Army Regulation 600–63

Personnel—General

Army Health Promotion

Headquarters
Department of the Army
Washington, DC
17 November 1987

SUMMARY of CHANGE

AR 600-63
Army Health Promotion

This is a new regulation. It--

o Establishes a health promotion program which integrates many existing programs for Total Army family well-being (throughout).

o Prescribes policies for each health promotion program area (chap 2).

o Establishes a Health Promotion Council to identify activities, assess effectiveness, prioritize resources, and develop and oversee an installation/community program (chap 3).

o Provides guidance for controlling smoking in DA controlled spaces, and incorporates the contents of AR 1-8, which is rescinded (chap 4).

o Establishes the Army Suicide Prevention Program and the Family Member Suicide Prevention Program (chap 5).

o Provides for a Fit To Win Coordinator to plan, initiate, evaluate, and administer the program in coordination with the Health Promotion Council (chap 3).

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Effective 17 December 1987

Personnel—General

Army Health Promotion

This UPDATE printing publishes a new regulation that is effective 17 December 1987.

By Order of the Secretary of the Army:

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General, United States Army
Chief of Staff

Official:

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Brigadier General, United States Army
The Adjutant General

Summary. This regulation prescribes policy, responsibilities, and procedures for the Army Health Promotion Program.

Applicability. This regulation applies to the Active Army, Army National Guard, U.S. Army Reserve, and civilians employed by the Army.

Impact on New Manning System. This regulation does not contain information that affects the New Manning System.

Internal control systems. This regulation is not subject to the requirements of AR 11–2. It does not contain internal control provisions.

Supplementation. Supplementation of this regulation is encouraged to tailor health promotion to the local command, but is not required. If supplements are issued, HQDA agencies and major Army commands will furnish one copy of each to HQDA (DAPE–MPH), WASH DC 20310–0300. Other commands will furnish one copy of each to the next higher headquarters. Policies established in this regulation may not be changed without prior approval of HQDA (DAPE–MPH).

Interim changes. Interim changes to this regulation are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested improvements. The proponent agency of this regulation is the Office of the Deputy Chief of Staff for Personnel. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DAPE–HRD), the Pentagon, WASH DC 20310–0300.

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*This regulation supersedes AR 1–8, 18 November 1977.

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Chapter 1
Introduction

Section I
General

1–1. Purpose
This regulation prescribes policies and responsibilities for the Army Health Promotion Program.

1–2. References
Required and related publications and prescribed forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Objective and scope of the Army Health Promotion Program
a. The goal of the Army Health Promotion Program is to maximize readiness, combat efficiency, and work performance. Objectives include enhancing the quality of life for all soldiers, Army civilians, family members and retirees; and encouraging lifestyles to improve and protect physical, emotional, and spiritual health.

b. The Army Health Promotion Program encompasses a variety of activities designed to facilitate behavioral and environmental alterations to improve or protect health. This includes a combination of health education and related organizational, social, emotional, spiritual, and health care activities and initiatives. These are integrated to produce a single, comprehensive program.

c. Functionally, the components of health promotion consist of all activities for members of the Total Army Family in the following areas:

(1) Antitobacco.
(2) Physical conditioning.
(3) Weight control.
(4) Nutrition.
(5) Stress management.
(6) Alcohol and drug abuse prevention and control.
(7) Early identification of hypertension.
(8) Suicide prevention.
(9) Spiritual fitness.
(10) Oral health.

d. In addition to the components listed above, health promotion necessarily includes other related activities. These include such things as physical and dental examinations, health risk appraisals, physical fitness facilities, recreation and leisure education and activities, as well as initiatives to promote social and emotional well-being. These activities are coordinated and integrated into a comprehensive Army Health Promotion Program called "Fit To Win."

e. Operationally, health promotion is implemented and enhanced at the installation level through a health promotion program as provided in this regulation.

Section II
Responsibilities

1–5. Deputy Chief of Staff for Personnel (DCSPER)
The DCSPER is the Army Staff proponent for the following:

a. The Army Health Promotion Program and implementing DOD Directive 1010.10.

b. The Alcohol and Drug Abuse Prevention and Control Program (ADAPCP).

c. Antitobacco program.

d. Army Weight Control Program.

e. Suicide prevention to include coordination and monitoring of the Army Suicide Prevention Program (ASPP).

1–6. Deputy Chief of Staff for Operations and Plans (DCSOPS)
The DCSOPS has Army Staff responsibility for the Army Physical Fitness Program (APFP).

1–7. Deputy Chief of Staff for Logistics (DCSLOG)
The DCSLOG is the proponent for development and implementation of policies and programs concerning nutrition in troop dining facilities and commissaries.

1–8. The Surgeon General (TSG)
TSG—

a. Develops policy for all medical, dental, psychological, physiological, and health areas including diet, weight and body fat standards, cardiovascular risk factor reduction, nutrition, and stress management, and assists in policy development in other areas including Army health promotion, physical fitness and exercise, control of substance abuse, suicide prevention, and antitobacco use.

b. Has Army Staff responsibility for stress management.

c. Acts as Department of Defense executive agent for nutrition (to include Army Staff responsibility) for policy, standards, and education programs.

d. Is the Army Staff proponent for early identification of hypertension.

e. Is the Army Staff proponent for oral health promotion.

f. Appoints a representative with an appropriate health care background to serve along with the representative from ODCSPER as a member of the DOD Health Promotion Coordinating Committee.

g. Plans, implements, and evaluates an automated health risk appraisal with procedures for administration and for processing and compiling the data at HQDA, MACOM, installation or community, and unit levels.

h. Advises the DCSPER with respect to all medical and psychiatric aspects of health promotion to include the epidemiological aspects of suicide.

i. Oversees the technical aspects of Army training programs in suicide prevention.

j. Assures that Army Medical Departments (AMEDDs) provide—

(1) Equipment and health care providers to administer and interpret the health risk appraisal, teach classes, and compile statistics to support the health promotion program.

(2) Training for health care providers in suicide risk identification and treatment for patients who may be at increased risk of suicide.

1–9. The Chief of Public Affairs (CPA)
The CPA is responsible for the development and implementation of a public affairs plan in support of the Army Health Promotion Program. This includes articles in internal print and broadcast media, and release of information about the Army Health Promotion Program to the public through the media and through community relations.

1–10. Chief of Chaplains (CCH)
The CCH—

a. Has Army special staff responsibility for the installation chaplain family life center program, spiritual fitness, and battle fatigue ministry.

b. Encourages and promotes concepts of spiritual well-being and good health among soldiers and family members.

c. Coordinates suicide prevention activities with the DCSPER and TSG.

1–11. The Judge Advocate General (TJAG)
TJAG—

a. Provides staff assistance and advice for the interpretation of appropriate laws and concerning regulations the Army Health Promotion Program.

b. Reviews the liability implications of nonhealth professionals providing health promotion programs.

1–12. Chief of Engineers (COE)
The COE has Army special staff responsibility for the construction of installation physical fitness and recreation facilities supported by appropriated funds.

1–13. Chief, National Guard Bureau (CNGB)
The CNGB prescribes policy and programs for health promotion within the Army National Guard (ARNG), and encourages State adjutants general to develop health promotion programs including suicide prevention and oral health.

1–14. U.S. Army Reserve (USAR)
Responsibilities for administering the health promotion program, to include suicide prevention, in the USAR are as follows:

a. The Chief, Army Reserve (CAR) The CAR, in coordination with the Deputy Chief of Staff for Personnel, prescribes policy and monitors health promotion for the USAR.

b. The Commanding General, U.S. Forces Command (CG, FORSCOM), executes health promotion policy and procedures for USAR troop program units

(TPUs) in the Continental United States (CONUS).

c. The Commanding General, U.S. Army Western Command (CG, WESTCOM) executes health promotion policy and procedures for all assigned USAR TPUs and activities in Hawaii and in possessions, trusts, and territories administered by the United States in the Pacific Command Area.

d. The Commander-in-Chief, U.S. Army Europe (CINCUSAREUR) and Seventh Army executes health promotion policy and procedures for all assigned USAR TPUs in Europe.

e. The Commanding General, U.S. Army Reserve Personnel Center (CG, ARPERCEN), is the administrator of health promotion policy and procedures for the Individual Ready Reserve (IRR).

