14.0 PSYCHIATRY

Last Revised: February 2019 Last Reviewed: February 2019

This section provides guidance on various psychiatric disorders likely to be seen in the military aviation community, the associated effects on aviation duties, and guidelines for requesting a waiver as applicable. The disorders are addressed in the following pages in the same sequence as found in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders-5th Edition (DSM-5), and as outlined below.

First, some general guidelines for submitting psychiatric waivers:

General waiver submission advice for most timely processing of requests:

1. Properly label uploaded documents for AERO waiver submissions (e.g., do not bundle psychiatry 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 AHLTA" is not sufficient) the submitting Flight Surgeon should upload all supporting documentation so that the package can be reviewed as a stand-alone document. If an AHLTA note is significant it should be uploaded to AERO.
3. Make sure the waiver package is internally consistent, or please explain any discrepancies in the Aeromedical Summary (AMS).

Information required for all psychiatric waivers:

1. Flight surgeon narrative 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 AHLTA records." Please also include items not in AHLTA (e.g., civilian medical records, legal records where applicable).
3. A current psychiatric evaluation to document complete, sustained remission of all symptoms.
4. Include a copy of any and all Medical Boards which have been written for the member (if applicable).

The above four items are the minimum required. Many psychiatric waivers 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 MAINTENANCE PHASE OF TREATMENT WILL TAKE GREATER THAN 60 DAYS, A GROUNDING PHYSICAL AND AERO GENERATED AMS IS REQUIRED AT THE TIME OF DIAGNOSIS AND THEN A LOCAL BOARD OF FLIGHT SURGEONS IS NOT APPROPRIATE TO BE CONVENED.

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

1. Neurodevelopmental Disorders (e.g., Specific Learning Disorders, Attention Deficit/Hyperactivity Disorder)
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders

4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma and Stressor-Related Disorders (e.g., Posttraumatic Stress Disorder, Acute Stress Disorder, Adjustment Disorder)
8. Somatic Symptom and Related Disorders
9. Feeding and Eating Disorders (e.g., Anorexia nervosa, Bulimia)
10. Sleep-Wake Disorders
11. Sexual Dysfunctions and Paraphilias
12. Disruptive, Impulse-Control, and Conduct Disorders
13. Substance-Related and Addictive disorders (e.g., Alcohol Use Disorder, Gambling Disorder)
14. Personality Disorders
15. Other Conditions that May Be a Focus of Clinical Attention

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 SHOULD BE SUBMITTED.

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

It is highly recommended that flight surgeons 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 flight surgeons 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.

- **DoDINST 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 flight surgeons in the consideration of mental health disorders and psychiatric treatments, and the associated impact of such in an operational setting.

- **DoDINST 6490.08 (August 17, 2011), "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 operation and risk-management decisions. The instruction states that healthcare providers shall notify the commander concerned when a service member meets any of the instruction's nine delineated criteria for mental

health and/or substance misuse conditions or related circumstances. A few of the criteria covered include those listed as: harm to self, harm to others, harm to mission, special personnel, and, acute medical conditions interfering with duty. 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.

- **DoDINST 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.

Flight surgeons are also 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.

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

Last Revised: September 16 Last Reviewed: September 16

AEROMEDICAL CONCERNS: 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. Attention Deficit/Hyperactivity Disorder (ADHD) involves a persistent pattern since childhood of problems in such areas as attention, vigilance, organization, impulse control, set shifting, dual tasking, working memory, and both verbal and visual memory. Depending on the severity of the disorder, aeromedical concerns include safety of flight, mission completion, and crew coordination. Current use of either non-stimulant or **s**timulant medication to treat ADHD is incompatible with aviation duty, and waivers are not granted in such cases.

DIAGNOSIS/ICD-10 Code:

F90.0	**Attention-Deficit/Hyperactivity Disorder, Predominantly inattentive presentation**
F90.2	**Attention-Deficit/Hyperactivity Disorder, Combined presentation**
F90.1	**Attention-Deficit/Hyperactivity Disorder, Predominantly hyperactive/impulsive presentation**
F81.0	**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**

WAIVER:

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

Attention Deficit/Hyperactivity Disorder: A diagnosis of ADHD at any time of life is considered disqualifying. Applicants with ADHD who have not taken medication for 12 months and who demonstrate no symptoms may be considered for a waiver.

