14.0 PSYCHIATRY

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This section provides guidance on various psychiatric disorders that may be seen in the military aviation community, the associated effects on aviation duties, and guidelines for requesting a waiver as applicable. For the benefit of mental health professionals conducting mental health, neuropsychological, and/or substance evaluations of individuals with flight status, guidance is provided to ensure evaluations provide sufficient information for NAMI to be able to make timely decisions.

First, some general guidelines for all flight waivers that also apply to psychiatric waivers as referenced in ARWG Chapter 2.1-2.3:

1. Waivers are considered for those who do not meet physical standards for special duty per the Manual of the Medical Department (MMD) Chapter 15, Section IV. Waivers for special duty may be granted on the need of the service, consistent with training, experience, performance, and proven safety of the aircrew personnel. In general, applicants are held to a stricter standard than designates and are less likely to be recommended for a waiver.

In addition to the criteria mentioned above, waivers are also based upon risk management and how it is applied to nine criteria as listed in ARWG 2.2 (please reference as needed). Further, waiver granting authority is a function of BUPERS, CMC (ASM), or other appropriate waiver granting authority. Waivers are not officially granted until BUPERS or CMC acts.

General waiver submission advice for the most timely processing of requests:

1. Properly label uploaded documents for AERO waiver submissions (e.g., do not bundle mental health records with PRK notes, ONLY upload PDF files).
2. Make sure the waiver package is complete, that is, it should contain all requested information (“See GENESIS/JLV” is not sufficient). The submitting Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) should upload all supporting documentation so that the package can be reviewed as a stand-alone document. A general rule of thumb is that if a GENESIS/JLV note is informative it should be uploaded to AERO.
3. Be sure the waiver package is internally consistent, or explain any discrepancies in the Aeromedical Summary (AMS).

Information required for all psychiatric waivers:

1. FS/APA AMS documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records where applicable).
3. A current mental health evaluation to document complete, sustained remission of all symptoms.
4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

The above four items are the minimum required. Many psychiatric waiver requests will need additional items, as listed for each specific condition below. Again, this is just an overview.

REMEMBER: IF THE ESTABLISTMENT OF THE DIAGNOSIS AND ACHIEVEMENT OF THE MAINTENANCE PHASE OF TREATMENT WILL TAKE GREATER THAN 60 DAYS, A GROUNDING PHYSICAL AND AERO GENERATED AMS IS REQUIRED AT THE TIME OF DIAGNOSIS. CLEARANCE CANNOT BE GRANTED BY A LOCAL BOARD OF FLIGHT SURGEONS.

This section of the ARWG will outline guidance for DSM-5-TR diagnoses in the following order:

1. Psychoeducation, Non-Medical Counseling, and Supportive Psychotherapy
2. Adjustment Disorders
3. ADHD/Neurodevelopmental Disorders (e.g., Specific Learning Disorders, Attention Deficit/Hyperactivity Disorder)
4. Alcohol/Substance-Related and Addictive Disorders (e.g., Alcohol Use Disorder, Gambling Disorder)
5. Anxiety Disorders
6. Bipolar and Related Disorders
7. Depressive Disorders
8. Disruptive, Impulse-Control, and Conduct Disorders
9. Eating Disorders (e.g., Anorexia Nervosa, Bulimia)
10. Obsessive-Compulsive and Related Disorders
11. Personality Disorders
12. Psychosis/Schizophrenia Spectrum and Other Psychotic Disorders
13. Sexual Dysfunctions and Paraphilias
14. Sleep-Wake Disorders
15. Somatic Symptom and Related Disorders
16. Suicidal Behavior and Non-Suicidal Self Harm
17. Trauma and Stressor-Related Disorders (e.g., Posttraumatic Stress Disorder, Acute Stress Disorder)

NOTA BENE: WHENEVER DESIGNATED AVIATION PERSONNEL ARE PSYCHIATRICALLY HOSPITALIZED, NO MATTER WHAT THE ULTIMATE DIAGNOSIS IS DETERMINED TO BE, A GROUNDING PHYSICAL AND AERO GENERATED AMS ARE TO BE SUBMITTED.

Because this document does not include all psychiatric disorders, FS/APA is encouraged to contact NAMI Psychiatry Department (850-452-2783) for specific assistance as needed.

It is highly recommended that all aeromedical officers become familiar with the following instructions and guidelines as well. The documents highlighted below are some of the more relevant sources of information to assist in the performance of aeromedical duties. However, it remains the professional obligation of aeromedical officers to keep up to date on any newly published instructions, and to continually expand awareness of other existing pertinent publications.

- **Assistant Secretary of Defense/Health Affairs (ASD/HA) Memorandum (November 7, 2006), "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications"** – This document provides guidance for deployment, and continued

service in a deployed environment, for military personnel who experience psychiatric disorders and/or who are prescribed psychotropic medications.

- **DoDI 6490.07 (February 5, 2010), "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees"** – This instruction expands upon the ASD/HA Memo above. Enclosure 3, "Medical Conditions Usually Precluding Contingency Deployment," is especially relevant for aeromedical officers in the consideration of mental health disorders and psychiatric treatments, and the associated impact of such in an operational setting.

- **DoDI 6490.04 (March 4, 2013), "Mental Health Evaluations of Members of the Military Services"** – This instruction establishes policy, assigns responsibilities, and prescribes procedures for the referral, evaluation, treatment, and medical and command management of service members who may require assessment for mental health issues, psychiatric hospitalization, and risk of imminent or potential danger to self or others.

- **DoDI 6490.08 (September 6, 2023), "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members"** – This instruction establishes policy, assigns responsibilities, and prescribes procedures for healthcare providers for determining command notification requirements. It also provides guidance to help achieve balance between service members' confidentiality rights and commanders' right to know for operational and risk-management decisions. The instruction states that healthcare providers shall notify the commander when a service member meets any of the instruction's nine delineated criteria for mental health and/or substance misuse conditions or related circumstances. Criteria covered include: harm to self, harm to others, harm to mission, special personnel, inpatient care, acute medical conditions interfering with duty, problematic substance use treatment program, command-directed mental health evaluation, and other special circumstances. The instruction contains discussion and examples for each of the criteria that warrant command notification. It also covers the appropriate manner in which disclosures should be made.

Flight Surgeons, Aerospace Clinical Psychologists, and Aeromedical Physician Assistants are encouraged to help expand the awareness and understanding of aeromedical issues/concerns/disposition by sharing relevant ARWG sections with local medical staff and specialists. Close collaboration with non-aeromedical colleagues not only ensures that the operational service member receives appropriate treatment and disposition but also improves cooperation between local medical and line units; these measures ultimately optimize force readiness and effectiveness.

General guidance for mental health professionals evaluating flight personnel:

Risks presented in the aviation environment cannot be overstated, and over 80% of aviation mishaps are attributable to human error. The thorough evaluation of mental health, cognitive, and addictive symptomatology is critical in ensuring flight safety, mission completion, and effective crew coordination. Thus, the psychological, psychiatric, and substance abuse evaluations of individuals with flight status have critical components which are considerate of the aviation culture and the risks and demands associated with military aviation.

One of the key challenges in conducting these evaluations is the tendency of aviation personnel to avoid disclosing medical and mental health concerns. In one study, researchers found that

72% of military aviators have engaged in healthcare avoidance.[1] Another study found that of those military aviators currently experiencing mental health concerns, 83% had not sought care.[2] Because of this substantially high prevalence of reluctance to disclose medical and mental health information, aeromedical psychological, psychiatric, and substance abuse evaluations must account for the high likelihood of an incomplete picture based solely on self-report.

In order to allow for a complete picture of aviation personnel, mental health evaluations of these individuals must include various forms of collateral information. Evaluations with which NAMI is best able to make timely decisions include:

- medical, legal, military, and/or academic record review (dependent on the referral question);
- psychological testing, using at least one psychometric test with validity scales (i.e., a version of the MMPI, MCMI, and/or PAI). Short face-valid screeners are considered inadequate forms of psychometric testing for flight personnel unless the individual is openly asking for help and freely disclosing concerns;
- collateral source information (e.g., flight surgeon, supervisor, etc.). Releases of information are required to talk to anyone besides the FS/APA and CO.

Evaluations reviewed by NAMI which are based solely on self-report are highly likely to result in the need for a second evaluation or a face-to-face evaluation at NAMI in Pensacola, FL.

Questions about evaluations, psychological or neurocognitive testing, waiver standards, etc. may be asked directly by calling NAMI Psychiatry at 850-452-2783.

[1]Hoffman WR, Aden JK, Barbera D, Tvaryanas A. *Self-Reported Health Care Avoidance Behavior in U.S. Military Pilots Related to Fear for Loss of Flying Status*. Mil Med. 2023 Mar 20;188(3-4):e446-e450. doi: 10.1093/milmed/usac311. PMID: 36242520.

[2]Weipert, M. J., Westerburg J. R., & Elliott, J. N. (2024, May 5-9). *Medical self-disclosure rates among Naval aviators* [Conference presentation]. Aerospace Medical Association 2024 Meeting, Chicago, IL, United States.

14.1 PSYCHOEDUCATION, NON-MEDICAL COUNSELING, AND SUPPORTIVE PSYCHOTHERAPY

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AEROMEDICAL CONCERNS: Conditions and situations such as relational/marital problems, housing and economic problems, abuse and neglect, educational and occupational problems, or other problems related to the social environment (Z Codes in the DSM-5-TR and ICD 10) may come to the attention of a Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) or other clinician, and/or result in a self-referral to a variety of support resources. Such issues may occur in isolation, result from a mental health disorder, or lead to or worsen an existing mental health problem. Given the complicated and stressful factors present in these situations, they may interfere with safe or effective flying.

The key component that distinguishes these entities from other disqualifying conditions (such as clinical depression and anxiety) is the *absence of clinically significant distress or impairment in social, occupational, or other important areas of functioning*.

If these conditions are untreated or the problems go unaddressed, there is the potential that they will develop into clinically significant depressive or anxiety conditions such as a Major Depressive Disorder or Generalized Anxiety Disorder. For this reason, all personnel on flight status are encouraged to seek services when they could benefit from extra support, and to seek this support from qualified resources (e.g., Fleet and Family Services, Marine Corps Community Services, Military One Source, college counseling center, military treatment facility, etc.).