1–15. Commanding General, U.S. Army Community and Family Support Center (CG, CFSC)

The CG, CFSC—

a. Appoints the CFSC Family Fitness Coordinator to serve as an adviser to the Army Health Promotion Council.

b. Has Army operational responsibility for installation physical fitness and recreation facilities supported by nonappropriated funds (NAF).

c. Has special staff responsibility for Total Army family recreation programs.

d. Defines the role and trains Army Community Service (ACS) personnel in support of suicide risk identification efforts using technical assistance from mental health officers.

e. Develops suicide prevention education and community awareness programs for family members.

1–16. Commanding General, U.S. Army Training and Doctrine Command (CG, TRADOC)

The CG, TRADOC—

a. Coordinates the inclusion of Army health promotion into Army school curricula.

b. Develops training support packages for suicide risk identification for unit leaders.

c. Provides suicide risk identification training for leadership courses.

d. Implements Army policy to control use of tobacco products during initial entry training.

1–17. Commanding General, U.S. Army Soldier Support Center (CG, USASSC)

The CG, USASSC, is responsible for Army physical fitness doctrine.

1–18. Commanders of major Army commands (MACOMs)

All MACOM commanders will—

a. Monitor data, and develop and implement programs to achieve Army health promotion.

b. Appoint a Fit To Win Coordinator to provide staff supervision for the implementation of actions and procedures of this regulation and its relationship to all members of the Total Army Family.

c. Appoint a Suicide Prevention Coordinator to provide installation assistance for and staff supervision of the ASPP.

d. Develop and implement a MACOM Suicide Prevention Plan.

1–19. Commanders of U.S. Army installations and military community activities

These commanders will—

a. Establish and chair a Health Promotion Council.

b. Appoint a Fit To Win Coordinator to integrate health promotion activities and monitor program progress at their installations.

c. Monitor aggregate data and implement a health promotion program at their installations in accordance with this regulation and instructions from their MACOM commanders.

d. Appoint a task force or committee and designate a presiding officer to plan, implement, and manage the ASPP.

e. Coordinate with union organizations representing civilians employed by the Army as applicable.

1–20. Medical Department Activity/ Medical Center (MEDDAC/MEDCEN) commanders

These commanders will—

a. Serve with Directors of Personnel and Community Activities (DPCAs) as principal advisers to the installation/community commander with respect to Army health promotion.

b. Provide equipment and health care providers to administer and interpret the health risk appraisal, teach classes, and compile statistics to support the health promotion program.

c. Integrate activities formerly planned and coordinated by the Community Health Education Program (CHEP) and the Health Initiatives Fitness Team (HIFIT) into the installation or community Health Promotion Council; and use ad hoc or subcommittees to address specific issues involving health promotion in the MTFs.

d. Develop protocols for the identification and management of suicidal patients in each patient care unit of the medical treatment facility (MTF) and provide inservice suicide prevention training for health care providers.

e. Provide a mental health officer to conduct a psychological autopsy when required by this regulation.

f. Provide advice and assistance to commanders of RC units in order to facilitate and implement health promotion policies.

1–21. Commanders at all levels

These commanders will—

a. Remain sensitive and responsive to the needs of soldiers, Army civilians, family members, and retirees.

b. Encourage soldiers, Army civilians, and family members to practice a lifestyle that improves and protects physical, emotional, and spiritual well-being.

c. Enhance unit readiness and maximize human resources by implementing the Fit To Win program within their units.

d. Initiate proactive measures to prevent loss of life within their unit due to suicide and to reduce the impact on survivors if a suicide takes place.

e. Demonstrate positive efforts to deglamorize the use of all forms of tobacco products.

f. Enhance unit readiness and maximize human resources by referring soldiers in Dental Fitness Classes 3 and 4 for examination and treatment to attain at least Dental Fitness Class 2. (See para 2–12.)

g. Ensure that all soldiers and family members understand the availability of dental care at post facilities and the use of the dental insurance plan for treatment at civilian facilities.

Chapter 2
Health Promotion Policies

2–1. General

a. Health promotion policies apply to all Total Army activities and operating agencies. Active participation in all aspects of health promotion will be encouraged.

b. Health promotion increases unit readiness and combat and organizational efficiency by maximizing human resources. These activities encompass physical, emotional, spiritual, and social dimensions. They are positive actions and health education whose total effect improves unit and organizational performance by enhancing individual well-being.

2–2. Antitobacco

a. The use of all forms of tobacco products during initial entry training is controlled for soldiers. (See chap 4.)

b. Commanders and supervisors will encourage family members and retirees to engage in appropriate antitobacco activities.

c. As part of routine physical and dental examinations and at other appropriate times, such as prenatal and well baby clinics, health care providers will inquire about the patient's tobacco use, including use of smokeless tobacco products, and advise them of risks associated with use, the health benefits of abstinence, and where to obtain help to quit.

d. Army policy on smoking in the workplace is in chapter 4.

2–3. Physical fitness

Physical fitness includes factors that allow people to function effectively in physical or mental work and in training or recreation, and still have energy to handle emergencies.

This includes cardiorespiratory fitness, muscular strength and endurance, flexibility, and body composition. (See AR 215–2, AR 350–15, DA Pam 350–18, and DA Pam 350–21 for specific information.)

a. Soldiers

(1) Commanders and supervisors will establish and conduct physical fitness programs for soldiers consistent with AR 350–15, FM 21–20, and the unit mission. Exercise periods are to be conducted with sufficient intensity, frequency, and duration to maintain adequate cardiorespiratory endurance, muscular strength and endurance, and flexibility.

(2) All soldiers in the Active Component (AC) and the Reserve Component (RC) are expected to take part in either collective or individual physical fitness training programs year-round.

(3) AC and RC soldiers, age 40 and over, are required to complete medical screening as prescribed in AR 40–501 and AR 350–15 in a timely manner and as close to their 40th birthday as possible. Once cleared, they will participate fully in unit or individual programs and testing in accordance with AR 350–15.

b. Civilians employed by the Army.

(1) Civilians employed by the Army are encouraged to engage in a regular program of exercise and other positive health habits.

(2) For employees engaged in an occupation that requires physical strength and stamina for satisfactory performance (for example, firefighter), a physical exercise program may be a part of their jobs and may be conducted during duty hours.

(3) For other employees, commanders may approve up to 3 hours administrative leave per week to allow employees to participate in command sponsored physical exercise training, monitoring, and/or education, provided these activities are an integral part of a total fitness program and are time-limited, that is, 6 to 8 weeks in duration.

(4) While formal physical fitness programs may be repeated from time-to-time, employees will not be given administrative leave for physical exercise training once they have already received such training. This grant is limited to one time only. It does not apply to other types of training or professional development. (See AR 690–400.)

(5) Beyond these situations, work schedules should be adjusted to permit training and exercise where possible and where consistent with workload and mission.

2–4. Nutrition

a. Dietary allowances prescribed in AR 40–25 provide guidelines and standards for feeding healthy soldiers. They are intended for use by personnel involved in menu planning, dietary evaluation, nutrition education and research, and food research and development.

b. Nutrient standards for operational rations establish the criteria for evaluating the nutritional adequacy of these rations. Operational rations are composed of nonperishable foods. They are designed to provide complete nutrition for the soldier in simulated or actual combat conditions.

c. Basic guidelines for nutrition education are used to promote optimal fitness in the military population. They guide modification in food procurement policy, food preparation, recipe formulation, and menu development.

d. Installation commanders, dietitians, food advisers, nutritionists, and food service noncommissioned officers (NCOs) will comply with the basic nutritional standards for garrison dining facilities in AR 30–1, appendix J. This appendix provides implementing guidance for meeting nutrition standards in garrison dining facilities and ensuring compliance with AR 40–25.

e. Commanders will ensure that nutrition information, education, and counseling programs are provided to soldiers, family members, Army civilians, and food outlet managers in activities under their control. These programs are provided by, or coordinated with, qualified health care professionals.