INFORMATION REQUIRED:

Specific Learning Disorder:

1. Flight surgeon 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.
3. Grade school report cards, high school, and college transcripts (if applicable).
4. If absence of academic/functional impairment cannot be determined from available records, a neuropsychological evaluation, conducted by a credentialed neuropsychologist is required.

Attention-Deficit/Hyperactivity Disorder (for a summary please see Table 1):

1. Flight surgeon Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, and current level of functioning.
2. For non-college graduates and graduates of non-traditional colleges/universities (e.g., internet degree), a comprehensive mental health evaluation which includes the following:
   - Review of report cards, high school transcripts and college transcripts (if applicable)
   - Review of Individual Education Plans (if applicable)
   - Review of Childhood Medical Records relevant to ADHD
   - 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 definitely rule it out, a neuropsychological evaluation is required (see below under #5 for requirements).
3. For traditional college graduates (i.e., campus based full-time education) 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 and any academic interventions
   - College transcripts
   - Letter from the college/university academic learning center (or equivalent) stating that the service member was never evaluated 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 for ADHD throughout college.
4. Given that there are no available academic accommodations at the U.S. Naval Academy, USNA Midshipmen in the senior year must provide:
   - Childhood medical and school records documenting the diagnosis and any academic interventions
   - College transcript
   - A member statement attesting to the fact that he/she did not use or require medications for ADHD throughout college.
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-II, Rey Complex Figure Test or equivalents)
   - Vigilance Testing (i.e., Conner's Continuous Performance Test-II, 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, 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

Table 1: Requirements for Specific Learning Disorder/ADHD Waivers by Service Member Category

	MH Evaluation	College Transcripts	Letter from University	Member Statement	NP Evaluation
No College Degree	Yes	No	No	No	If Specific Learning Disorder/ADHD cannot be ruled out by MH Exam
Traditional College Degree with no meds or academic accommodations	No	Yes	Yes	Yes	No
Traditional College Degree with meds or academic accommodations	No	Yes	No	No	Yes
Non-Traditional College Degree	Yes	Yes	No	No	If Specific Learning Disorder/ADHD cannot be ruled out by MH Exam
USNA Midshipmen	No	Yes	No	Yes	No

14.2 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. Fifty per cent of patients with schizophrenia make a suicide attempt, and ten per cent will succeed. 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
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

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: 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 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 AHLTA records.” Please also include items not in AHLTA (e.g., civilian medical records, legal records including treatment summary).

3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.
4. Include a copy of any and all Medical Boards which have been written for the member (if applicable).

14.3 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 be psychotic 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**
F34.0	**Cyclothymic disorder**

14.4 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
F32.9 Other Specified Depressive Disorder

The above diagnoses are disqualifying for aviation. Waiver may be requested 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. Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Please see Section 18.7 of the ARWG for full details.

INFORMATION REQUIRED:

1. Flight surgeon 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 AHLTA records." Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.
4. Include a copy of any and all 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: 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.

Further recurrences are CD, waiver not recommended**. A history** of recurrent mood disorders is disqualifying as well. Many diagnoses may not reveal a recurrent nature by name alone. These include:

DIAGNOSIS/ICD-10 Code:

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)**

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. Behavioral therapy, including relaxation, biofeedback, and anxiety management, is permitted in a flying status if the symptoms are so mild that it does not meet the criteria for Panic Disorder.

DIAGNOSIS/ICD-10 Code:

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

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 one year after completion of all treatment. Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Please see Section 18.7 of the ARWG for full details.

INFORMATION REQUIRED:

1. Flight surgeon 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 AHLTA records." Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.
4. Include a copy of any and all 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: 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 OBSESSIVE-COMPULSIVE DISORDER AND RELATED DISORDERS

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AEROMEDICAL CONCERNS: Service members with Obsessive Compulsive Disorder complain of 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.