WAIVER PROCESS: For all Navy and Marine Corps personnel on flight status, temporary aeromedical disqualification (i.e. grounding) is NOT required while receiving psychoeducation, non-medical counseling, or supportive psychotherapy services for any of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR) conditions included in the chapter, Other Conditions That May Be a Focus of Clinical Attention (i.e. Z codes), *in the absence of clinically significant distress or impairment in social, occupational, or other important areas of functioning*. If an individual pursues any of these services, however, they must report this to their flight surgeon and, for applicants, any history of receiving these services must be reported on any flight physical.

INFORMATION REQUIRED: No information is required to be submitted to NAMI for Naval aviation personnel who are receiving any of the services noted above. However, it is imperative that the squadron FS/APA develop a sufficiently-robust rapport with those in their care that service members feel comfortable discussing all aspects of their medical care. These problems frequently need additional administrative, medical, or mental health support, as well as support from the chain of command to effect the best outcomes for service members. Unqualified support from the flight surgeon/APA for seeking these services early can prevent further problems from developing.

DIAGNOSIS/ICD 10 CODE:
The use of psychoeducation, non-medical counseling, or supportive psychotherapy services for any condition that is listed in the “Other Conditions That May Be a Focus of Clinical Attention” section of the DSM-5-TR is not considered disqualifying for continued duty involving flying *as long as the FS/APA concurs that it is not associated with functional impairment*. Should the FS/APA assess that there are concerns related to functional impairment, a referral will be made for formal mental health evaluation for differential diagnosis and recommendations.

14.2 ADJUSTMENT DISORDERS

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AEROMEDICAL CONCERNS: Adjustment Disorders are characterized by the development of emotional or behavioral symptoms in response to an identifiable stressor or stressors, occurring within three months of the onset of the stressor(s). The development of psychiatric symptoms as a consequence of adverse life events is considered an expectable part of the human experience, so the diagnosis of this - or any - psychiatric disorder requires that symptoms exceed a "clinical significance threshold." This means the presence of "marked distress that is out of proportion to the severity or intensity of the stressor," and/or "significant impairment in social, occupational, or other important areas of functioning." Symptoms can vary widely in form and severity, and unlike other DSM-5-TR disorders, adjustment disorder diagnostic criteria have no clear and specific symptom profile to define the condition. When symptoms such as depressed mood, anxiety, fatigue, problems with concentration, attention, judgment and decision-making, misconduct, and others reach the diagnostic threshold, the potential for adverse effects on flight safety, crew coordination, and mission effectiveness necessitate grounding until the condition has fully resolved, either naturalistically or by way of treatment.

Adjustment disorder cannot be diagnosed if the disturbance meets criteria for another mental health disorder (e.g. a depressive or anxiety disorder), or is merely an exacerbation of a preexisting mental disorder. In addition, symptoms must not represent normal bereavement, or be better explained by prolonged grief disorder. Per DSM-5-TR, "By definition, an adjustment disorder must resolve within 6 months of the termination of the stressor or its consequences; if symptoms persist beyond 6 months after the stressor or its consequences have ceased, the diagnosis of adjustment disorder would no longer apply." Well-meaning clinicians, considering a diagnosis of adjustment disorder "less stigmatizing" than other psychiatric disorders, may choose this diagnosis, to protect patients, for example, from the risk of discrimination in health, life, and disability insurance. In the aviation community, this category of diagnosis has sometimes been chosen in order to speed up waiver approval by side-stepping the *Period of Observation in a Non-flying Status* (PONS) stipulated for other diagnostic categories. This practice is at odds with the need for diagnostic precision in applying proper aeromedical risk controls. Regarding treatment, psychotherapy is the mainstay, generally short-term, goal-focused approaches. While it is reasonable to consider short-term pharmacologic interventions for insomnia and severe anxiety, the evidence for effectiveness of antidepressants for depressive symptoms in adjustment disorder is scant. Need for medication generally suggests another mental health disorder.

The current policy is to submit a grounding physical once the diagnosis is established. Once the condition is resolved, a new physical and AMS must be submitted in AERO with all supporting documentation for the member to be returned to flight status (since the member must be returned to flight duty by the waiver authority after a grounding physical). An adjustment disorder which resolves within 60 days is NCD while one which takes longer to resolve will remain CD, with waiver required for return to duty involving flying. Aeromedical clearance, with or without a waiver, depending on the duration of the adjustment disorder, may be requested when the member is completely asymptomatic in a "Fit for Full Duty" status after completion of all treatment.

It should be noted that multiple adjustment disorders warrant further scrutiny to ensure that the disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a pre-existing mental health disorder.

Suicidal Behavior and Non-Suicidal Self-Harm (see also Section 14.17): When suicidal thoughts and behavior or non-suicidal self-harm occurs in the context of an Adjustment Disorder (or Z Code), a minimum 6-month PONS is required, after symptom remission has occurred. In these cases, given the seriousness of suicidal thinking, planning, and actions, and their high risk for recurrence, immediate return to flying upon initial resolution of symptoms is not considered safe. Additionally, in these cases there must be evidence of psychotherapy or education/training in stress management, coping, and/or resilience, as well as evidence of the development of improved and effective coping strategies.

Maintenance Pharmacotherapy: Maintenance pharmacotherapy is sometimes used to mitigate the risk of future recurrence of, for example, depressive disorders, after several discrete episodes. It is rarely, if ever, a rational choice in the treatment of adjustment disorders, given the transient and usually self-limited nature of the condition, especially in the hardy and resilient population of Naval Aviation. In those rare instances of persistent (chronic) adjustment disorders, maintenance pharmacotherapy may be considered. In such cases, Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Waiver consideration may be requested after a suitable PONS has elapsed, which for adjustment disorder is 12 months. The PONS begins once an authorized mental health provider (an aeromedically trained clinical psychologist or psychiatrist whenever possible) has declared, by way of a formal medical record entry, that the service member's condition is in full remission. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Please see Section 18.7 of the ARWG for full details.

DIAGNOSIS/ICD-10 Code:

F43.21 Adjustment Disorder with depressed mood
F43.22 Adjustment Disorder with anxiety
F43.23 Adjustment Disorder with mixed anxiety and depressed mood
F43.24 Adjustment Disorder with disturbance of conduct
F43.25 Adjustment Disorder with mixed disturbance of emotions and conduct
F43.20 Adjustment Disorder unspecified

Specify if:

Acute: Persistence of symptoms for less than six months.
Persistent (chronic): Persistence of symptoms for six months or longer. By definition, symptoms cannot persist for more than six months after termination of the precipitating stressor or its consequences. The "persistent" specifier thus applies when the duration of the disturbance is longer than six months in response to a chronic stressor that has enduring consequences.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, "See GENESIS/JLV records." Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records).

3. A current mental health evaluation is required to document complete, sustained remission of all symptoms. Evaluation should be completed by an aeromedically-trained clinical psychiatrist or psychologist whenever possible.
4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

14.3 NEURODEVELOPMENTAL DISORDERS (E.G., SPECIFIC LEARNING DISORDER, ATTENTION DEFICIT/ HYPERACTIVITY DISORDER)

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AEROMEDICAL CONCERNS: Continuing symptomatology of Neurodevelopmental Disorders present a number of challenges in the aviation environment, which routinely demands sustained attention, vigilance, dual tasking, working memory, processing speed, reaction time, vigilance, concise communication, effective decision-making, and a host of other cognitive abilities. Symptoms of Neurodevelopmental Disorders which persist into adulthood are not conducive to safe and effective flight duties. Communication Disorders are associated with deficits in language, speech, and communication. Aeromedical concerns are foremost in the domains of crew coordination and mission completion (e.g., effective radio communications). Autism Spectrum Disorder involves pervasive problems with social communication, social interaction, and restricted patterns or behavior, interests and/or activities. Aeromedical concerns include safety of flight, mission completion, and crew coordination. Attention Deficit/Hyperactivity Disorder (ADHD) involves a pattern beginning in childhood of problems in such areas as attention, vigilance, organization, impulse control, set shifting, dual tasking, working memory, and both verbal and visual memory. Aeromedical concerns include safety of flight, mission completion, and crew coordination. Current use of either non-stimulant or stimulant medication to treat ADHD is incompatible with aviation duty, and waivers are not granted in such cases. Specific Learning Disorders may be associated with underlying abnormalities in cognitive processes, including deficits in specific academic abilities, visual perception, or linguistic processes. Depending on the severity of the disorder, these deficits may jeopardize both safety and mission execution in the highly dynamic aviation environment. Motor Disorders include impairments in motor abilities and can impact safety of flight, mission completion, and crew coordination.

DIAGNOSIS/ICD-10 Code:

F89.9	**Language Disorder**
F80.81	**Childhood-Onset Fluency Disorder (Stuttering)**
F80.89	**Social (Pragmatic) Communication Disorder**
F80.9	**Unspecified Communication Disorder**
F84.0	**Autism Spectrum Disorder**
F90.0	**Attention-Deficit/Hyperactivity Disorder, Predominantly inattentive presentation**
F90.1	**Attention-Deficit/Hyperactivity Disorder, Predominantly hyperactive/impulsive presentation**
F90.2	**Attention-Deficit/Hyperactivity Disorder, Combined presentationF81.0 Specific Learning Disorder with impairment in reading**
F81.2	**Specific Learning Disorder with impairment in mathematics**
F81.81	**Specific Learning Disorder with impairment in written expression**
F82	**Developmental Coordination Disorder**
F98.4	**Stereotypic Movement Disorder**
F95.2	**Tourette's Disorder**
F95.1	**Persistent (Chronic) Motor or Vocal Tic Disorder**
F95.8	**Other Specified Tic Disorder**
F95.9	**Unspecified Tic Disorder**

WAIVER:

Communication Disorders: History of a communication disorder is not necessarily disqualifying. The severity, nature, and course of the disorder should be documented. Any residual problems or history of a persistent communication disorder requires a mental health evaluation, speech-language pathology evaluation, and for mild residual symptoms (e.g., stuttering), a functional assessment may be required.