2–5. Weight control

a. Commanders and supervisors will monitor all soldiers in their commands in accordance with AR 600–9 to ensure they maintain proper body weight, body composition, and personal appearance standards. At a minimum, AC and RC soldiers will be weighed when they take the APFT or for AC soldiers at least every 6 months.

b. Commanders and supervisors will provide educational and other motivational programs in accordance with AR 600–9 in order to encourage persons to attain and maintain proper body fat standards. Army civilians, family members, and retirees should be included in these programs.

c. Soldiers exceeding body fat standards are subject to the restrictions established in AR 600–9.

2–6. Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)

The ADAPCP includes all activities to eliminate substance abuse, including prevention, identification, education, and rehabilitation services. It includes residential and nonresidential treatment. (See AR 600–85.)

a. Alcohol and drug abuse is incompatible with military service. Soldiers identified as alcohol or drug abusers who, if in the opinion of their commanders, warrant retention, will be afforded the opportunity for rehabilitation in accordance with AR 600–85. Soldiers identified as alcohol abusers who do not warrant retention are to be considered for separation. Consideration and processing for separation for soldiers identified as drug abusers will be in accordance with AR 600–85 and applicable administrative regulations.

b. All levels of the chain of command must take prompt action, regardless of rank or grade, if alcohol or other drug abuse is suspected.

c. Implementation of an ADAPCP capability is required for installations, communities, and activities in accordance with AR 600–85.

d. Installation, community, and activity commanders will ensure that an active and aggressive drug testing program is maintained.

e. Alcohol and drug abuse policy will be given adequate publicity to ensure that eligible civilians, family members, and retirees are aware of—

(1) Command support.

(2) Available information.

(3) Referral procedures.

(4) Rehabilitation services of ADAPCP.

f. Enrollment of Army civilians, family members, and retirees is voluntary. The commander of the servicing installation or activity is responsible for developing procedures by which Army civilians may use ADAPCP facilities and services.

g. Commanders, supervisors, and hospitality, recreation, and health care providers will provide education for all members of the Total Army family on the detrimental effects of alcohol and drug abuse on combat readiness and a healthy lifestyle.

2–7. Stress management

Stress management includes all assistance provided to cope with the demands, real or perceived, from the environment, and from within the individual.

a. Stress, its effects, and its management, is a concern for leaders at every level. Techniques and considerations for the management of stress in Army operations are in FM 26–2.

b. Health care providers and unit ministry team (UMT) personnel assist commanders in the development and implementation of a comprehensive stress prevention effort to increase the ability of individual soldiers and Army civilians to positively deal with stress.

c. Health care providers implement health education and treatment programs for individuals affected by stress. Protocols for referring soldiers, family members, and Army civilians to other agencies will agree with established procedures.

d. Health care providers conduct training programs designed to alert health care providers, commanders, and supervisors regarding evidence of stress affecting an individual.

e. Community recreation professionals will develop and execute leisure activities designed to enhance self-esteem and provide outlets for tension and stress-related energies.

f. The stress of active combat operations often leads to a combat stress reaction called battle fatigue. Commanders, staff officers, and proponent agencies should be aware how—

(1) Unit ministry teams provide preventive, immediate, and replenishing spiritual

and emotional support and care to soldiers experiencing battle fatigue.

(2) Combat stress teams trauma implement the medical recovery aspects of battle fatigue.

2–8. Suicide prevention

a. Suicide prevention is the concern of every leader, commander, supervisor, soldier, and Army civilian.

b. A coordinated program for suicide prevention will be established at every Army installation, community, and activity in accordance with the policies set forth in chapter 5.

2–9. Spiritual fitness

A spiritually fit person recognizes there are multiple dimensions that make up the human being. He or she seeks to develop the total person concept. This includes enhancing spiritual fitness through reflection and practice of a lifestyle based on personal qualities needed to sustain a person in times of stress, hardship, and tragedy. When a person's actions are different from his or her stated values, the person lives with inner conflict. This person struggles for integrity and congruity, but cannot find inner peace until this struggle is dealt with. The extent to which this is accomplished is a measure of spiritual fitness.

a. Commanders at all levels shall encourage and provide for human self-development activities leading to increased spiritual fitness in accordance with this regulation, AR 600–20, AR 165–20, and other applicable directives.

b. Army leaders should develop an awareness of the lifestyles, cultural backgrounds, stages of development, possible relationships to religious beliefs, and needs of soldiers, Army civilians, and family members. HPCs will recommend, coordinate, and ensure the integration of spiritual fitness programs for units, soldiers, family members, and Army civilians in their area of responsibility.

c. Commanders at the installation and community level shall develop soldier and family support activities to undergird, reinforce, and implement the enhancement of spiritual fitness. They will ensure the scheduling of time for activities, programs, and training to accomplish the goals of spiritual fitness, as well as recommending and conducting spiritual fitness programs.

d. In providing for self-development activities, commanders and other leaders must ensure advocacy of a religion does not occur. The practice of religion, to the extent it relates to spiritual fitness, must be left to the sole discretion of the individual soldier, family member, or Army civilian. They must be free to worship or not as he or she may choose without fear of being disciplined or stigmatized by his or her choice. (See AR 165–20, AR 600–20 and DA Pam 600–75.)

e. All soldiers and Army civilians are expected to live by the tenets of the professional Army ethic and those individual values that support and sustain the Army way of life. (See FM 100–1.)

2–10. Physical examination

a. Health care providers will conduct physical examinations and a health risk appraisal in accordance with the procedures of AR 40–501 and separate directives.

b. All soldiers age 40 and over will be screened for cardiovascular risk as well as other limiting factors as part of their periodic physical examinations and in accordance with AR 40–501.

2–11. Hypertension identification

a. The early identification of hypertension includes all initiatives to identify those with a positive family history, and to identify and treat the following health risk factors:

(1) High blood pressure
(2) Tobacco use
(3) Elevated cholesterol level
(4) Obesity
(5) Poor nutrition
(6) Inactivity
(7) Stress
(8) Alcohol and drug abuse

b. These initiatives include early identification, information regarding control and lifestyle factors, and treatment referral. Health care providers will—

(1) Inform soldiers during the periodic physical examination about the effects on hypertension of cholesterol, weight, blood pressure, family history, and lifestyle habits.

(2) Develop and implement protocols for referring individuals with significant health risk factors.

(3) Conduct a cardiovascular screening program for soldiers age 40 and over as prescribed in AR 40–501 and separate directives.

(4) Provide basic information materials on hypertension suitable for use by commanders, supervisors, or counselors outside the health care setting.

(5) Develop and implement procedures to provide annual blood pressure measurement for soldiers and selected family members. As a minimum, hypertension screening is provided as part of all medical examinations, health risk appraisals, and the annual dental examinations for members of the Total Army family. Screening is also provided to other beneficiaries, including those in the Children's Preventive Dentistry Program at the time of their original request for care. Patients with abnormal screening results will receive appropriate medical referrals.

2–12. Oral health

a. Oral health promotion includes all initiatives to increase the overall fitness and dental readiness of soldiers, reduce the incidence of dental disease in the community, identify community members in need of dental treatment, and direct them to sources of appropriate care. It expands the traditional dental program by—

(1) Requiring a minimum level of dental health for active duty soldiers.

(2) Providing to the community information concerning the dental insurance program for family member dental care.

(3) Using the HRA questionnaire dental data as a tool to help evaluate community oral health.

(4) Integrating hypertension screening and tobacco use counseling into the dental examinations and treatment plans.

b. This program includes all traditional preventive dentistry activities described in AR 40–35.

(1) *Oral Health Fitness Program.* The Oral Health Fitness Program is designed to ensure that soldiers maintain optimum oral health and do not lose valuable personal or unit time due to preventable dental disease. Each active duty soldier is required to receive an annual dental examination. Results of the examination are used to establish a Dental Fitness Classification which is monitored by the soldier's unit through the installation automated personnel data base. Commanders will ensure that soldiers receive examinations and required treatment to maintain at least a Dental Fitness Class 2. A brief description of the classifications follows. The complete description is found in AR 40–35.