DIAGNOSIS/ICD-10 Code:
F42 Obsessive Compulsive 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 one year after completion of all treatment. Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Please see Section 18.7 of the ARWG for full details.

INFORMATION REQUIRED:

1. Flight surgeon 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 AHLTA records." Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.
4. Include a copy of any and all 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: 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.

14.7 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

The above diagnoses are all CD for aviation. **For Posttraumatic 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 one year after completion of all treatment. Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Please see Section 18.7 of the ARWG for full details.

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. Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Please see Section 18.7 of the ARWG for full details.

INFORMATION REQUIRED:

1. Flight surgeon 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 AHLTA records." Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.
4. Include a copy of any and all Medical Boards which have been written for the member (if applicable).

Adjustment Disorders involve a response to an identifiable stressor, and can result in significant emotional and behavioral symptoms, such as depressed mood, anxiety, fatigue, changes in social relationships, problems with concentration, attention, and decision-making, and at least temporary functional impairment.

These include:
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

Adjustment Disorder is temporarily considered disqualifying for aviation until resolved. Adjustment disorders diagnosed by mental health personnel are not considered resolved until a mental health provider makes that statement in the service member's health record.

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, must be requested when the member is completely asymptomatic in a “Fit for Full Duty” status after completion of all treatment. Designated Members are eligible for waiver consideration while on maintenance pharmacotherapy. Applicants will not be considered for a waiver if on maintenance pharmacotherapy. Please see Section 18.7 of the ARWG for full details.

It should be noted that multiple Adjustment Disorders warrant further scrutiny to discern possible underlying characterologic psychopathology**.**

14.8 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 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 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 AHLTA records.” Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. All relevant general medical records (once again, “See AHLTA” will not suffice).
4. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.
5. Include a copy of any and all Medical Boards which have been written for the member (if applicable).

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 suicide is also a risk. Relapse rate is high. Follow-up studies of Anorexia Nervosa have revealed that approximately 30 per cent 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.

WAIVER: 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. In general a NAMI Psychiatry evaluation will be required.

DIAGNOSIS/ICD-10 Code:

Anorexia Nervosa

F50.01	**Anorexia Nervosa restricting type**
F50.02	**Anorexia Nervosa binge-eating purging type**
F50.2	**Bulimia Nervosa**
F50.8	**Binge-Eating Disorder**
F50.8	**Other Specified Feeding or Eating Disorder**
F50.9	**Unspecified Feeding or Eating Disorder**

INFORMATION REQUIRED:

1. Flight surgeon 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 AHLTA records.” Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.
4. Include a copy of any and all Medical Boards which have been written for the member (if applicable).
5. Service members must meet the minimum aviation weight standards.

14.10 SLEEP/WAKE DISORDERS

Last Revised: September 16 Last Reviewed: September 16

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.

14.11 SEXUAL DYSFUNCTIONS AND PARAPHILIAS

Last Revised: September 16 Last Reviewed: September 16

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 is incompatible with 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.

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 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 AHLTA records." Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.

14.12 DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

Last Revised: September 16 Last Reviewed: September 16

AEROMEDICAL CONCERNS: These 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 when gratified. Such impulsive or stereotyped behavior may lead to aviation safety problems. 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 with Intermittent Explosive Disorder are incompatible with aviation duty. Kleptomania is generally treated with behavior therapy.

WAIVER: Impulse Control Disorders are CD for aviation. Waiver requests 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**
F91.8	**Other Specified Disruptive, Impulse-Control, and Conduct Disorder**
F91.9	**Unspecified Disruptive, Impulse-Control, and Conduct Disorder**

INFORMATION REQUIRED:

1. Flight surgeon 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 AHLTA records.” Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms.

14.13 SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

Last Revised: September 16 Last Reviewed: September 16

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 may even confer modest health benefits. A minority of drinkers, however, 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 low blood alcohol levels (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 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 an inhospitable environment, 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, 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 lie to conceal the extent of involvement with gambling. Gambling Disorder is generally treated with behavior therapy. A solid aftercare program, similar to that required for Alcohol Use Disorder, is required for a waiver.

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 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.

