiazide	Edidrix
2. Furosemide	Lasix
3. Ethacrynic Acid	Edecrin
4. Spironolactone	Aldactone
5. Triamterene	Dyrenium
6. Amiloride	Midamor
Dyazide, Maxzide	
8. 1 + 6	Moduretic
9. Metalazone	Zaroxolyn
ACE INHIBITORS	
1. Captopril	Capoten
2. Enalapril	Vasotec
3. Lisinopril	Prinivil, ZestrilALPHA
4. Ramipril	Altace
5. Fosinopril	Monopril
6. Benazapril	Lotensin
7. Quinapril	Accupril

*** Note: This list represents most of the current cardiovascular medications but new ones may be added.**

APPENDIX E. RESOURCE LIST

Wellness and Health Promotion Program Administrator, G-WKW-1 .....(202) 267-2225

Health Risk Appraisal Program Administrator, G-WKW-1.....(202) 267-6624

Alcohol Program Administrator, G-WKW-1 .....(202) 267-6658

Alcohol Program Representative, MLCLANT(kma).....(757) 628-4358

Alcohol Program Representative, MLCPAC(kma) .....(510) 437-3959

American Cancer Society..(connects to regional chapter) .....(800) 227-2345

American Heart Association..(connects to local chapter).....(800) 242-8721

American Lung Association..(connects to local chapter) .....(800) 586-4872

American Red Cross..(ask for your local chapter).....(703) 206-6000

National Clearinghouse for Alcohol and Drug Information .....(800) 729-6686

Presidential Sports Award.....(407) 363-6170

APPENDIX F. ACRONYM LIST

1RM---------- one repetition maximum
AFRS ---------- Armed Forces Recipe Service
AOR ---------- area of responsibility
BF ---------- body fat
CPR ---------- cardiopulmonary resuscitation
CRE ---------- cardiorespiratory endurance
DBW ---------- desired body weight
EPA ---------- Environmental Protection Agency
ETS ---------- environmental tobacco smoke
FL ---------- Fitness Leader
FS ---------- Food Service Specialist
FSO ---------- Food Service Officer
HAW ---------- Heart at Work Program
HDL ---------- high density lipoprotein (H is for healthy)
HRA ---------- health risk appraisal
LBM ---------- lean body mass
LDL ---------- low density lipoprotein (L is for lousy)
PALS ---------- Personalized Aerobics Lifestyle System
PARQ ---------- Physical Activity Readiness Questionnaire (enclosure (5))
PDR ---------- personal data record
WC ---------- Wellness Coordinator
WR ---------- Wellness Representative

<u>CHAPTER 2 Acronyms</u>
AA ---------- Alcoholics Anonymous
AECC ---------- Aeromedical Evacuation Coordination Center
APA ---------- Addictions Program Administrator
APR ---------- Addictions Program Representative
APS ---------- Addictions Prevention Specialist
ATF ---------- Alcohol Treatment Facility
CAAC ---------- Counseling and Assistance Center
CDAR ---------- Collateral Duty Addictions Representative
DABSII ---------- Drug and Alcohol Beneficiaries System II
DAC ---------- Drug and Alcohol Counselor
DSM ---------- Diagnostic & Statistical Manual for Mental Disorders of the American Psychiatric Association
DUI ---------- driving under influence
DWI ---------- driving while intoxicated
O&P ---------- Outreach and Prevention Specialist
PPC ---------- patient placement criteria
PREVENT -------- personal responsibility, values education & training
SAFE ---------- Substance Abuse Free Environment
SASSI2 ---------- Substance Abuse Subtle Screening Inventory

U.S. Department of Transportation
United States Coast Guard

Commanding Officer
USCGC KEEP FIT

2100 Second Street, S.W.
Washington, DC 20593-0001
Phone: (202) 267-0528

6200
27 May 1997

From: Commanding Officer, USCGC KEEP FIT (WELL 2000)
To: FS1 Well Being, XXX XX XXXX, USCG

Subj: DESIGNATION AS UNIT WELLNESS REPRESENTATIVE (WR)

Ref: (a) WELLNESS MANUAL, COMDTINST M6200.1

1. In accordance with reference (a), you are hereby designated as USCGC KEEP FIT's Wellness Representative (WR).

2. You shall comply with the guidance provided in reference (a) and all applicable directives and instructions.

I. M. HEALTHY

Copy: ISC (PW), Wellness Coordinator
Unit PDR

U.S. Department of Transportation
United States Coast Guard

Commanding Officer
USCGC KEEP FIT

2100 Second Street, S.W.
Washington, DC 20593-0001
Phone: (202) 267-0528

6200
27 May 1997

From: Commanding Officer, USCGC KEEP FIT (WELL 2000)
To: FS1 Well Being, XXX XX XXXX, USCG

Subj: DESIGNATION AS UNIT FITNESS LEADER (FL)

Ref: (a) WELLNESS MANUAL, COMDTINST M6200.1

1. In accordance with reference (a), you are hereby designated as USCGC KEEP FIT's Fitness Leader (FL).

2. You shall comply with the guidance provided in reference (a) and all applicable directives and instructions.

I. M. HEALTHY

Copy: ISC (PW), Wellness Coordinator
Unit PDR

FOR OFFICIAL USE ONLY

CDAR REFERRAL AND FOLLOW-UP REPORT

This report is required to be submitted to MLCLANT or PAC (kma) on all members referred to unit CDAR!