(a) Dental Fitness Class 1: Requires no dental treatment.

(b) Dental Fitness Class 2: Unlikely to have a dental emergency within 12 months.

(c) Dental Fitness Class 3: Likely to have a dental emergency within 12 months.

(d) Dental Fitness Class 4: Needs a dental examination, or status is unknown.

(2) *Preventive Dentistry Program for children.* This program allows DENTACS to provide, on a space available basis, an oral screening examination, instructions on hygiene procedures, and topical application of anticariogenic agents. Sports mouthguards and pit and fissure sealants may be provided as appropriate.

(3) *Clinical Preventive Dentistry Program.* Clinical preventive measures are included in this program and include all plaque control technique instruction and evaluation, oral prophylaxis, and nutritional counseling as appropriate.

(4) *Community Preventive Dentistry Program.* Community education programs and fluoridation of community water supplies and/or alternative fluoride administration procedures are prescribed under this program. Also included are programs for reporting child neglect or abuse to the local Family Advocacy Program.

2–13. Health risk appraisal

a. Individuals will be aware of their health risk profile and of ways to improve their lifestyles to reduce health risks.

b. Health care providers will use the approved health risk appraisal instrument in accordance with applicable regulations and directives to screen soldiers, family members, Army civilians, and retirees for health risk factors. The results of this appraisal will be given to the individual as a health risk appraisal profile.

c. Enlistees will be administered a health risk appraisal in the reception battalion upon entry into the Army. IET trainees will be given a health risk appraisal profile either in basic training, advanced individual training (AIT), or one-station unit training (OSUT). Officers will be administered a health risk appraisal during the officer basic course (OBC).

d. All soldiers will receive a health risk appraisal as part of the ongoing periodic physical examination (for example, 5-year, over-40 screen, or flight physical). The health appraisal profile is the responsibility of the administering MTF commander.

e. Commanders will ensure—

(1) During PCS inprocessing that soldiers receive a health risk appraisal unless their current health risk appraisal occurred within the last 12 months.

(2) During regular records screening that soldiers have a current (not more than three years old) health risk appraisal.

(3) A program of education and consultation is available to meet identified needs.

(4) Soldiers understand their health risk appraisal profile and the command actions that can be taken to manage health risks.

2–14. Family Fitness Program

a. Existing Army fitness programs that promote well-being will include family members. A total program of family fitness supports—

(1) Readiness
(2) Leadership
(3) Quality of life
(4) Sustainment
(5) Personnel functions

b. This program will promote all aspects of Army Health Promotion addressed by this regulation. (See AR 215–2 and DA Pam 350–21.)

2–15. Acquisition and use of physical fitness and recreation facilities

a. Commanders may use appropriated funds to obtain service contracts to provide physical fitness facilities for soldiers and Army civilians through routine procurement channels. When physical fitness facilities exist in a building that has been leased for use by DA agencies, it is appropriate for the lease to be amended to provide access to these facilities for soldiers and Army civilians. Specific procedures and policies concerning the use of appropriated funds for such acquisition are in purchasing and contracting regulations and guidelines, and in AR 215–2, paragraph 6–4.

b. Army civilians who are not subject to mandatory physical fitness standards may use physical fitness and other recreation facilities to the maximum extent possible consistent with AR 215–2.

c. As an inherent responsibility of command, commanders may establish the priority between soldiers, Army civilians, and family members for the use of physical fitness facilities, consistent with resource availability, mission, and training requirements. Policies discussed in this paragraph apply to those minimally essential facilities whose primary purpose is physical fitness. They do not apply to those designed principally for community recreation activities such as bowling alleys, golf courses, and tennis courts. AR 215–2 permits Army civilians to use community recreation facilities on a space available basis at no cost to the Government.

2–16. Army Fit to Win program

a. The Army Fit to Win program provides the means to begin integrated and coordinated implementation of the health promotion program at the installation level. When fully implemented, such an activity should allow commanders to—

(1) Actively market all aspects of the installation program.

(2) Conduct community needs assessments in health promotion areas.

(3) Provide a program of education and consultation to meet identified needs.

(4) Sustain program participation.

(5) Support Army-wide data collection for program evaluation.

b. DA Pam 600–63 (1–13) details operations and education.

Chapter 3
Installation Health Promotion Program

3–1. Implementation guidance

a. The success of the Army Health Promotion Program is determined by the effectiveness of the efforts of installation and community commanders. An effective, comprehensive program at the installation and community level is the key to achieving the overall goals.

b. Installation and community health promotion programs must focus on initiatives and activities to enhance individual health in each of the major areas of the program.

c. The operational pamphlets for implementing the program are contained in the Army's Fit To Win program. (See DA Pam 600–63).

d. Installation or community health promotion programs should contain the following key elements:

(1) Health education to raise individual awareness of all aspects of the program.

(2) Lifestyle assessment to identify individuals who could benefit from program participation.

(3) Counseling programs to reduce risk factors.

(4) Counseling programs to motivate and help sustain a healthy lifestyle for all.

(5) Proactive programs to foster suicide prevention and increase spiritual fitness.

(6) A program directed at the total population (soldiers, family members, retirees, and Army civilians).

(7) A means to allow commanders to monitor program effectiveness.

3–2. Installation or community Health Promotion Council

a. The installation or community commander administers and controls the health promotion program through the Health Promotion Council (HPC) and the Fit To Win Coordinator. These are the commander's primary advisers. The presiding officer of the HPC is the commander or his or her designated representative from the command group. The Family Fitness Coordinator prescribed in AR 215–2 may be used, if qualified, to be the installation or community Fit To Win Coordinator.

b. The membership encompasses the full scale of health and fitness interests on the installation—

(1) Deputy for Personnel and Community Activities (DPCA)
(2) Commander, Medical Treatment Facility (MTF)
(3) Director of Logistics (DOL)
(4) Director for Plans, Training, and Mobilization (DPTM)
(5) Commander, Dental Activity/Director of Dental Services
(6) Staff Chaplain
(7) Fit To Win Coordinator
(8) Civilian personnel officer (CPO)
(9) Public affairs officer (PAO)
(10) Chief, Community Mental Health Service (CMHS)
(11) Community health nurse
(12) Safety officer
(13) Chief, Family Support Division (FSD)
(14) Chief, Community Recreation Division (CRD)
(15) Chief, Community Operations Division (COD)
(16) Post librarian
(17) Family Fitness Coordinator
(18) Alcohol and Drug Abuse Control Program Officer
(19) Post Food Adviser
(20) MTF Dietitian/Division nutritionist
(21) Field Director, American Red Cross (ARC)
(22) Tenant unit commanders
(23) Master fitness trainer
(24) MTF Fitness Facilitator
(25) Reserve Component advisers
(26) Others as desired

c. Principal tasks of each installation or community HPC are to—

(1) Identify existing health promotion programs.

(2) Integrate MTF programs with other post health promotion programs.

(3) Assess the strengths and weaknesses of programs.

(4) Identify and assess other existing resources.

(5) Assess community needs.

(6) Develop a plan for a health promotion program based on the health and fitness needs for the Total Army family.

(7) Develop a comprehensive marketing plan based on existing resources, demographics, and identified fitness needs.