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**

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

- Navy/Marine Corps active/reserve serving in a flying status involving operational or training flights (DIFOT)
- Duty in a flying status not involving flying (DIFDEN) orders
- Personnel serving as hypobaric chamber inside observers
- 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) or Gambling Disorder and a waiver has not been granted, follow the guidelines for *New Diagnosis of Alcohol Use or Gambling Disorder* (outlined below)

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

NEW DIAGNOSIS OF ALCOHOL USE DISORDER OR GAMBLING DISORDER: Flight Surgeon must submit 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/gambling 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, Alcoholics 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 AA, e.g., when there are not sufficient GA meetings available locally to satisfy the requirement). Unless otherwise specified, the requirement for mutual support group participation must be in the form of attendance at “face-to-face” meetings. 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. In addition to mutual support group attendance, the member must meet with designated professionals for the following specified timeframes:

Aftercare Timeframe

Professional /Meetings	First Year	Second/Third Year	Fourth Year +
Flight Surgeon	Monthly	Quarterly	Annually
DAPA/SACO	Monthly	Monthly	No formal requirement
Psychiatrist/Psychologist/Licensed Clinical Social Worker	Annually	Annually	No formal requirement
Alcoholics Anonymous (or for Gambling Disorder, Gamblers Anonymous)	3x weekly	1x weekly	Strongly recommended but not required

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. Flight Surgeon's narrative (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 AA/GA attendance.
3. Outpatient/Intensive Outpatient/Residential treatment summary.
4. DAPA's statement documenting aftercare including AA/GA attendance.
5. Psychiatric evaluation by a privileged psychiatrist, clinical psychologist or licensed clinical social worker—this should be completed at the 90-day mark following successful completion of the appropriate level of treatment.
6. Commanding officer's endorsement on command letterhead.
7. 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. 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 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."

8. Internal Medicine evaluation (if indicated).

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. Flight Surgeon's 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. DAPA's statement documenting aftercare including AA attendance.
   d. Psychiatric evaluation by a privileged psychiatrist, clinical psychologist or licensed clinical social worker.
2. After three years of aftercare
   a. Short-form flight physical (NAVMED 6410/10)
   b. Flight Surgeon's 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 member's continued abstinence

NONCOMPLIANCE OR AFTERCARE FAILURE: The following guidance pertains to any member in denial of an alcohol or gambling problem, 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 to NAMI Code 53HN (MED-236).
3. Re-evaluation by Flight Surgeon, DAPA, and Alcohol Treatment Facility to determine potential for re-treatment.

NOTE: The member's command must recommend a revocation of the current waiver. If member requests waiver after the 6-12 month grounding period, please 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) criteria to diagnose Substance-Related and Addictive Disorders. It should be noted that no difference exists in the waiver process or aftercare requirements for a member diagnosed with Alcohol Abuse versus Alcohol Dependence (categories used in earlier editions of the DSM). The evidenced-based aftercares requirements (outlined above) will help a member diagnosed with Alcohol Use Disorders maintain long-term sobriety/abstinence in the interest of aviation safety.

HISTORY OF ALCOHOL USE DISORDER TREATMENT:

BUMEDINST 5300.8, the now-discontinued instruction governing alcohol waivers, was written in the early 1990s, prior to widespread acceptance of ASAM's Patient Placement Criteria. At that time the Navy had a three-tier system of alcohol treatment:

Level I - PREVENT/IMPACT for an alcohol related incident or prevention.
Level II - OUTPATIENT for a diagnosis of Alcohol Abuse.
Level III - INPATIENT for a diagnosis of Alcohol Dependence.

In the late 1990s the Navy adopted the ASAM criteria, then in its second edition, “ASAM PPC-2,” as part of a “continuum of care” model of treatment. One feature of this model is the use of multiple dimensions of disease severity and level of function, rather than mere diagnostic categories, as the basis for assignment of patients to specific levels of treatment. The importance of this to the aviation waiver process was that aviation personnel with either Alcohol Abuse or Alcohol Dependence could be treated at any of the three new treatment levels, and upon successful completion, be eligible for waivers. While the fine print of the ASAM Criteria has evolved over the years, the levels of treatment have remained essentially the same since first adopted:

Level 0.5 – IMPACT/”Prime for Life” (USMC). Early intervention service 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 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.