Autism Spectrum Disorder: A diagnosis of Autism Spectrum Disorder at any time of life is considered disqualifying. Because symptoms of Autism Spectrum Disorder are pervasive, are frequently associated with intellectual impairment, have high rates of co-morbidity with other medical and mental health diagnoses, and interfere with requisite social abilities, job demands, and stress tolerance, waivers are not considered.

Attention Deficit/Hyperactivity Disorder: A diagnosis of ADHD at any time of life is considered disqualifying. Applicants with childhood diagnoses of ADHD who have not taken medication for the past 12 months for enlisted and 24 months for officers, have received no academic or occupational accommodations during that time, who have been engaged in consistent academic and/or occupational activities (e.g., formal school or training, employment) during that time, and who demonstrate no symptoms/functional impairment may be considered for a waiver. Documentation of the initial diagnosis, severity, nature, and course of the disorder will be reviewed, including all medical records, Individual Educational Plans/504 Plans, high school and/or college transcripts, and other pertinent documentation (e.g., letters from employers). Waivers are not considered for applicants who have continuing evidence of symptoms or disability into adulthood, as indicated for example, by the need for medication and/or accommodations in graduate school, need for ADHD medications while serving on active duty, or other evidence of continuing symptoms. For active-duty service members who believe they were erroneously diagnosed with ADHD as adults or who used stimulant medications in an effort to improve grades or job performance, a waiver will not be considered until the service member has been off of medications for 24 months and has demonstrated sustained successful occupational performance during that time.

Specific Learning Disorders: History of a learning disorder is not necessarily disqualifying. The severity, nature, and course of the disorder should be documented. Any residual problems or history of a persistent learning disorder requires a neuropsychological evaluation, which includes formal academic testing.

Motor Disorders: History of a motor disorder is not necessarily disqualifying, if problems resolve in childhood. Depending on the history, documentation of initial diagnosis, severity, nature, and course of the disorder will be reviewed, including all medical, educational, and mental health records. Any residual problems will require a current mental health, neurologic, occupational therapy, and/or functional assessment.

INFORMATION REQUIRED:

Communication Disorder:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, and current level of functioning.
2. Childhood medical and school records documenting the diagnosis and any academic interventions and accommodations (e.g., Individual Educational Plans/504 Plans).
3. High school and college transcripts (if applicable).

4. If absence of academic/functional impairment cannot be determined from available records, a speech-language pathology evaluation and/or a comprehensive neuropsychological evaluation is required.
5. A functional assessment may be required. This would be determined by NAMI Psychiatry.

Attention-Deficit/Hyperactivity Disorder:

1. FS/APA AMS documenting all prior symptoms, absence of persistent features, severity and course of the disorder, medication use, need for academic or other accommodations, and current level of functioning.
2. For non-college graduates, a comprehensive mental health evaluation which includes the following:
    - Review of high school transcripts and college transcripts (if applicable)
    - Review of high school and college Individual Education Plans and other accommodations (if applicable)
    - Review of all medical records relevant to ADHD and any comorbidities
    - Review of the last 5 years of prescription data
    - Standard elements of mental health evaluations (substance use history, social history, mental health and medical history, family mental health and medical history, legal history, mental status examination)
    - Evaluation must be performed by a clinical psychologist or psychiatrist
    - If the mental health evaluation substantiates the diagnosis of childhood ADHD or cannot definitively rule it out, a comprehensive neuropsychological evaluation is required which includes:
        a. Administration of the full current edition of the Wechsler Adult Intelligence Scale with all index scores
        b. Verbal and Visual Memory Testing (i.e., current Wechsler Memory Scale Logical Memory, California Verbal Learning Test, Rey Complex Figure Test or equivalents)
        c. Vigilance Testing (i.e., current Conner's Continuous Performance Test, Aviation Vigilance Test or equivalent)
        d. Testing of Executive Function (FOUR of the following are required: Trail Making A and B, Wisconsin Card Sorting Test or Booklet Category Test, Paced Auditory Serial Addition Test, Iowa Gambling Task, Stroop Color and Word Test, Tower of London-Drexel).
        e. ADHD Self Report Measures
        f. Alcohol Screening (Alcohol Use Disorders Identification Test or equivalent)
        g. Depression Screening (Beck Depression Inventory-II or equivalent)
        h. Personality Testing (Minnesota Multiphasic Personality Inventory-II, RF, or 3, Personality Assessment Inventory or equivalent)
        i. Standard elements of mental health evaluations (substance use history, social history, mental health and medical history, family mental health and medical history, legal history, mental status examination)
        j. Evaluation must be performed by a credentialed neuropsychologist
        k. Evaluation must be performed when the service member is off of ADHD medications. This must be confirmed by laboratory testing for the specific ADHD medication(s) that the individual was previously prescribed. Testing must be conducted immediately following cognitive test administration.

3. For college graduates who did not require (or use) either medication or academic accommodations for the entire college experience, no mental health evaluation is required. The service member must provide:
    - Childhood medical and school records documenting the diagnosis, course and cessation of treatment
    - College transcripts
    - Letter from the college/university academic learning center (or equivalent) stating that the service member was never evaluated for, qualified for, or provided academic accommodations during their entire college experience. If the service member transferred to/from another college at any time, letters from both academic centers are required.
    - A member statement attesting to the fact that he/she did not use or require medications or accommodations/extra assistance for ADHD throughout college. The statement must also include a narrative of their ADHD diagnosis, evolution over time, and personal perceptions of their current level of functioning.
4. Given that there are no available academic accommodations at the U.S. Naval Academy, USNA Midshipmen in their senior year must provide:
    - Childhood medical and school records documenting the diagnosis, course, and cessation of treatment
    - College transcripts
    - Last 5 years of prescription data.
    - A member statement attesting to the fact that he/she did not use or require medications or accommodations/extra assistance for ADHD throughout college. The statement must also include a narrative of their ADHD diagnosis, evolution over time, and personal perceptions of their current level of functioning.
5. For college graduates who required and/or utilized ADHD medication (stimulant or non-stimulant) and/or academic accommodations at any time while in college, a neuropsychological evaluation is required which includes:
    - Administration of the full current edition of the Wechsler Adult Intelligence Scale with all index scores
    - Verbal and Visual Memory Testing (i.e., current Wechsler Memory Scale Logical Memory, California Verbal Learning Test, Rey Complex Figure Test or equivalents)
    - Vigilance Testing (i.e., current Conner's Continuous Performance Test, Aviation Vigilance Test or equivalent)
    - Testing of Executive Function (FOUR of the following are required: Trail Making A and B, Wisconsin Card Sorting Test or Booklet Category Test, Paced Auditory Serial Addition Test, Iowa Gambling Task, Stroop Color and Word Test, Tower of London-Drexel).
    - ADHD Self Report Measures
    - Alcohol Screening (Alcohol Use Disorders Identification Test or equivalent)
    - Depression Screening (Beck Depression Inventory-II or equivalent)
    - Personality Testing (Minnesota Multiphasic Personality Inventory-II, RF, or 3, Personality Assessment Inventory or equivalent)
    - Standard elements of mental health evaluations (substance use history, social history, mental health and medical history, family mental health and medical history, legal history, mental status examination)
    - Evaluation must be performed by a credentialed neuropsychologist
    - Evaluation must be performed when the service member is off of ADHD medications. This must be confirmed by laboratory testing for the specific ADHD medication(s)

that the individual was previously prescribed. Testing must be conducted immediately following cognitive test administration.

Specific Learning Disorder:

1. FS/APA AMS documenting all prior symptoms, absence of persistent features, course of the disorder, and current level of functioning.
2. Childhood medical and school records documenting the diagnosis and any academic interventions and accommodations (e.g., Individual Educational Plans/504 Plans).
3. High school and college transcripts (if applicable).
4. For college graduates who did not require (or use) academic accommodations for the entire college experience, no evaluation is required. The service member must provide:
   - Childhood medical and school records documenting the diagnosis, course and cessation of treatment
   - College transcripts
   - Letter from the college/university academic learning center (or equivalent) stating that the service member was never evaluated for, qualified for, or provided academic accommodations during their entire college experience. If the service member transferred to/from another college at any time, letters from both academic centers are required.
   - A member statement attesting to the fact that he/she did not use or require accommodations/extra assistance for the learning disorder throughout college. The statement must also include a narrative of their diagnosis, evolution over time, and personal perceptions of their current level of functioning.
5. If absence of academic/functional impairment cannot be determined from available records, a comprehensive neuropsychological evaluation including academic testing and conducted by a credentialed neuropsychologist is required.

Motor Disorder:

1. FS/APA AMS documenting all prior symptoms, absence of persistent features, course of the disorder, and current level of functioning.
2. Childhood medical and school records documenting the diagnosis and any academic interventions and accommodations (e.g., Individual Educational Plans/504 Plans).
3. High school and college transcripts (if applicable).
4. If absence of academic/functional impairment cannot be determined from available records, an occupational therapy, neurology, or other applicable specialty evaluation is required.
5. A functional assessment may be required. This would be determined by NAMI Psychiatry.

14.4 SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

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AEROMEDICAL CONCERNS: The consumption of alcoholic beverages is a widely accepted practice in our society, and most people are able to drink moderately and responsibly without any adverse effects. In addition to its use as a “social lubricant,” alcohol used in moderation was long thought to confer modest health benefits, although more recent findings have effectively dispelled that notion. While most aviators can drink with impunity, a minority suffer from an Alcohol Use Disorder which, unless properly treated, presents an unacceptable risk to aviation safety. Alcohol is a sedative and hypnotic drug that has both acute and chronic effects on cognitive and physical performance. Cognitive effects include impairment of short-term memory, degradation of reasoning and decision-making, and inattentiveness. Psychomotor dysfunction includes an increase in reaction time and procedural errors. These damaging effects can occur at blood alcohol levels as low as 0.02 mg/dL, or after as little as a single standard drink. In addition, after moderate alcohol consumption, these effects can persist for many hours even after the blood alcohol level has returned to zero. Alcohol can also cause problems with visual acuity, oculovestibular dysfunction (positional alcohol nystagmus), and vertigo. This susceptibility persists long into the "hangover" period. In addition, alcohol reduces Gz tolerance by 0.1-0.4 G. Acute alcohol intoxication can also produce ataxia, vertigo, nausea, and cardiac dysrhythmias that usually disappear quickly but can leave moderate conduction delays for up to one week (the "holiday heart" syndrome). Aviation duties involve highly demanding cognitive and psychomotor tasks, frequently performed in inhospitable environments, so it is not difficult to see how the presence of an untreated Alcohol Use Disorder with impaired control over drinking, or even the injudicious use of alcohol by non-alcoholic individuals, can introduce a potentially lethal risk to the safety-sensitive occupation of flying.