3–3. Development of the installation or community health promotion program

a. The installation or community commander develops and implements the health promotion program. Key stages are shown in figure 3–1.

b. Once community or installation needs are identified, specific program elements to address each of the major health promotion areas must be initiated. These include classes, seminars, workshops, and activities in each of the Fit To Win program areas. Existing programs may be used to meet these needs.

c. Commanders will ensure the goals, objectives, and purposes of the health promotion program are well-publicized throughout the command. Such efforts should keep soldiers, Army civilians, family members, and retirees aware of program benefits. This includes the relationship and interaction among members of the overall program and its component parts.

d. These initiatives, facilitated by the Fit to Win Coordinator using all the resources of the HPC, will ensure the effectiveness of the overall program and should ensure participation by all elements of the command.

e. Screening and assessment of individuals are primarily accomplished by using a health risk appraisal to assess the current state of health and fitness. This is an automated, personalized instrument, asking the participant about family health history, lifestyle, and attitudes. Other data, such as height, weight, blood pressure, and cholesterol level are also used.

f. Assessment begins during IET and OBC. It is continued during periodic physical examinations, PCS inprocessing, by referral, or is unit initiated. Self-referral is the principal means of accessing family members, Army civilians, and retirees.

g. The data enter the installation or community data base, are compiled, and used by the Fit To Win Coordinator, HPCs, and commanders to allocate resources, revise programs, and monitor progress and unit well-being.

h. Individual data from the health risk appraisal are compared, where possible, against predetermined standards. If standards are met, no intervention or education is required. Interim referrals may be initiated by the commander or health care providers prior to the next scheduled health risk appraisal.

i. A health risk appraisal profile, compiled and printed using an automated process, is given to the individual. Profile data are also placed in the person's MTF medical record or given to the person if a record is not maintained.

j. If followup based on identified individual or unit needs is required, the intervention and education stage begins and strategies are targeted. Purely medical interventions are referred to the MTF for soldiers, family members, and retirees, and to private physicians for Army civilians.

k. Reevaluation occurs with the next scheduled health risk appraisal.

l. Figure 3–2 portrays the health risk appraisal process in all its stages.

3–4. Health promotion process

a. The health promotion process described in paragraph 3–3 encompasses actions that will—

(1) Bring people into the program.

(2) Gather the necessary data.

(3) Enter data into a computer program and data base.

(4) Measure data against Army standards.

(5) Educate and intervene for individual and unit well-being.

(6) Reevaluate the program.

b. Army health promotion emphasizes positive action to increase physical, emotional, and spiritual well-being.

3–5. Health risk appraisal administration and command requirements

a. Administering the health risk appraisal at installation/community and unit level involves the individual, the commander, health care providers, and other resources available within the command. Their interaction is monitored by the HPC.

b. The laboratory analysis of the health risk appraisal is done by drawing blood.

c. Blood pressure, height, weight, and heart rate are measured and entered on health risk appraisal instrument.

d. After completion of the health risk appraisal questionnaire, all data are entered into the computer. An individual health risk appraisal profile is printed. One copy is given to each individual and one is placed into medical records maintained by the MTF. Supporting personnel service centers (PSCs) and unit personnel NCOs are provided a by-name roster of those who have taken a health risk appraisal. Unit commanders will ensure all personnel in their command are evaluated.

e. Unit health care providers will monitor unit soldiers recommended for or enrolled in health education programs, and advise the commander on the state of unit well-being.

f. Aggregate data are also compiled by health care providers using the individual data. Quarterly reports allow commanders and the HPC to—

(1) Monitor program status, progress of fitness initiatives, and overall installation, community, and unit well-being.

(2) Ensure appropriate health promotion programs are initiated.

(3) Manage resources necessary to support the program.

3–6. Unit Climate Profile (UCP)

a. Unit "climate" factors such as cohesiveness, morale, and attitude have a profound impact on the effectiveness and efficiency of a unit. DA Pam 600–69 provides a way for company-level commanders to identify unit strengths and weaknesses associated with unit climate factors. An easy-to-use UCP questionnaire and its resulting profile provide information on—

(1) Officer leadership.

(2) NCO leadership.

(3) Immediate leaders.

(4) Leader accessibility.

(5) Promotion policy.

(6) Rewards and corrective actions.

(7) Quality of training.

(8) Tools, equipment, and supplies.

(9) Job satisfaction.

(10) Freedom from harassment.

(11) Military courtesy and discipline.

(12) Human relations.

(13) Unit cohesiveness.

(14) Athletic and nonathletic recreational activities.

(15) Social activities.

(16) Freedom from substance abuse.

(17) Food service and soldier eating habits.

(18) Soldier attitude toward unit.

(19) Morale.

(20) Reenlistment potential.

b. The UCP requires no specific training to administer or analyze.

Chapter 4
Controlling Smoking

4–1. Guidance for controlling smoking in DA controlled areas

a. Smoking tobacco harms readiness by impairing physical fitness and by increasing illness, absenteeism, premature death, and health care costs. Readiness will be enhanced by establishing the standard of a smoke-free environment that supports abstinence from and discourages use of tobacco.

b. Full cooperation of all commanders, supervisors, soldiers, and Army civilians is expected to ensure people are protected from the effects of secondhand smoke. However, persons who desire to smoke will not be inconvenienced unnecessarily. An equitable balance must be struck.

c. All organizational elements that occupy space in or on conveyances, offices, buildings, or facilities over which DA has custody and control will comply with Army policy and guidance. This includes space assigned to the Army by General Services Administration (GSA).

d. This policy does not cancel or supersede other instructions that control smoking because of fire, explosion, or other safety considerations.

4–2. Policy

Smoking is prohibited in DA-occupied space, except for designated smoking areas necessary to avoid undue inconvenience to persons who desire to smoke. Supervisors may designate smoking areas for persons who desire to smoke. Supervisors may designate smoking areas only where they have determined that the secondhand smoke

from tobacco usage can be sufficiently isolated to protect nonsmokers from its effects.

a. Notices will be displayed at entrances to DA-occupied space which state smoking is not allowed except in specifically designated areas.

b. Smoking areas will not be designated in auditoriums, conference rooms, classrooms, restrooms, gymnasiums, fitness centers, and elevators.

c. Smoking is prohibited in all military vehicles and aircraft.

d. Smoking areas will be designated and posted in all eating facilities in DA-controlled buildings. Smoking areas are permitted only if adequate space is available for nonsmoking patrons, and ventilation is adequate to provide them with a healthy environment.

e. When individual living quarters are not available and two or more soldiers are assigned to one room, smoking and nonsmoking preferences will be considered in the assignment of rooms.

f. Health care providers will not smoke in the presence of patients.

g. Smoking by students is prohibited on the grounds of DOD Dependent Schools (DODDS), Section 6, or other schools over which DA exercises control, except as provided for by the Director, DODDS. Visiting adults, faculty, and staff may smoke out of the presence or view of students in smoking areas designated in accordance with this policy.

h. Smoking is prohibited in all child development centers and youth activity facilities, except that visiting adults and staff may smoke out of the presence or view of children in smoking areas designated in accordance with this policy.

i. Smoking is prohibited where it presents a safety hazard, for example, firing ranges, ammunition storage areas, fuel dumps, motor pools, and equipment maintenance shops.

j. Smoking during basic combat or one-station unit training is prohibited. Smoking during advanced individual training or officer basic courses is controlled and limited to designated times and places during the training day.

4–3. Signs for controlling smoking

a. Commanders are authorized to continue to use locally manufactured signs already reproduced or posted.

b. If locally manufactured signs are not in use, DA Form 5560–R (No Smoking Except in Designated Smoking Areas) and DA Form 5560–1–R (Designated Smoking Area) will be used for restricting smoking. These will be locally reproduced on 8½ by 11 inch paper. A copy for local reproduction is at the back of this regulation. The letters will be printed in red or black on a white background.

c. DA Form 5560–R may also be enlarged for use as a highway type sign at the entrance to installations and activities.

4–4. Enforcement

Failure to comply with the prescribed policy subjects soldiers, Army civilians, and contractor personnel to possible adverse administrative action. Soldiers normally will not be punished under the UCMJ for use of tobacco unless the offense is clearly promulgated as a punitive restriction in a lawful order or regulation, and involves either a direct threat to safety or security, or evidences a willful disregard for the health or comfort of a nonsmoker. Violators of this policy may be removed from or denied access to DA-occupied space.

Chapter 5
Suicide Prevention and Psychological Autopsy

5–1. General

This chapter sets guidelines for establishing the Army Suicide Prevention Program (ASPP). This program—

a. Supports the Army's goal to reduce the suicide risk for AC and RC soldiers, Army civilians, and AC family members.

b. Establishes requirements for suicide risk identification training.

c. Outlines responsibilities for the ASPP.

d. Requires a psychological autopsy for specified deaths.