Once again, with the release of DSM-5, the previous categories of Alcohol Abuse and Alcohol Dependence were subsumed under the new heading of Alcohol Use Disorder, with severity specifiers of Mild, Moderate and Severe. Depending upon the multidimensional assessment by the treatment facility, a patient with a given degree of severity might be appropriate for Level 1, 2, or 3; any of these will be acceptable for a waiver upon successful completion and demonstrated compliance with the other waiver elements described above.

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 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.
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 should be grounded for 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.

14.14 PERSONALITY DISORDERS

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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 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 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 requires long term intensive psychotherapy, which is incompatible with aviation duty.

WAIVER: Aviation personnel are considered to be Not Aeronautically Adaptable (applicants) or Not Aeronautically Adapted (designated) if diagnosed as having a Personality Disorder or 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 usually permanent. Therefore, no waivers can be considered for aeronautical adaptability. Questions regarding the aeronautical adaptation of designated aviation personnel should be referred to NAMI Psychiatry; most cases will require in-person evaluation at NAMI.

DIAGNOSIS/ICD-10 Code:

F21 Schizotypal Personality Disorder
F60.0 Paranoid Personality Disorder
F60.1 Schizoid Personality DisorderF60.2 Antisocial Personality Disorder
F60.3 Borderline Personality Disorder
F60.4 Histrionic Personality Disorder
F60.5 Obsessive-Compulsive Personality Disorder
F60.6 Avoidant Personality Disorder
F60.7 Dependent Personality Disorder
F60.81 Narcissistic Personality Disorder
F60.89 Other Specified Personality Disorder
F60.9 Unspecified Personality Disorder

INFORMATION REQUIRED:

1. Flight surgeon 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 AHLTA records.” Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. In most cases when evaluation of designated aviation personnel suggests that an individual is no longer AA, collateral sources of history will be requested to assess the impact of the Personality Disorder or maladaptive personality traits on interpersonal and

occupational functioning, with special emphasis on flight safety, mission completion, and crew coordination.

14.15 OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

Last Revised: September 16 Last Reviewed: September 16

AEROMEDICAL CONCERNS: Conditions such as relational problems, housing and economic problems, abuse and neglect, educational and occupational problems, or other problems related to the social environment (previously called V Codes in the DMS-IV-TR) may come to the attention of a flight surgeon or other clinician though they may not necessarily constitute a clinical disorder. Such issues may prompt a visit to a provider, result from another mental disorder, or potentially cause or worsen a mental disorder, and subsequently, may interfere with safe or effective flying. These conditions are not necessarily disqualifying, but flight surgeons are encouraged to pay attention to possible underlying psychopathology and maladaptive personality traits.

SUICIDE ATTEMPT: It should be noted that suicide attempt by itself is a behavior, not a DSM-5 psychiatric diagnosis. Waivers are based on the psychiatric diagnosis of which the suicide attempt is a manifestation. For example, if the suicide attempt was a manifestation of an Adjustment Disorder, the service member would be PQ when the Adjustment Disorder is fully resolved. If the suicide attempt was the manifestation of a Personality Disorder, the service member is NAA. Recurrent suicide attempts, however, may be disqualifying regardless of the diagnosis. There is a risk that a person may make an attempt which would compromise the safety of others (pilots sometimes use their aircraft as the instrument of suicide).

14.16 MENTAL HEALTH, PERFORMANCE OPTIMIZATION, AND PSYCHOTHERAPY

Last Revised: June 17 Last Reviewed: June 17

AEROMEDICAL CONCERNS: There are several psychiatric conditions and problems that may be a focus of clinical attention but are not medical disorders. Examples include relational problems, educational and occupational problems, housing and economic problems, and problems related to the social environment just to name a few. 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, there is the potential that their symptoms could 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 treatment from qualified resources.