Gambling Disorder also involves an inability to resist acting on impulse that may lead to aviation safety problems. Individuals with Gambling Disorder are generally preoccupied with gambling, irritable or distracted when attempting to cut down or stop gambling, and often lie to conceal the extent of involvement with gambling. Gambling Disorder is typically treated with behavior therapy. A solid aftercare program, similar to that required for Alcohol Use Disorder, is required for a waiver.

With the publication of DSM-5 in 2013, Internet Gaming Disorder was included as a Condition for Further Study, and remained in that section of the Manual a decade later when DSM-5-TR was released. In 2018, the World Health Organization added Gaming Disorder to the International Classification of Disease (ICD-11), with subcategories for “predominantly online” and “predominantly offline” types. Other behavioral (i.e. non-substance) addictions, including “sex addiction,” were considered for inclusion by the *DSM*-5 working group, but ultimately rejected, due to what the group considered insufficient scientific evidence of the validity of those as diagnostic categories. The WHO took the other side in the sexual addictions classification debate, and added the new category of Compulsive Sexual Behaviour Disorder to ICD-11. The aeromedical relevance of this is that NAMI has reviewed multiple waiver requests for gaming and sex addiction, and when waivers were recommended, aeromedical risk controls analogous to the published stipulations for substance addictions were implemented, with good success. For that reason, these behavioral addictions have been included in the ARWG.

HISTORY OF ALCOHOL RELATED INCIDENT: (Applicants and Designated Personnel): Any history of an Alcohol Related Incident (e.g. DUI, Minor in Possession/Underage Drinking, Open Container, Drunk and Disorderly, etc.) requires due diligence to rule out a possible Alcohol Use

Disorder or a pattern of hazardous use requiring early intervention. To that end, all Police/Arrest Reports and Court Records of the incident(s) are required, as are certificates of completion of any court-directed substance use evaluation(s), alcohol education, or alcohol treatment program(s). Upload these documents into AERO with the Physical. Also required is an Aeromedical Summary (AMS) with a detailed history of events surrounding the incident. An alcohol related incident in the absence of a diagnosed Alcohol Use Disorder is Not Considered Disqualifying (NCD) for Duty Involving Flying.

DIAGNOSIS/ICD-10 Code:

F10.10	**Alcohol Use Disorder, Mild**
F10.20	**Alcohol Use Disorder, Moderate**
F10.20	**Alcohol Use Disorder, Severe**
F10.99	**Unspecified Alcohol-Related Disorder**
F63.0	**Gambling Disorder**
F91.9	**Gaming Disorder, unspecified (ICD-11 Code 6C51.Z)**
F91.9	**Gaming Disorder, predominantly online (ICD-11 Code 6C51.0)**
F91.9	**Gaming Disorder, predominantly offline (ICD-11 Code 6C51.1)**
F91.9	**Compulsive Sexual Behavior Disorder (ICD-11 Code 6C72)**

ABSTINENCE: Abstinence is required of all aeronautically designated personnel or students (aviators, aircrew, air traffic controllers, unmanned aerial vehicle operators, and instructors) diagnosed with Alcohol Use Disorder, Gambling Disorder, or other behavioral addiction, as follows:

- Navy/Marine Corps active/reserve personnel serving in a flying status involving operational or training flights (DIFOT)
- Personnel on orders to duty in a flying status not involving flying (DIFDEN) orders
- Instructors under hazardous duty incentive pay (HDIP) orders
- Civilian DON employees including non-appropriated fund employees and contract employees involved with frequent aerial flights or air traffic control duties

PREVIOUS DIAGNOSIS OF ALCOHOL USE/GAMBLING DISORDER:
If the member has a previous diagnosis of Alcohol Abuse or Dependence (DSM-III through DSM-IV-TR) or Alcohol Use Disorder (DSM-5 and DSM-5-TR), Gambling Disorder, or other behavioral addiction, and a waiver has not been granted, follow the guidelines for *New Diagnosis of Alcohol Use or Behavioral Addiction (Gambling Disorder, Sex or Gaming Addiction)* as outlined below.

If the member has a previous diagnosis of Alcohol Abuse or Dependence or Alcohol Use Disorder, Gambling Disorder, or other behavioral addiction, and has been granted a waiver, follow the guidelines for *Annual Waiver Continuance Process* (outlined below).

NEW DIAGNOSIS OF ALCOHOL USE DISORDER OR BEHAVIORAL ADDICTION (GAMBLING DISORDER, SEX OR GAMING ADDICTION): Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) must submit a grounding physical to NAMI Code 53HN. Waiver is possible 90 days after the service member has:

1. Successfully completed Outpatient, Intensive Outpatient, or Residential treatment (the appropriate level of treatment will be determined by the treatment facility, using the

current edition of the American Society of Addiction Medicine treatment criteria, The ASAM Criteria).
2. Maintained a positive attitude and an unqualified acknowledgment of the alcohol use/addictive disorder.
3. Remained abstinent from alcohol without the need for amethystic medications.
4. Fully complied with aftercare requirements post-treatment during the minimum of 90 days (see below).

AFTERCARE REQUIREMENTS: The member must document participation in an organized recovery program. **FOR ALCOHOL USE DISORDER, THIS IS ALCHOLICS ANONYMOUS (AA), INCLUDING "BIRDS OF A FEATHER" FOR PILOTS AND COCKPIT CREW MEMBERS**. For Gambling Disorder, Gamblers Anonymous (GA) is preferred, but the member may use a combination of GA and (open) AA meetings, e.g., when there are not sufficient GA meetings available locally to satisfy the requirement. For other behavioral addictions, appropriate mutual support meeting attendance and participation will likewise be required. Unless otherwise specified, the requirement for mutual support group participation must be in the form of attendance at "face-to-face" meetings. Documentation, in the form of attendance sheets or cards including the name and/or location of the meeting, date/time, and signature of the meeting chairperson, must be reviewed and approved by the DAPA/SACO, and may be requested by NAMI if there are questions about compliance. Alternatives, such as online or telephone "meetings" may be considered on a case-by-case basis, but will only be approved if operational limitations preclude attendance at face-to-face meetings; in all such cases, prior approval by NAMI will be required. Under no circumstances will such alternatives be considered for approval if face-to-face meetings are available. The following table summarizes requirements the member must satisfy and their specified timeframes:

Aftercare Timeframe

Professional /Meetings	**First Year**	**Second/Third Year**	**Fourth Year +**
FS/APA	Monthly	Quarterly	Annually
DAPA/SACO	Monthly	Monthly	No formal requirement
Psychiatrist/Psychologist/Licensed Clinical Social Worker/Psychiatric Nurse Practitioner	Annually	Annually	No formal requirement
Alcoholics Anonymous, Gamblers Anonymous, or other appropriate mutual support meetings for Sex or Gaming Addiction	3x weekly	1x weekly	Strongly recommended but not required
Random Urine Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS)	Quarterly	Quarterly	No formal requirement
Random Blood Phosphatidylethanol (PEth)	Annually	Annually	No formal requirement

INITIAL WAIVER PROCESS: As with any other waiver, the member should initiate the request. *In the waiver request letter, the member must acknowledge the specific aftercare requirements listed above.* Further, the member must provide specific evidence of current compliance. This will avoid claims that the member was never advised of all the requirements for requesting and maintaining an alcohol waiver.

INFORMATION REQUIRED:

1. Complete flight physical, including Mental Status Exam.
2. Aeromedical Summary (AMS) to include:
   a. Detailed review of all factors pertaining to the diagnosis, including events preceding and after the initial clinical presentation.
   b. Statements concerning safety of flight, performance of duties, potential for recovery, and any symptoms of co-occurring disorders or significant stressors.
   c. Documentation of compliance with aftercare requirements including abstinence and attendance at AA meetings for Alcohol Use Disorder, GA meetings for Gambling Disorder, or other appropriate mutual support group meetings for Sex or Gaming Addiction.
3. Outpatient/Intensive Outpatient/Residential treatment summary.
4. Blood Phosphatidylethanol (PEth) level – may utilize level drawn from SARP or other evaluation. If no recent PEth, obtain a separate lab value prior to submission.
5. DAPA's statement documenting aftercare including attendance at AA meetings for Alcohol Use Disorder, GA meetings for Gambling Disorder, or other appropriate mutual support group meetings for Sex or Gaming Addiction. Signature sheets/cards may be requested on a case-by-case basis.
6. Psychiatric evaluation by a privileged psychiatrist, clinical psychologist, licensed clinical social worker, or psychiatric nurse practitioner—this should be completed at the 90-day mark following successful completion of the appropriate level of treatment.
7. Commanding officer's endorsement on command letterhead.
8. Signed member statement:

   The waiver request must include a personal statement, written, signed and dated by the member, that includes the following paragraph (**NOTA BENE:** the member's statement should contain not only the following paragraph, but also demonstrate unqualified acknowledgment of the condition and give evidence of a positive attitude towards recovery. In other words, simply copying and pasting this paragraph is necessary but NOT SUFFICIENT for the purpose of gaining waiver approval; the member MUST also write a personal statement). In the case of Gambling Disorder or other behavioral addiction, the appropriate verbiage, pertaining to the specific condition, should be substituted.

   "I have reviewed the relevant sections of the Aeromedical Reference and Waiver Guide with my Flight Surgeon/Aeromedical Physician Assistant. I understand that I must remain abstinent from alcohol for the duration of my flying career in order to remain eligible for this waiver. I must meet with my Flight Surgeon/Aeromedical Physician Assistant monthly for the first year, then quarterly for the next two years of formal aviation aftercare. I must meet with the command DAPA/SACO monthly and undergo a mental health evaluation yearly throughout the first three years of formal aviation aftercare. And I must document required attendance at meetings of Alcoholics Anonymous (AA) a MINIMUM of three times per week for the first year and once per week for the next two years of formal aviation aftercare."