5–2. Army Suicide Prevention Program

A coordinated suicide prevention program will be established at every Army installation or community and separate activity. ASPPs will provide—

a. A suicide prevention education awareness program for both military and civilian leaders, managers, and supervisors, as well as family members. This program will train personnel in suicide risk identification and in procedures for crisis intervention and referral.

b. For the concentration of mental health and UMT resources to provide assistance as required to organizations and their members following the suicide of a soldier or Army civilian.

c. Assistance for families who have experienced the loss of a family member to suicide to the extent permitted by applicable laws and regulations.

5–3. Suicide Prevention Task Force

a. Each installation or community will establish, plan, implement, and manage the local ASPP.

b. Installation and community commanders may assign the suicide prevention mission to the installation HPC or may elect to establish a separate Suicide Prevention Task Force (SPTF) to function as a subcommittee of the HPC. When using the HPC to manage the ASPP, care must be taken so that suicide prevention does not take a second place to other responsibilities of the council. Responsibilities of HPC members, with respect to suicide prevention, must be clearly established. Where a separate SPTF has not been established, the HPC will perform all the duties given to the SPTF.

5–4. Coordination of helping services

a. ASPPs will make provision for the coordination of services provided by military and civilian helping agencies such as the Community Mental Health Service (CMHS), UMTs and the Chaplain Family Life Center, ACS, ADAPCP, American Red Cross, Youth Activities (YA), Child Development Services (CDS), local public schools or DODDS, and other agencies as appropriate.

b. This coordination will include information about and planning for programs and services as well as information pertaining to specific clients, if it is in the best interests of the client and done with regard for the requirements of client confidentiality. Non-Army persons are not permitted at meetings where information about individual cases is discussed without the permission of the individual concerned.

5–5. Training

a. Sequential and progressive suicide risk identification training will be integrated, without increasing the length of the program of instruction, into every Army leadership development course conducted by the Army school system. Specifically, this information will be provided at all levels of the Noncommissioned Officer Education System (NCOES) and officer leadership courses. As a minimum, students will receive a copy of DA Pam 600–70, or a locally produced information pamphlet containing essentially the same information. Students will also be given the opportunity to view the Army videotape "Suicide Prevention" (SAVPIN 701299DA (TVT 8–93)).

b. Formal training in suicide prevention and suicide risk identification will be presented as part of the unit level officer and NCO professional developement courses.

c. Regularly scheduled installation level courses for civilian supervisors and designated CPO personnel will include training in suicide prevention.

d. Helping professionals (physicians, nurses, psychologists, social workers, chaplains, and counselors) and military police will receive regular inservice training in suicide prevention and crisis intervention.

e. Army mental health officers will provide the technical expertise for all suicide prevention education/awareness training. It is the role of mental health officers to "train the trainers" in all suicide prevention education programs.

f. UMTs (chaplains and chaplain assistants) will be trained by mental health officers in suicide prevention and suicide risk identification. Chaplains will assist mental health officers by providing suicide prevention education awareness training. This is a

staff function at battalion or lower levels for the chaplain.

g. ACS personnel will be trained by mental health officers and will conduct a suicide prevention education program for family members. Inservice training in suicide prevention for the staffs of ACS, YA, and CDS will be coordinated by ACS officer/director and may be conducted by mental health officers or chaplains. ACS personnel will not be used to conduct suicide prevention training for military units or soldiers.

5–6. Family Member Suicide Prevention Program (FMSPP)

a. The FMSPP will be implemented by ACS in coordination with the SPTF or HPC. It is intended to promote an understanding of the potential for suicide in the community. The installation ACS officer will conduct an education awareness program for family members to help them recognize the signs of increased suicide risk, and to learn about referral sources for friends and family members. Educational programs will focus on three groups: parents, teenagers, and spouses.

b. ACS programs that include suicide prevention efforts will be coordinated with the overall suicide prevention efforts of the installation and the Army. ACS personnel will not provide crisis intervention services for suicidal individuals, except when needed during the providing of ACS services. ACS crisis intervention for persons who may be suicidal is limited to referral to the MTF or CMHS. ACS personnel will not provide counseling or clinical services to any individual or family where suicide may be a concern. Such individuals or families will be referred to the MTF or CMHS. Persons for whom suicide is not an immediate concern may also be referred to the UMT or the Chaplain Family Life Center.

5–7. Reporting and data analysis

a. Suicides and suspected suicides of AC and RC soldiers, AC family members, and Army civilians will be reported immediately to the military police for preparation a Serious Incident Report (SIR) to HQDA in accordance with AR 190–40. Thoses cases involving Army jurisdiction will be referred by the military police to the local United States Army Criminal Investigation Command (USACIDC) field element for appropriate investigation in accordance with AR 195–2.

b. The SPTF will collect and analyze local data on suicide attempts. (RCS exempt: AR 335–15, para 5–2*e*(7).) This analysis will include the numbers of high, medium, and low lethality attempts by category of personnel and by unit. Data reflecting the reasons for suicide attempts will be collected.

5–8. Psychological autopsy

a. As provided in AR 195–2, a psychological autopsy will be conducted by a mental health officer and provided to USACIDC for deaths that meet the criteria established below. Subjects for investigation include all AC soldiers and all RC soldiers who are on active duty or active duty for training, and any active member of other armed forces of the United States assigned or attached to an Army unit or installation under any of the following conditions:

(1) Confirmed or suspected suicides.

(2) Single car motor vehicle accidents with no survivors, when requested by the commander of the local USACIDC office.

(3) Accidents involving unusual or suspicious circumstances: for example, deaths due to substance abuse, or resulting from self-inflicted gunshot wounds.

(4) All cases in which the mode (manner) of death is equivocal, that is, death cannot be readily established as natural, accidental, a suicide, or a homicide.

(5) Other cases when requested by the commander or special agent in charge of the local USACIDC office.

b. The report of the psychological autopsy (RCS exempt: AR 335–15, para 5–2*b*(8)) will be included in the CID Report of Investigation as prescribed in AR 195–2.

c. Reports of psychological autopsies are sent by the preparing officer through the MACOM to each of the following:

(1) HQDA (SGPS–CP–F), 5111 Leesburg Pike, Falls Church, VA 22041–3258.

(2) HQDA (DAPE–MPH), WASH DC 20310–0300.

(3) Commander, Walter Reed Army Institute of Research, ATTN: SGRD–UWI–A, WASH DC 20307–5100.

Appendix A
References

Section I
Required Publications

AR 30–1
The Army Food Service Program. (Cited in para 2–4.)

AR 40–501
Standards of Medical Fitness. (Cited in paras 2–3, 2–10, and 2–11.)

AR 165–20
Duties of Chaplains and Responsibilities of Commanders. (Cited in para 2–9.)

AR 190–40
Serious Incident Report. (Cited in para 5–7.)

AR 195–2
Criminal Investigation Activities. (Cited in para 5–8.)

AR 215–2
The Management of Army Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentalities. (Cited in paras 2–3, 2–14, and 2–15.)

AR 350–15
Army Physical Fitness Program. (Cited in para 2–3.)

AR 600–9
The Army Weight Control Program. (Cited in para 2–5.)

AR 600–20
Army Command Policy and Procedures. (Cited in para 2–9.)

AR 600–85
Alcohol and Drug Abuse Prevention and Control Program. (Cited in para 2–6.)

AR 690–400
Employee Performance and Utilization. (Cited in para 2–13.)

DA Pam 350–18
The Individual's Handbook on Physical Fitness. (Cited in para 2–3.)

DA Pam 350–21
Family Fitness Handbook. (Cited in paras 2–3 and 2–14.)

DA Pam 600–63
(1–13) Fit to win (cited in para 2–16)

DA Pam 600–69
Unit Climate Profile Commander's Handbook. (Cited in para 2–6.)