WAIVER PROCESS: For all Naval personnel on flight status, temporary aeromedical disqualification (i.e. grounding) is NOT required while receiving supportive psychotherapy for any of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) conditions included in the chapter cited below *in the absence of clinically significant distress or impairment in social, occupational, or other important areas of functioning*. HOWEVER, the presence of a co-morbid diagnosis that is associated with functional impairment may require grounding and a waiver prior to resumption of flight status.

INFORMATION REQUIRED: No information is required to be submitted to NAMI for Naval aviation personnel who are receiving supportive psychotherapy. However, it is imperative that the squadron flight surgeon develop a sufficiently-robust rapport with those in their care that service members feel comfortable discussing all aspects of their medical care with their flight surgeon.

Ultimately, it is the responsibility of the service member to perform ongoing self-monitoring and to keep their flight surgeon and chain of command informed of any change in status that might affect flight performance or safety.

DIAGNOSIS/ ICD 10 CODE:
Supportive psychotherapy for any condition that is listed in the “Other Conditions That May Be a Focus of Clinical Attention” section of the DSM 5 is not considered disqualifying for continued duty involving flying *as long as the flight surgeon concurs that it is not associated with functional impairment*.

14.17 GENDER DYSPHORIA

Last Revised: December 2023 Last Reviewed: August 2023

AEROMEDICAL CONCERNS: The prevalence ranges of gender dysphoria per the DSM-5 among people assigned male at birth is 0.005% to 0.014%, and 0.002% to 0.003% for people assigned female at birth. The proportion of transgender adults is collectively estimated to be around 0.3% to 0.5%, and for children and adolescents estimated to be 1.2% to 2.7%. Although relatively uncommon from an epidemiological standpoint, there is a potential for interference with daily activities, including the safe performance of duty involving flying (DIF). In addition, adults with clinically significant gender dysphoria may have coexisting mental health conditions, most commonly anxiety and depressive disorders.

DIAGNOSIS/ ICD-10 Code:
F64 Gender Dysphoria
F64.0 Gender Dysphoria in Adolescents and Adults
F64.8 Other Specified Gender Dysphoria
F64.9 Unspecified Gender Dysphoria

The above diagnoses are all CD for aviation. Waiver may be requested when the applicant or designated service member is stable in the self-identified gender for a minimum period of observation of six months.

Stability in the self-identified gender is defined as: The absence of clinically significant distress or impairment in social, occupational, or other important areas of functioning associated with a marked incongruence between an individual's experienced or expressed gender and the individual's biological sex. Continuing medical care including, but not limited to, cross-sex hormone therapy may be required to maintain a state of stability.

While all cases of Gender Dysphoria will need a psychiatric waiver, additional waivers may be required, depending on the specifics of the case. For example, cases involving gender-affirming medications will require review by NAMI Internal Medicine, and cases involving surgical procedures will require review by OB/GYN, urology or general surgery consultants. Surgical treatment completed after a period of observation while stable would not require additional observation periods. NAMI Psychiatry and/or Code 53HN can assist with coordinating these reviews.

INFORMATION REQUIRED:
1. Flight surgeon Aeromedical Summary (AMS) documenting all prior symptoms, absence of persistent features, course of the disorder, medication use, current level of functioning, and status regarding regulations governing service by transgender personnel
2. All mental health notes including treatment summary (e.g., mental health evaluation, treatment summary/termination notes). Please do not simply state "See AHLTA records." Please also include items not in AHLTA (e.g., civilian medical records, legal records).
3. Include a copy of any Medical Board results for the member (if applicable).
4. A NAMI psychiatric in-person evaluation (may be deferred on a case-by-case basis).

REFERENCES:

Executive order 14001, January 2021
DODI 1300.28 Change 1, April 2021
DODI 6130.03 Vol 1 Change 4, November 2022
DHA PI 6025.21, May 2023
SECNAV 1000.11A, June 2023
ALNAV 031/21
NAVADMIN 112/21
MARADMIN 260/21
DSM (5th ed.), 2013
RAND Report, Assessing the Implications of Allowing Transgender Personnel to Serve Openly, 2016
WPATH SOC Version 8, September 2022