ANNUAL WAIVER CONTINUANCE PROCESS:

1. During first three years of aftercare
   a. Complete long-form flight physical (SF 88 and SF 93 or DD2807/2808).

b. FS/APA statement (must address the following)
   (1) Safety of flight, performance of duties, potential for sustained recovery, and any symptoms of co-occurring disorders
   (2) Documentation of compliance with aftercare requirements including abstinence and AA attendance.
c. Alcohol Biomarkers obtained either from other required evaluations (e.g. SARP) or separately by FS/APA. Random, unannounced testing is preferred. Biomarker testing shall include:
   (1) **Quarterly Monitoring**: Urine ethyl glucuronide (EtG) and ethyl sulfate (EtS) tests conducted on a random basis at least once quarterly. Alternatively, blood phosphatidylethanol (PEth) levels may be used as a substitute for EtG/EtS testing, as PEth is a more sensitive and reliable biomarker for alcohol consumption.
   (2) **Annual Monitoring**: A blood phosphatidylethanol (PEth) level test conducted on a random basis at least once annually.
d. DAPA's statement documenting aftercare including attendance at AA meetings for Alcohol Use Disorder, GA meetings for Gambling Disorder, or other appropriate mutual support group meetings for Sex or Gaming Addiction. Signature sheets/cards may be requested on a case-by-case basis.
e. Psychiatric evaluation by a privileged psychiatrist, clinical psychologist, licensed clinical social worker, or psychiatric nurse practitioner.

2. After three years of aftercare
   a. Short-form flight physical (NAVMED 6410/10)
   b. Aeromedical Summary (must address the following)
      (1) Safety of flight, performance of duties, potential for sustained recovery, and any symptoms of co-occurring disorders.
      (2) Documentation of member's continued abstinence

NONCOMPLIANCE OR AFTERCARE FAILURE: The following guidance pertains to any member in denial of an alcohol, gambling, or other behavioral addiction, failing to abstain, or not compliant with all aftercare requirements as enumerated above. These members are to be considered NPQ and the following actions shall be performed:

1. Ground the member immediately! Grounding period is a minimum of 6-12 months.
2. Submit grounding physical via AERO to NAMI Code 53HN.
3. Re-evaluation by Flight Surgeon, DAPA, and Alcohol Treatment Facility to determine potential for re-treatment.

NOTE: If member requests a waiver after the 6-12 month grounding period, follow the Initial Waiver Process (above). Please discuss these waiver requests with NAMI Psychiatry Department before submission. NAMI will review these waiver requests on a case by case basis.

DISCUSSION: Use the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (as of this writing, DSM-5-TR) criteria to diagnose Substance-Related and Addictive Disorders. The evidenced-based aftercare requirements (outlined above) will help a member diagnosed with an Addictive Disorder maintain long-term sobriety/abstinence/recovery in the interest of aviation safety.

To assist with deterrence of lapses and relapses that may occur with Alcohol Use Disorders, the inclusion of EtG, EtS, and PEth laboratory values into the monitoring process aligns with evolving medical practices, the FAA and other military services, and highlights the need for a

compassionate, disease-focused framework that prioritizes safety and rehabilitation. Utilizing EtG and EtS together for random quarterly urine collections as well as at least annual random PEth levels offers enhanced sensitivity and specificity for detecting alcohol use, enabling a more objective and reliable assessment of abstinence. This modernization emphasizes deterrence rather than punitive measures, recognizing the vulnerability to relapse during the early recovery stages of the disease. By providing clear, measurable feedback on alcohol use, these biomarkers reinforce the importance of abstinence while supporting aviation personnel in maintaining their health and readiness.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) CRITERIA LEVELS OF CARE

Early intervention and secondary prevention services are recommended for individuals at risk of developing a Substance-Related or Addictive Disorder, usually recommended after a single ARI; analogous to the civilian “DUI school.” This was known as “Level 0.5” in the Third Edition of The ASAM Criteria, and is not considered adequate for anyone meeting diagnostic criteria for a Substance-Related or Addictive Disorder and hence is not sufficient for waiver eligibility.

Level 1 – OUTPATIENT.
Level 2 – INTENSIVE OUTPATIENT.
Level 3 – RESIDENTIAL.
Level 4 – MEDICALLY MANAGED INTENSIVE INPATIENT. (Rarely necessary for military aviation personnel.

TOBACCO-RELATED DISORDERS AND SMOKING CESSATION:

DIAGNOSIS/ICD-10 Code:
Z72.0 Tobacco Use Disorder, Mild
F17.200 Tobacco Use Disorder Moderate
F17.200 Tobacco Use Disorder Severe

Tobacco use in any form, while Not Considered Disqualifying for Duty Involving Flying, should nonetheless be discouraged, as the evidence for adverse health effects is overwhelming and there can be no doubt that many, if not most, regular users meet DSM-5-TR criteria for Tobacco Use Disorder. Happily, many patients are able to quit without pharmacologic intervention once equipped with the knowledge and behaviors needed to abstain. For those who do require pharmacologic support, the following aeromedical guidelines apply.

Nicotine replacement therapy (transdermal and gum) is approved with the following stipulations:

NICORETTE GUM®: NCD if the following conditions are met:

1. Enrolled in formal organized stop smoking program.
2. Close observation by Flight Surgeon (FS)/Aeromedical Physician Assistant (APA).
3. No adverse effects.
4. Duration of use does not exceed three months.

NICOTINE TRANSDERMAL SYSTEM (NICODERM®): NCD. Aviators should be grounded for 48 hours following application of first patch.

All other medications for tobacco cessation are not approved for use by personnel on active flight status, so require grounding during treatment. This can often be planned to coincide with non-flying periods. Guidance for timing of return to flight is based on the elimination half-life of the drug being used, as follows:

VARENICLINE (CHANTIX®): Varenicline has an elimination half-life of 24 hours, so individuals may be returned to flight no sooner than one more week after finishing Chantix.

BUPROPION (ZYBAN®, WELLBUTRIN®): Bupropion is cleared more quickly, but only about 1% is excreted unchanged in the urine; the rest is metabolized to three major active metabolites, threohydrobupropion, erythrohydrobupropion and hydroxybupropion, which accumulate to levels much higher than the parent compound and can have extended half-lives of as long as 43 hours. Individuals taking bupropion should therefore be kept down for two weeks following completion of treatment.

14.5 ANXIETY DISORDERS

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AEROMEDICAL CONCERNS: The symptoms associated with anxiety disorders may produce sudden and dangerous distraction in flight with autonomic symptoms as well. Panic attack episodes are particularly hazardous due to the risk that symptoms that can appear unexpectedly and lead to sudden incapacitation. Service members with Panic Disorder and Generalized Anxiety Disorder may complain of palpitations, dizziness, headaches, shortness of breath, tremulousness, and impaired concentration and memory. Panic Disorder has a high rate of recurrence, and is associated with increased mortality from cardiovascular disease and suicide. Some medications used to treat these disorders are incompatible with flying status.

DIAGNOSIS/ICD-10 Code:

F40.00	**Agoraphobia**
F40.10	**Social Anxiety Disorder (Social Phobia)**
F40.218–298	**Specific Phobia (animal, natural environment, blood-injection-type, situational, other)**
F41.0	**Panic Disorder**
F41.1	**Generalized Anxiety Disorder**
F41.8	**Other Unspecified Anxiety Disorder**
F41.9	**Unspecified Anxiety Disorder**

The above diagnoses are all CD for aviation. **Waiver may be requested when the member has been completely asymptomatic in a "Fit for Full Duty" status for a minimum of 12 months after completion of all treatment.**

Maintenance Pharmacotherapy: Maintenance pharmacotherapy is sometimes used to mitigate the risk of future recurrence of Anxiety Disorders, typically after several discrete episodes. In cases of persistent (chronic) or recurrent Anxiety Disorders, maintenance pharmacotherapy may be considered. In such cases, Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Waiver consideration may be requested after a suitable Period of Observation in a Non-flying Status (PONS) has elapsed, which for Anxiety Disorders is 12 months. The PONS begins once an authorized mental health provider (an aeromedically trained clinical psychologist or psychiatrist whenever possible) has declared, by way of a formal medical record entry, that the service member's condition is in full remission. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Waivers will not normally be recommended for acute-phase treatment of initial episodes of Anxiety Disorders. Please see Section 18.7 of the ARWG for full details.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.

2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Please also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms. Evaluation should be completed by an aeromedically-trained clinical psychiatrist or psychologist whenever possible.
4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

Substance/Medication-Induced Anxiety Disorder: Substance/Medication-Induced Anxiety Disorder with clear evidence from the history, physical examination, or laboratory findings that the disturbance is etiologically related to substance/medication use is CD and waivers are considered on a case-by-case basis after all symptoms have cleared. In the case of psychiatric syndromes caused by alcohol or illicit drugs, a SARP evaluation should be included in the waiver package to rule out a Substance-Related or Addictive Disorder. A Local Board of Flight Surgeons (LBFS) may issue a temporary up-chit in accordance with Manual of the Medical Department Article 15-80.

Anxiety Disorder Due To Another Medical Condition (F06.4): NCD when resolved if precipitating organic factors identified and not likely to recur. Physical illness or other disorders causing persistent delirium are permanently disqualifying and should be referred to a medical board.

14.6 BIPOLAR AND RELATED DISORDERS

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AEROMEDICAL CONCERNS: Bipolar spectrum disorders are especially concerning due to lack of insight and impaired reality-testing, often coupled with compromised judgment and poor treatment compliance. Lifetime prevalence of Bipolar I Disorder is estimated at about 1% of the general population. Prevalence of Bipolar II Disorder, characterized by episodes of hypomania instead of mania, is 0.8%. As with most psychiatric conditions, the prevalence is undoubtedly much lower among designated aviation personnel. The mean age of onset for Bipolar I disorder is 18 years of age, but onset throughout the life cycle is possible, including cases with first diagnosis well into the seventh and eighth decades of life (although in many such cases, thorough exploration of the past history reveals earlier mild, forgotten or undiagnosed episodes of depressed or abnormally elevated mood). Many individuals do well between episodes, but as many as 30% have severe inter-episode occupational impairment; some of this is attributable to persistent cognitive dysfunction, even during periods of normal mood. After an initial manic episode, more than 90% of individuals will have recurrent episodes of mood disturbance, either manic or depressive or both. If the initial episode included psychotic features, subsequent episodes are more likely to include psychosis as well. Onset of manic episodes is typically rapid, i.e. over hours or days. All Bipolar and Related Disorders are disqualifying for aviation duty, and waivers are not granted. The service member should be referred to a Physical Evaluation Board for determination of fitness for general duty/retention.