DA Pam 600–70
U.S. Army Guide to the Prevention of Suicide and Self-destruction Behavior. (Cited in para 5–5.)

FM 21–20
Physical Fitness Training. (Cited in para 2–3.)

FM 26–2
Management of Stress in Army Operations. (Cited in para 2–7.)

FM 100–1
The Army. (Cited in para 2–9.)

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand the regulation.

AR 5–3
Installation Management and Organization

AR 40–25
Nutrition Allowances, Standards, and Education

AR 40–35
Preventive Dentistry

AR 40–216
Neuropsychiatry and Mental Health

AR 215–1
The Administration of Army Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentalities

AR 360–5
Public Information

AR 360–61
Community Relations

AR 385–10
Army Safety Program

AR 600–21
Equal Opportunity in the Army

AR 608–1
Army Community Service Program

AR 608–10
Child Development Services

AR 672–1
Award of Trophies and Similar Devices in Recognition of Accomplishments

AR 690–990–2
Hours of Duty, Pay, and Leave

AR 930–5
American National Red Cross Service Program and Army Utilization

DA Pam 28–9
Unit Level Recreational Sports

DA Pam 350–15
Commander's Handbook on Physical Fitness

FM 21–20
Physical Fitness Training

FM 26–2
Management of Stress in Army Operations

DOD Directive 1010.10
Health Promotion

Section III
Prescribed Forms

DA Form 5560–R
No Smoking Except in Designated Smoking Areas. (Prescribed in para 4–3.)

DA Form 5560–1–R
Designated Smoking Area. (Prescribed in para 4–3.)