Member's Name:_____ SSN:__ __ __-__ __-__ __ __ __
Unit:_____ Date Interviewed: ___/___/___
Incident__ Situation___ Command Referral ___ Self-Referral ___
Rank/Pay grade :_____ Rotation date: __/__/__ EOAS: ___/___/___

Substance of use or abuse:
__ Alcohol __ THC __ Cocaine __ Steroids __ Tobacco: __ Prescription Drugs
__ Other drugs (specify)_____ __ other behavior: (specify) _____
Please give brief description of events that led to member's referral: _____
_____
_____
_____

If recommended, what type of education or treatment is member being referred to?
Location :
_____?

Education
__Impact __Prevent
__Local Prevention
__Other_____

Treatment
__Pre-treatment
__Outpatient
__Intensive Outpatient
__Inpatient/Residential

If this is a follow-up report, please indicate case's disposition:

___ Screened, no other referrals required.
___ Referred for additional assistance
___ Attended Outpatient treatment
___ Attended Inpatient treatment.
___ Aftercare Report (Initial/3mos/6mos/9mos)
___ Successfully completed aftercare.
___ Relapsed. Retained on aftercare.
___ Relapsed. Discharged.
___ Transferred to _____
___ Regular Discharged/retirement.

We would appreciate any additional comments. _____
_____
_____

_____	___/___/___	_____	___/___/___
Signature of CDAR	Date	Signature of CO/OINC	Date

FOR OFFICIAL USE ONLY

USCG REHABILITATION TREATMENT REQUEST FORM

FOR ATF/APR USE ONLY -- please print/type BOLDLY all entries!:

Reg #_____ **Group No.**_____ **TAD**_____ **TEMDU**_____
Admit Date _____, ___/___/___ **Complete** ____/____/____ **Unit PDR**_____ **Health Record**_____
Sked by _____ **Date** _____ **Data Entered By** _____ **Date** _____/___/_____

APR will NOT confirm inpatient date unless this form shows XO //s// & ALL data. Telefax on fine setting to MLC LANT (kma) @ (757)628-4337 or MLC PAC (kma) @ 510-437-5805 (ATTN: APR)

UNIT CDARS: Call CAAC or ATF to setup treatment dates!

Circle treatment (Tx) desired: (ALCOHOL) (DRUG) (OTHER_____)
Indicate Tx facility location: _____
Medical Diagnoses: _____ Treatment Start Date: _____

NAME (Last, First, Mid Init) RATE/RANK SVC BR SSAN (USCG)
_____
Unit Address: _____
_____ OPFAC Number _____-_____
_____ CDAR: _____
_____ CMD PH:(___)___-____FAX #:___-____ MLC # : _____
Birth date: ___/___/___ Gender:_____ Ethnicity: _____ Education: _____
Marital Status:_____ Next of Kin (name/relationship):_____
Home Phone; address/zip: (__) ___-_____, _____
Prior Treatment?(dates/locations) _____ Number of Dependents_____
EOAS date: ___/___/___ Religious Preference _____

Does client have a valid driver's license? Yes No State___ Restrictions?_____
Civilian/military legal action/medical appointments. pending? Yes No

CO's name/rank:_____ Psych Hx?_____
Date of CAAC Screening (if any): ___/___/___ Medical Officer's Evaluation: ___/___/___
Date tested for HIV___/___/___
Note: [HIV test MUST be performed within 30 days of inpatient date (NAVY facilities only).]

Approved by:
Executive Officer, requesting command: _____
(XO's //s//)

Approved by:
MLCLANT/MLCPAC Alcohol Programs Manager: _____
(APR's //s//)

PHYSICIAL ACTIVITY READINESS QUESTIONNAIRE

NAME:_____ **DATE:**_____.

Answer each of the following questions by checking either YES or NO.

YES	NO	
___	___	Has your doctor ever said you have heart trouble?
___	___	Do you frequently have pains in your heart and chest?
___	___	Do you often feel faint or have spells of severe dizziness?
___	___	Has a doctor ever said your blood pressure was too high?
___	___	Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be made worse with exercise?
___	___	Is there a good physical reason, not mentioned here, why you should not follow an activity program even if you wanted to?
___	___	Are you over the age of 65 and not accustomed to vigorous exercise?
___	___	Are you taking any medications?
___	___	Do you feel unhealthy today?

If you answered **YES** to any of the above questions, you should check with medical prior to vigorous physical activity.