DIAGNOSIS/ICD-10 Code:

F31.11	**Bipolar I Disorder, mild, most recent episode manic**
F31.12	**Bipolar I Disorder, moderate, most recent episode manic**
F31.13	**Bipolar I Disorder, severe, most recent episode manic**
F31.2	**Bipolar I Disorder, with psychotic features**
F31.31	**Bipolar I Disorder, mild, most recent episode depressed**
F31.32	**Bipolar I Disorder, moderate, most recent episode depressed**
F31.4	**Bipolar I Disorder, severe, most recent episode depressed**
F31.81	**Bipolar II Disorder**
F31.89	**Other Specified Bipolar and Related Disorder**
F31.9	**Unspecified Bipolar and Related Disorder**
F34.0	**Cyclothymic disorder**

The above diagnoses are CD for aviation, with no waiver considered. Service members should be referred to a Physical Evaluation Board for determination of fitness for general duty/retention.

Substance/Medication-Induced Bipolar and Related Disorder: Substance/Medication-Induced Bipolar and Related Disorder with clear evidence from the history, physical examination, or laboratory findings that the disturbance is etiologically related to substance/medication use is CD and waivers are considered on a case-by-case basis after all symptoms have cleared. In the case of psychiatric syndromes caused by alcohol or illicit drugs, a SARP evaluation should be included in the waiver package to rule out a Substance-Related or Addictive Disorder. A Local Board of Flight Surgeons (LBFS) may issue a temporary up-chit in accordance with Manual of the Medical Department Article 15-80.

Bipolar and Related Disorder Due To Another Medical Condition (F06.33/34): NCD when resolved if the precipitating organic factors are identified and considered not likely to recur. Physical illness or other disorders causing persistent impairment are permanently disqualifying and should be referred to a medical board.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, "See GENESIS/JLV records." Please also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records including treatment summary).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms. Evaluation should be completed by an aeromedically-trained clinical psychiatrist or psychologist whenever possible.
4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

14.7 DEPRESSIVE DISORDERS

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AEROMEDICAL CONCERNS: Depressive disorders are associated with decreased concentration, inattention, indecisiveness, fatigue, insomnia, agitation, and sometimes psychosis, all of which are incompatible with aviation duties. Risk of suicide is 15 per cent, the highest of all psychiatric disorders. Thirty per cent of dysthymic patients develop subsequent depression or mania. Fifty to 75 per cent of affected patients have a recurrent episode. There is a strong association with substance abuse. However, it should be noted that acute major depression is treatable in 80 per cent of patients, and waivers for single episodes of depression will be considered.

DIAGNOSIS/ICD-10 Code:

F32.0	**Major Depressive Disorder, Single episode, mild**
F32.1	**Major Depressive Disorder, Single episode, moderate**
F32.2	**Major Depressive Disorder, Single episode, severe**
F32.81	**Premenstrual Dysphoric Disorder***
F32.89	**Other Specified Depressive Disorder**
F32.9	**Unspecified Depressive Disorder**
F33.0	**Major Depressive Disorder, Recurrent episode, mild***
F33.1	**Major Depressive Disorder, Recurrent episode, moderate***
F33.2	**Major Depressive Disorder, Recurrent episode, severe***
F34.1	**Persistent Depressive Disorder (Dysthymia)***

The above diagnoses are disqualifying for aviation. **Waiver may be requested after a single episode when the member has been completely asymptomatic in a "Fit for Full Duty" status for a minimum of six months after completion of all treatment.** Recurrent Disorders are CD, waiver not recommended.*

Maintenance Pharmacotherapy: Maintenance pharmacotherapy is sometimes used to mitigate the risk of future recurrence of Depressive Disorders, typically after several discrete episodes. In cases of persistent (chronic) or recurrent Depressive Disorders, maintenance pharmacotherapy may be considered. In such cases, Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Waiver consideration may be requested after a suitable *Period of Observation in a Non-flying Status* (PONS) has elapsed, which for Depressive Disorders is six months. The PONS begins once an authorized mental health provider (an aeromedically trained clinical psychologist or psychiatrist whenever possible) has declared, by way of a formal medical record entry, that the service member's condition is in full remission. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Waivers will not normally be recommended for acute-phase treatment of initial episodes of Depressive Disorders. Please see Section 18.7 of the ARWG for full details.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.

2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms. Evaluation should be completed by an aeromedically-trained clinical psychiatrist or psychologist whenever possible.
4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

Substance/Medication-Induced Depressive Disorder: Substance/Medication-Induced Depressive Disorder with clear evidence from the history, physical examination, or laboratory findings that the disturbance is etiologically related to substance/medication use is CD and waivers are considered on a case-by-case basis after all symptoms have cleared. In the case of psychiatric syndromes caused by alcohol or illicit drugs, a SARP evaluation should be included in the waiver package to rule out a Substance-Related or Addictive Disorder. A Local Board of Flight Surgeons (LBFS) may issue a temporary up-chit in accordance with Manual of the Medical Department Article 15-80.

Depressive Disorder Due To Another Medical Condition (F06.31/F06.32/F06.34): NCD when resolved if the precipitating organic factors are identified and considered not likely to recur. Physical illness or other disorders causing persistent delirium are permanently disqualifying and should be referred to a medical board.

*In some cases, waivers may be considered for recurrent depressive disorders in designated personnel being treated with maintenance pharmacotherapy.

14.8 DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

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AEROMEDICAL CONCERNS: Impulse Control Disorders involve an inability to resist acting on an impulse that is dangerous to the service member or others, and that is characterized by a sense of pleasure or relief when gratified. Such impulsive or stereotyped behavior may jeopardize aviation safety. Differential diagnosis should include substance abuse, temporal lobe epilepsy, head trauma, bipolar disorder, and antisocial personality disorder. The diagnosis is usually not made if the behavior occurs only in the context of another disorder such as schizophrenia, bipolar disorder, or adjustment disorder. Psychotropic medications used to treat these disorders are incompatible with aviation duty.

WAIVER: Impulse Control Disorders are CD for aviation. Waiver requests for all disorders in this section are handled on a case-by-case basis, and questions should be referred to NAMI Psychiatry via email, telephone consultation or referral for formal evaluation.

DIAGNOSIS/ICD-10 Code:

F63.1	**Pyromania**
F63.3	**Kleptomania**
F63.81	**Intermittent Explosive Disorder**
F91.1/2/9	**Conduct Disorder**
F91.3	**Oppositional Defiant Disorder**
F91.8	**Other Specified Disruptive, Impulse-Control, and Conduct Disorder**
F91.9	**Unspecified Disruptive, Impulse-Control, and Conduct Disorder**

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling records, academic records, legal records).
3. A current mental health evaluation is required to document complete, sustained remission of all symptoms. Evaluation should be completed by an aeromedically-trained clinical psychiatrist or psychologist whenever possible.

14.9 FEEDING AND EATING DISORDERS

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AEROMEDICAL CONCERNS: Eating disorders can cause potentially life-threatening metabolic alkalosis, hypochloremia, and hypokalemia, which can have drastic implications for aviation safety. Anxiety and depressive symptoms are common, and death by suicide is a risk. Relapse rate is high. Follow-up studies of Anorexia Nervosa have revealed that approximately 30 per cent of individuals recover completely, 30 per cent are partially improved, 30 per cent are chronically ill, and 10 per cent have died. Many of these patients also have persistent mood, anxiety and personality disorders. Anorexia Nervosa is potentially fatal in five to 12 per cent of cases. Bulimia Nervosa is often associated with alcohol abuse. Treatment is very difficult and involves intensive long-term therapy, group therapy, and possibly pharmacotherapy, all of which are incompatible with aviation duty. Maintenance pharmacotherapy, including lisdexamfetamine dimesylate, is not waiverable.

WAIVER: Feeding and Eating Disorders are CD for aviation. Waiver may be considered on a case-by-case basis if the service member is off medication, asymptomatic, and out of active treatment for a minimum of one year for mild cases and two years for moderate-severe cases. In general a NAMI Psychiatry evaluation will be required.

DIAGNOSIS/ICD-10 Code:

F50.01	**Anorexia Nervosa restricting type**
F50.02	**Anorexia Nervosa binge-eating purging type**
F50.2	**Bulimia Nervosa**
F50.8	**Pica**
F50.8	**Avoidant/Restrictive Food Intake Disorder**
F50.8	**Binge-Eating Disorder**
F50.8	**Other Specified Feeding or Eating Disorder**
F50.9	**Unspecified Feeding or Eating Disorder**
F98.21	**Rumination Disorder**
F98.3	**Pica (in childhood)**

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See Genesis/JLV records.” Also include items not in the electronic health record (e.g., civilian medical records, legal records, college counseling center records, etc.).
3. A current mental health evaluation conducted by an aeromedically-trained psychologist or psychiatrist is required to document complete, sustained remission of all symptoms.
4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).
5. Service members must meet the minimum aviation weight standards.

14.10 OBSESSIVE-COMPULSIVE DISORDER AND RELATED DISORDERS

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AEROMEDICAL CONCERNS: Service members with Obsessive Compulsive Disorder experience obsessional thoughts and/or compulsive behavior. Those with Body Dysmorphic Disorder are preoccupied with perceived defects or flaws in appearance not significantly observable to others. Both are aeromedically disqualifying, as they create substantial distractions in attention, and may be associated with high levels of anxiety and depression. Other less common Obsessive-Compulsive and Related Disorders requiring an approved waiver are also listed below.