DEVELOPMENT OF AN INSTALLATION HEALTH PROMOTION PROGRAM

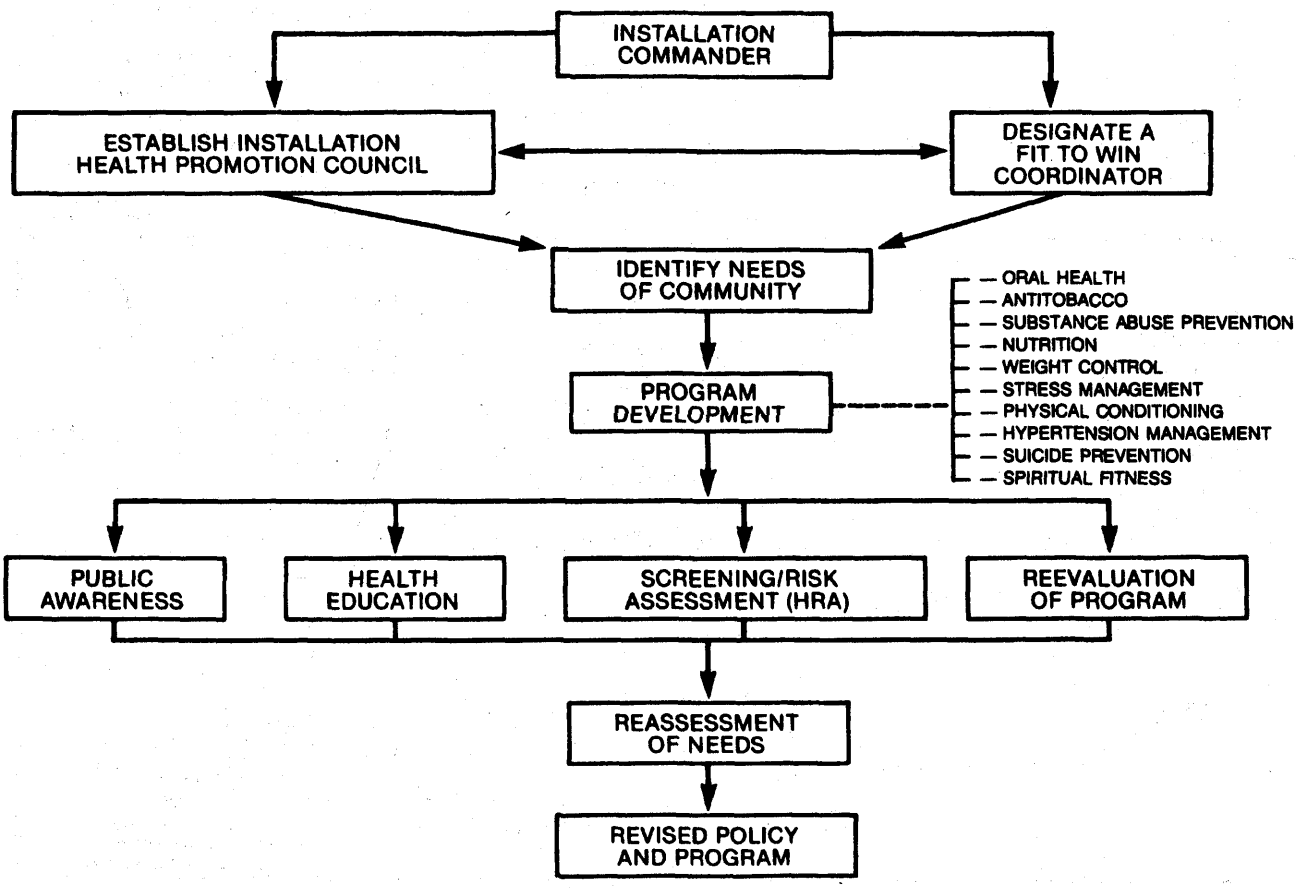


Figure 3–1. Development of an installation health promotion program

HEALTH PROMOTION PROCESS

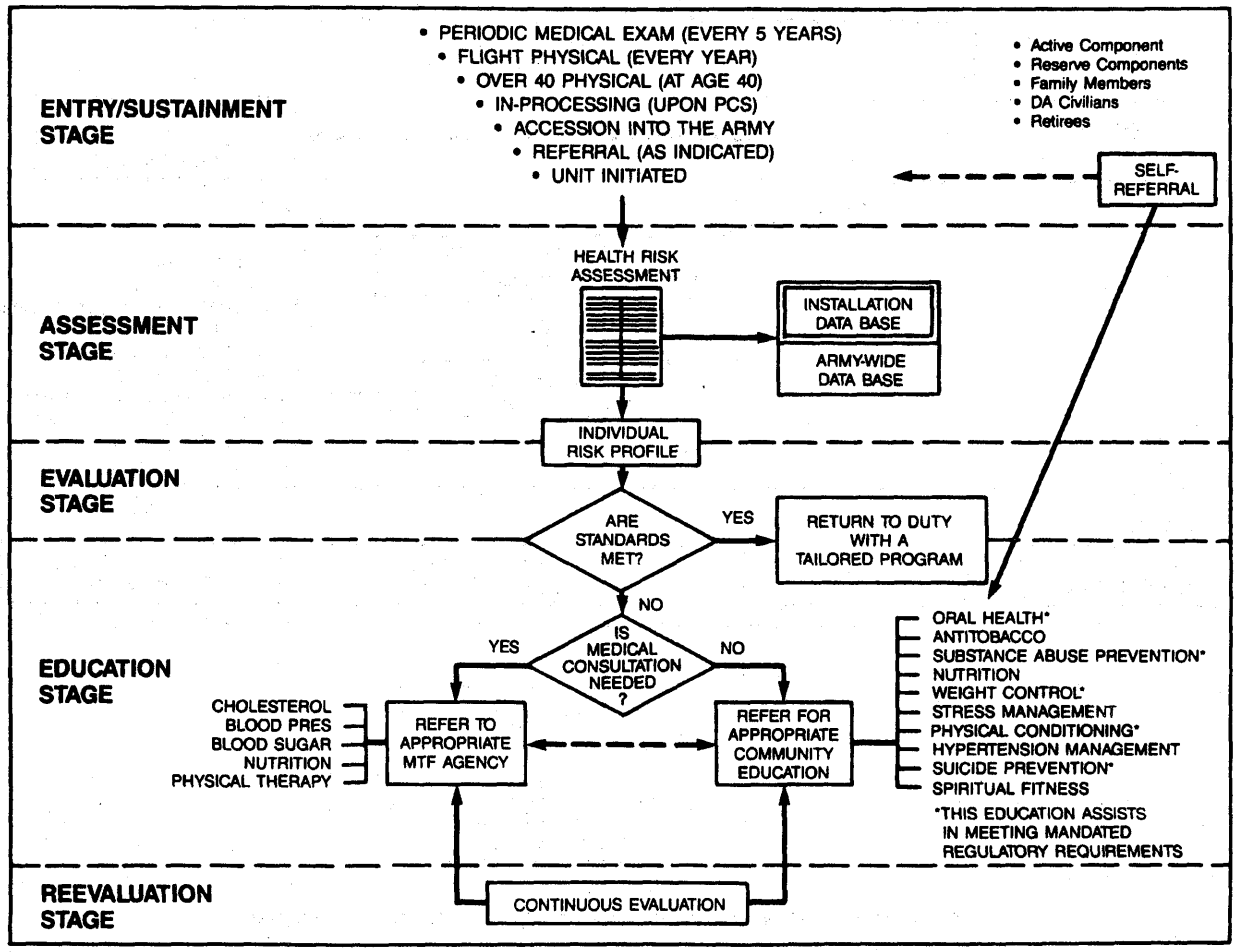


Figure 3–2. Health promotion process

Glossary

Section I
Abbreviations

AC
active component

ADAPCP
Alcohol and Drug Abuse Prevention and Control Program

AMEDD
Army Medical Department

APFP
Army Physical Fitness Program

APFT
Army Physical Fitness Test

ARC
American Red Cross

ARNG
Army National Guard

ARPERCEN
U.S. Army Reserve Personnel Center

ASC
Army Community Service

ASPP
Army Suicide Prevention Program

CCH
Chief of Chaplains

CDS
Child Development Services

CFSC
U.S. Army Community and Family Support Center

CG
commanding general

CHEP
Community Health Education Program

CINCUSAREUR
Commander-in-Chief, U.S. Army Europe and Seventh Army

CNGB
Chief, National Guard Bureau

COD
Community Operations Division

COE
Chief of Engineers

CONUS
continental United States

CMHS
Community Mental Health Service

CPA
Chief of Public Affairs

CPO
civilian personnel officer

CRD
Community Recreation Division

DA
Department of the Army

DCSLOG
Deputy Chief of Staff for Logistics

DCSPER
Deputy Chief of Staff for Personnel

DENTAC
dental activity

DOD
Department of Defense

DODDS
DOD Dependent Schools

DOL
Director of Logistics

DPCA
Director of Personnel and Community Affairs

FORSCOM
U.S. Forces Command

FMSPP
Family Member Suicide Prevention Program

FSD
Family Support Division

GSA
General Services Administration

HIFIT
Health Initiatives Fitness Team

HPC
Health Promotion Council

HQDA
Headquarters, Department of the Army

IET
initial entry training

IRR
Individual Ready Reserve

MACOMs
major Army commands

MEDDAC/MEDCEN
Medical Department Activity/Medical Center

MTF
medical treatment facility

NAF
nonappropriated funds

NCO
noncommissioned officer

NCO
noncommissioned Officer Education System

OBC
officer basic course

OSUT
one-station unit training

PAO
public affairs officer

PSC
personnel service center

RC
Reserve Component (ARNG and USAR)

SIR
Serious Incident Report

SPTF
Suicide Prevention Task Force

SRMT
Suicide Risk Management Team

TJAG
The Judge Advocate General

TPU
troop program unit

TRADOC
U.S. Army Training and Doctrine Command

TSG
The Surgeon General

UCP
unit climate profile

UMT
unit ministry team

USACFSC
U.S. Army Community and Family Support Center

USACIDC
U.S. Army Criminal Investigation Command

USAR
U.S. Army Reserve

USASSC
U.S. Army Soldier Support Center

WESTCOM
U.S. Western Command

YA
Youth Activities

Section II
Terms

Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)
A comprehensive program to eliminate substance abuse, including prevention, identification, education, and rehabilitation services. It includes nonresidential and residential treatment.

Antitobacco
The reduction, elimination, and deglamorization of tobacco product usage to improve the health and readiness of the Total Army.

Body composition
Quantification of the major structural components of the human body (fat and lean body mass).

Cardiorespiratory endurance
Functional capability of the heart, lungs, and blood vessels to take in and deliver oxygen to the working muscles and remove waste products. Essentially, it is the body's ability to receive and utilize oxygen in the cells for energy production.

Equivocal death
Cases where the available facts and circumstances do not immediately distinguish the mode of death are called "equivocal." Ambiguity or uncertainty existing among any of the four identified modes of death makes it equivocal.

Fitness Coordinator
Civilian health and fitness individual under the supervision of the installation commander with the responsibility of managing and coordinating the installation's program of health fitness.

Flexibility
Functional capability of the joint to move through a normal range of motion. It is highly specific and dependent on the muscles and connecting tissue surrounding a joint. Good flexibility is characterized by a freedom of movement, which contributes to ease of movement and economy of muscular effort.

Health
Optimal functioning with freedom from disease and abnormality.

Health care providers
Physicians, physician assistants, registered nurses, mental health specialists, occupational and physical therapists, and registered dietitians under the supervision of the unit surgeon or the commander of the medical treatment facility. For the purpose of this regulation, this term includes comparable personnel of U.S. Armed Forces and host nations.

Health promotion
Any combination of health education and related organizational, social, economic, or health care programs designed to improve or maintain health.

Hypertension identification
Actions to identify early those health risk factors such as high blood pressure, including smoking, cholesterol level, weight, family history, nutrition, and inactivity. These actions include early identification, provision of information regarding control and lifestyle factors, and treatment referral.

Master fitness trainer
Graduate of the 4-week course developed by the Soldier Physical Fitness School to train selected officers and noncommissioned officers in all aspects of the Army fitness program. They perform as unit advisers to commanders/supervisors on fitness programs, and they establish and monitor both unit and individual fitness programs.

Mental health officer
Trained mental health person who is credentialed or licensed as a psychiatrist, clinical or counseling psychologist, social worker, or psychiatric nurse specialist.

Mode (manner) of death
Five categories: natural, accidental, suicide, homicide, unknown. These categories are distinguished from the cause of death, for example, gunshot wound, heart disease.

Muscular endurance
Capability of a muscle, or group of muscles, to perform repeated functions for an extended period of time.

Muscular strength
Maximal force that can be exerted in a single voluntary contraction of a muscle or a muscle group. (Both muscular strength and endurance are related to age, selected general health factors, genetics, level of training, and level of effort.)

Nutrition
An appropriate intake of food that meets nutritional needs for calories and the macro- and micro-nutrients essential for health, and indispensable for individual well-being and productivity.

Physical fitness
Ability to cope within the physical demands of one's job, including the use of adequate reserves to cope with emergency situations. Components of physical fitness include cardiorespiratory endurance, muscular strength and endurance, flexibility, and body composition.

Psychological autopsy
Clarification of the nature of death focusing on the psychological aspects of the dead person. Primary purpose is to reconstruct and understand the circumstances, lifestyle, and state of mind at the time of death.

Spiritual fitness
The development of those personal qualities needed to sustain a person in times of stress, hardship, and tragedy. These qualities come from religious, philosophical, or human values and form the basis for character, disposition, decision making, and integrity.

Stress management
Assistance provided to cope with the demands, real or perceived, from the environment and from within the individual.

Suicide attempt
Any overt act of self-destructive behavior not resulting in death.

Suicide prevention
The initiatives and activities taken to reduce the incidence of suicide and improve the identity ratio of at-risk people.

Unit ministry team
The chaplain and chaplain assistant who provide direct religious support for the religious needs of a unit.

RESERVED

NO SMOKING



Except in Designated Smoking Areas

Sign should be posted *ONLY* at entrance(s) to Department of the Army owned or controlled buildings/facilities.

DA FORM 5560-R, AUG 86

Designated Smoking Area

DA FORM 5560-1-R, AUG 86

* U.S. G.P.O.:1996-404-641:20202