DIAGNOSIS/ICD-10 Code:

F42.2	**Obsessive-Compulsive Disorder**
F42.3	**Hoarding Disorder**
F42.4	**Excoriation (Skin-Picking) Disorder**
F42.8	**Other Specified Obsessive-Compulsive and Related Disorder**
F42.9	**Unspecified Obsessive-Compulsive and Related Disorder**
F45.22	**Body Dysmorphic Disorder**
F63.3	**Trichotillomania**

The above diagnoses are all CD for aviation. **Waiver may be requested when the member has been completely asymptomatic in a "Fit for Full Duty" status for a minimum of 12 months after completion of all treatment.**

Maintenance Pharmacotherapy: Maintenance pharmacotherapy is sometimes used to mitigate the risk of future recurrence of Obsessive-Compulsive and Related Disorders, typically after several discrete episodes. In cases of persistent (chronic) or recurrent Obsessive-Compulsive and Related Disorders, maintenance pharmacotherapy may be considered. In such cases, Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Waiver consideration may be requested after a suitable *Period of Observation in a Non-flying Status* (PONS) has elapsed, which for Obsessive-Compulsive and Related Disorders is 12 months. The PONS begins once an authorized mental health provider (an aeromedically trained clinical psychologist or psychiatrist whenever possible) has declared, by way of a formal medical record entry, that the service member's condition is in full remission. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Waivers will not normally be recommended for acute-phase treatment of initial episodes of Obsessive-Compulsive and Related Disorders. Please see Section 18.7 of the ARWG for full details.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, "See GENESIS/JLV records." Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms. Evaluation should be completed by an aeromedically-trained clinical psychiatrist or psychologist whenever possible.

4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder:
Substance/Medication-Induced Obsessive-Compulsive and Related Disorder with clear evidence from the history, physical examination, or laboratory findings that the disturbance is etiologically related to substance/medication use is CD and waivers are considered on a case-by-case basis after all symptoms have cleared. In the case of psychiatric syndromes caused by alcohol or illicit drugs, a SARP evaluation should be included in the waiver package to rule out a Substance-Related or Addictive Disorder. A Local Board of Flight Surgeons (LBFS) may issue a temporary up-chit in accordance with Manual of the Medical Department Article 15-80.

Obsessive-Compulsive and Related Disorder Due To Another Medical Condition (F06.8):
NCD when resolved if the precipitating organic factors are identified and considered not likely to recur. Physical illness or other disorders causing persistent delirium are permanently disqualifying and should be referred to a medical board.

14.11 PERSONALITY DISORDERS, MALADAPTIVE PERSONALITY TRAITS, AND AERONAUTICAL ADAPTABILITY

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AEROMEDICAL CONCERNS: Aeronautical Adaptability involves a person's coping mechanisms, personality style, and defense mechanisms. Personality Disorders as well as maladaptive personality traits may lead to flight safety problems. Such traits in an applicant or student may interfere with adaptation to the rigors of aviation training, and in designated aviation personnel may affect flight performance and the ability to tolerate the stress and demands of operational training and deployment, maintain safety in aviation environments, and interact in a harmonious and effective way with other crew members. Certain personality traits may produce thrill seeking behavior, conflicts with authority, emotional lability, indecisiveness, questionable judgment, poor impulse control, or inflexibility, and are incompatible with the safe performance of aviation duty. Treatment of personality disorders and maladaptive personality traits requires long term intensive psychotherapy, which is incompatible with aviation duty.

WAIVER: Aviation personnel are considered to be NAA, or Not Aeronautically Adaptable (applicants or students) or Not Aeronautically Adapted (designated) if diagnosed as having a Personality Disorder or are characterized as having prominent maladaptive personality traits affecting safety of flight, mission completion, or crew coordination. Because personality traits are enduring patterns of thinking, feeling and behaving that are relatively stable over time, once an individual is found to be NAA this finding is permanent. Therefore, no waivers are considered for aeronautical adaptability. Questions regarding the aeronautical adaptation of undesignated personnel (applicants, students) should be directed to NAMI, and will generally be followed by an evaluation by a local aeromedically trained clinical psychologist or psychiatrist in order for an aeromedical disposition to be made. Designated aviation personnel should be referred to NAMI Psychiatry and in most cases will require in-person evaluation at NAMI.

DIAGNOSIS/ICD-10 Code/AERO Code:

F60.0	**Paranoid Personality Disorder**
F60.1	**Schizoid Personality Disorder**
F21	**Schizotypal Personality Disorder**
F60.2	**Antisocial Personality Disorder**
F60.3	**Borderline Personality Disorder**
F60.4	**Histrionic Personality Disorder**
F60.81	**Narcissistic Personality Disorder**
F60.6	**Avoidant Personality Disorder**
F60.7	**Dependent Personality Disorder**
F60.5	**Obsessive-Compulsive Personality Disorder**
F60.89	**Other Specified Personality Disorder**
F60.9	**Unspecified Personality Disorder**
AA3019N	**Aeromedically Maladaptive Personality Traits**

INFORMATION REQUIRED:

1. Grounding physical and Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, persistent features, course of the disorder, medication use (if any), and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Also include items not in GENESIS/JLV (e.g., civilian medical records, legal

records, any formal boards conducted by the command, e.g. Human Factors Board, FNAEBs, etc.). A current local mental health evaluation is required for all undesignated personnel suspected of being NAA and should be completed by an aeromedically-trained clinical psychologist or psychiatrist.

3. In cases when the presentation of designated aviation personnel suggests that an individual is NAA, in-person NAMI evaluation is needed for diagnostic clarification and to assess the impact of any potentially maladaptive personality traits on interpersonal and occupational functioning, with special emphasis on flight safety, mission completion, and crew coordination.

14.12 PSYCHOSIS/SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

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AEROMEDICAL CONCERNS: Symptoms of aeromedical concern include eccentric behavior, illogical thinking, hallucinations, social withdrawal, and the risk of suicide. Recurrence is abrupt, unpredictable, and incapacitating in aviation. Increased vulnerability to stress is considered lifelong in these disorders. Among patients with schizophrenia, one third will lead somewhat normal lives, one third will continue to have significant symptoms, and one third require frequent hospitalization and chronic care. Suicide attempts are made by up to fifty per cent of individuals with schizophrenia with long term suicide rates of ten to thirteen per cent. The majority of patients with these disorders require Physical Evaluation Boards due to their incompatibility with general military duty. Antipsychotic medications and close psychiatric follow-up care are incompatible with aviation duty.

DIAGNOSIS/ICD-10 Code:

F20.81	**Schizophreniform Disorder**
F20.9	**Schizophrenia**
F22	**Delusional Disorder**
F23	**Brief Psychotic Disorder**
F25.0	**Schizoaffective Disorder, Bipolar Type**
F25.1	**Schizoaffective Disorder, Depressive Type**
F28	**Other Specified Schizophrenia Spectrum and Other Psychotic Disorders**
F29	**Unspecified Schizophrenia Spectrum/Other Psychotic Disorders**
F32.3	**Major Depressive Disorder, single episode with psychotic features**
F33.0 – F33.2	**Major Depressive Disorder, recurrent with psychotic features**
F06.1	**Catatonia Associated with Another Mental Disorder/Catatonic Disorder Due to Another Medical Condition/Unspecified Catatonia**

The above diagnoses are CD for aviation, with no waiver considered. Service members should be referred to a Physical Evaluation Board for determination of fitness for general duty/retention.

Substance/Medication-Induced Psychotic Disorder: Substance/Medication-Induced Psychotic Disorder with clear evidence from the history, physical examination, or laboratory findings that the disturbance is etiologically related to substance/medication use is CD and waivers are considered on a case-by-case basis after all symptoms have cleared. In the case of psychiatric syndromes caused by alcohol or illicit drugs, a SARP evaluation should be included in the waiver package to rule out a Substance-Related or Addictive Disorder. A Local Board of Flight Surgeons (LBFS) may issue a temporary up-chit in accordance with Manual of the Medical Department Article 15-80.

Psychotic Disorder Due To Another Medical Condition (F06.0/2): NCD when resolved if the precipitating organic factors are identified and considered not likely to recur. Physical illness or other disorders causing persistent delirium are permanently disqualifying and should be referred to a medical board.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.

2. All mental health notes (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Also include items not in GENESIS/JLV (e.g., civilian medical records, legal records, etc.).
3. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

14.13 SEXUAL DYSFUNCTIONS AND PARAPHILIAS

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AEROMEDICAL CONCERNS: Generally, sexual dysfunctions such as sexual desire/arousal/orgasm disorders do not affect aviation performance. The paraphilias, however, such as exhibitionism and fetishism, may impact aviation performance. Individuals with these disorders may exhibit compulsive behavior and poor impulse control, and repeatedly engage in risk-taking behavior, which generally only increases when the individual feels stressed, anxious, or depressed. Certain legal ramifications may cause the person to be inattentive to detail and a safety risk. The legal consequences generally preclude treatment within the military.

WAIVER: Sexual Dysfunctions may be NCD if they do not impact aviation performance. The treatment of sexual desire/aversion/arousal/pain/orgasm disorders generally involves behavioral techniques which should not preclude aviation duty. However, use of medication requires a waiver for aviation duty. In contrast, paraphilias are generally CD. Treatment of paraphilias is typically less successful and generally requires intensive long-term interventions. Waiver requests are handled on a case-by-case basis by NAMI Psychiatry after the service member has completed treatment and been asymptomatic for one year. Factors that will be considered in waiver requests include the type of paraphilia, duration and frequency, type of treatment required, and the adequacy of follow-up care. However, many cases are handled by administrative disposition due to the legal implications and impact on good order and discipline. Waivers are not considered for criminal paraphilias.

SEXUAL DYSFUNCTIONS

DIAGNOSIS/ICD-10 Code:

F52.0	**Male Hypoactive Sexual Desire Disorder**
F52.21	**Erectile Disorder**
F52.22	**Female Sexual Interest/Arousal Disorder**
F52.31	**Female Orgasmic Disorder**
F52.32	**Delayed Ejaculation**
F52.4	**Premature (Early) Ejaculation**
F52.6	**Genito-Pelvic Pain/Penetration Disorder**
F52.8	**Other Specified Sexual Dysfunction**
F52.9	**Unspecified Sexual Dysfunction**

PARAPHILIC DISORDERS

DIAGNOSIS/ICD-10 Code:

F65.0	**Fetishistic Disorder**
F65.1	**Transvestic Disorder**
F65.2	**Exhibitionistic Disorder**
F65.3	**Voyeuristic Disorder**
F65.4	**Pedophilic Disorder**
F65.51	**Sexual Masochism Disorder**
F65.52	**Sexual Sadism Disorder**
F65.81	**Frotteuristic Disorder**
F65.89	**Other Specified Paraphilic Disorder**
F65.9	**Unspecified Paraphilic Disorder**

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, "See GENESIS/JLV records." Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records).
3. A current mental health evaluation is required to document complete, sustained remission of all symptoms.

14.14 SLEEP/WAKE DISORDERS

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AEROMEDICAL CONCERNS: Sleep/Wake Disorders frequently result in demonstrable deficits in cognitive and psychomotor performance, and thus have a critical effect on aviation safety. Generally, these cases are referred to Neurology, but because there is often an association between disorders of sleep architecture and timing and underlying psychiatric disorder, cognitive disturbance, or other pathology, these conditions may be addressed by aeromedical mental health professionals as well.

WAIVER: See Neurology Section of ARWG.

DIAGNOSIS/ICD-10 Code:

G47.2	**Circadian Rhythm Sleep-Wake Disorders**
G47.21	**Circadian Rhythm Sleep-Wake Disorders, Delayed sleep phase type**
G47.22	**Circadian Rhythm Sleep-Wake Disorders, Advanced sleep phase type**
G47.23	**Circadian Rhythm Sleep-Wake Disorders, Irregular sleep-wake type**
G47.24	**Circadian Rhythm Sleep-Wake Disorders, Non-24-hour sleep-wake type**
G47.26	**Circadian Rhythm Sleep-Wake Disorders, Shift work type**
G47.20	**Circadian Rhythm Sleep-Wake Disorders, Unspecified type**

Non-Rapid Eye Movement Sleep Arousal Disorders

F51.3	**Sleepwalking type**
F51.4	**Sleep terror type**

F51.5	**Nightmare Disorder**
G25.81	**Restless Legs Syndrome**
G47.52	**Rapid Eye Movement Sleep Behavior Disorder**

G47.4	**Narcolepsy and Cataplexy**
G47.411	**Narcolepsy with cataplexy but without hypocretin deficiency**
G47.419	**Narcolepsy without cataplexy but with hypocretin deficiency**
G47.419	**Autosomal dominant cerebellar ataxia, deafness, and narcolepsy**
G47.419	**Autosomal dominant narcolepsy, obesity, and type 2 diabetes**
G47.429	**Narcolepsy secondary to another medical condition**

F51.01	**Insomnia Disorder**
F51.11	**Hypersomnolence Disorder**

INFORMATION REQUIRED: See Neurology Section of ARWG.

14.15 SOMATIC SYMPTOM AND RELATED DISORDERS

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AEROMEDICAL CONCERNS: These disorders often have a chronic course and service members make repeated visits to physicians due to multiple physical or somatic complaints. The psychotropic medications used in somatoform disorders are incompatible with aviation status. Service members with Factitious Disorders may seriously injure themselves, and are at extreme risk in the aviation environment. These individuals also have a high risk of substance abuse over time. Treatment offers little hope of return to flight status in factitious disorders, as these individuals are rarely motivated for psychotherapy, and generally change physicians when confronted.

WAIVER: These disorders are CD, and may be referred to a Medical Board for treatment. Waivers may be considered for those cases that are successfully treated and remain asymptomatic and off medications for a minimum of one year in a full duty status.

DIAGNOSIS/ICD- 10 Code:

F44.4	**Conversion Disorder with weakness or paralysis, with abnormal movement, with swallowing symptoms, with speech symptom**
F44.5	**Conversion Disorder with attacks or seizures**
F44.6	**Conversion Disorder with anesthesia or sensory loss or with special sensory symptoms**
F44.7	**Conversion Disorder with mixed symptoms**
F45.1	**Somatic Symptom Disorder**
F45.21	**Illness Anxiety Disorder**
F45.8	**Other Specified Somatic Symptom and Related Disorder/Unspecified Somatic symptom and Related Disorder**
F54	**Psychological Factors Affecting Other Medical Conditions**
F68.10	**Factitious Disorder**

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records, etc.).
3. All relevant general medical records (once again, “See GENESIS/JLV” will not suffice).
4. A current mental health evaluation is required to document complete, sustained remission of all symptoms.
5. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).

14.16 SUICIDAL BEHAVIOR AND NONSUICIDAL SELF HARM

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AEROMEDICAL CONCERNS: Suicidal ideation and behavior and non-suicidal self-harm comprise a significant risk for both individual and aviation safety. For the purpose of the ARWG, suicidal behavior is defined as suicidal thoughts, considerations, communications, planning and/or intent, as well as self-destructive actions, and overt suicide attempts. Nonsuicidal self-harm, which is defined separately from suicidal behavior, consists of intentional injury (cutting, burning, etc.) without intent to die. For the purposes of the ARWG and waiver consideration, both suicidal behavior (including ideation) and nonsuicidal self-harm are treated identically.

These behaviors typically reflect a current mental health condition, a decline from previous levels of functioning, and/or inadequate capability to manage current stressors. These behaviors have high rates of recurrence, particularly in the first 6 months, and they are related to future suicide attempt and death by suicide. Recurrence of suicidal behavior and/or nonsuicidal self-harm is incompatible with aviation duties, and therefore waivers will not normally be considered, unless the behavior is remote and there is clear indication of a prolonged period of mental health and adaptive coping strategies.

Suicidal behavior and nonsuicidal self-harm are CD for aviation. It should be noted that suicidal behavior and nonsuicidal self-harm in and of themselves do not reflect DSM-5-TR psychiatric diagnoses. Consequently, waivers are generally predicated on the psychiatric diagnosis of which the behavior is a manifestation. For example, if the behavior occurs in the context of Major Depressive Disorder (MDD), the waiver guideline for MDD would be followed. See below for exceptions.

Adjustment Disorder (see also Section 14.2): When the suicidal thoughts and behavior or nonsuicidal self-harm occurs in the context of an Adjustment Disorder (or Z Code), a minimum 6-month period in a non-flying status (PONS) is required, after symptom remission has occurred. In these cases, given the seriousness of suicidal thinking, planning, and actions, and their high risk for recurrence, immediate return to flying upon initial resolution of symptoms is not considered safe. Additionally, in these cases there must be evidence of psychotherapy or education/ training in stress management, coping, and/or resilience, as well as evidence of the development of improved and effective coping strategies.

Remote history of nonsuicidal self-harm: When there is a remote, pre-military history of nonsuicidal self-harm in adolescence without evidence of a DSM-5-TR diagnosis, and there is evidence of the development of healthy coping strategies, these histories are routinely waived. When occurring within the context of a diagnosis, the waiver process for that specific diagnosis should be followed.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, treatment, including medication use (if any), and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See Genesis/JLV records.” Also include items not in the electronic health record (e.g., civilian medical records, college counseling center records, etc.).

3. A current psychiatric or psychological evaluation, preferably conducted by an aeromedically-trained psychologist or psychiatrist, is required to document complete, sustained remission of all symptoms and demonstration of improved coping strategies.
4. Follow the appropriate ARWG section for the specific diagnosis of which the suicidal behavior, or the nonsuicidal self-harm, was a manifestation.

14.17 TRAUMA AND STRESSOR-RELATED DISORDERS

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AEROMEDICAL CONCERNS: Trauma and Stressor-Related Disorders are often associated with decreased concentration, inattention, depression, insomnia, fatigue, indecisiveness, anxiety, and impairment of occupational or social functioning, all of which are incompatible with aviation duties.

DIAGNOSIS/ICD-10 Code:

F43.0	**Acute Stress Disorder**
F43.10	**Posttraumatic Stress Disorder**
F43.8	**Prolonged Grief Disorder**
F43.8	**Other Specified Trauma- and Stressor-Related Disorder**
F43.9	**Unspecified Trauma- and Stressor-Related Disorder**
F94.1	**Reactive Attachment Disorder**
F94.2	**Disinhibited Social Engagement Disorder**

The above diagnoses are all CD for aviation. **For all Disorders listed above (with exception of Acute Stress Disorder)**, a waiver may be requested when the member has been completely asymptomatic in a "Fit for Full Duty" status for a minimum of 12 months after completion of all treatment.

For Acute Stress Disorder, a waiver may be considered if the member has remained asymptomatic in a "Fit for Full Duty" status for a minimum of six months after completion of all treatment.

Maintenance Pharmacotherapy: Maintenance pharmacotherapy is sometimes used to mitigate the risk of future recurrence of Trauma- and Stressor-Related Disorders, typically after several discrete episodes. In cases of persistent (chronic) or recurrent Trauma- and Stressor-Related Disorders, maintenance pharmacotherapy may be considered. In such cases, Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Waiver consideration may be requested after a suitable *Period of Observation in a Non-flying Status* (PONS) has elapsed, which for Trauma- and Stressor-Related Disorders is 12 months, with the exception of Acute Stress Disorder, for which the PONS is six months. The PONS begins once an authorized mental health provider (an aeromedically trained clinical psychologist or psychiatrist whenever possible) has declared, by way of a formal medical record entry, that the service member's condition is in full remission. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Waivers will not normally be recommended for acute-phase treatment of initial episodes of Trauma- and Stressor-Related Disorders. Please see Section 18.7 of the ARWG for full details.

Treatment Note: Trauma focused therapy is the gold standard treatment for Trauma and Stressor-Related Disorders. Examples of trauma focused therapy are: Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR) Therapy and/or Prolonged Exposure (PE) Therapy as detailed in the VA/DOD Clinical Practice Guidelines for Management of PTSD.

INFORMATION REQUIRED:

1. Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state, “See GENESIS/JLV records.” Also include items not in GENESIS/JLV (e.g., civilian medical records, college counseling center records, legal records, etc.).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms. Evaluation should be completed by an aeromedically-trained clinical psychiatrist or psychologist whenever possible.
4. Include a copy of all mental health-related Medical Boards which have been written for the member (if applicable).