“The P. and P. Evaluation”

(With an Emphasis on the first “P”)

William E. “Win” Green, III, MD, DFAPA, FASAM

williamegreeniiimd@gmail.com
Four Common Referral Issues

- Assessment for Substance Abuse/Dependence (Ex.- after DUI/DWI)
- Post-treatment- “psychiatric” part of P&P.
- Depression/Anxiety Disorders- on or off SSRI medication.
- “Behavioral Issues” or “Fitness for Duty”- is there a “severe” personality disorder or psychiatric disorder?
Psychiatric Diagnoses: Medically “Disqualifying” In F.A.R.’s

- Psychosis
- Bipolar Disorder
- Personality Disorder “severe enough to have manifested itself by repeated overt acts”
- Substance Dependence, UNLESS satisfactory evidence of total (documented) abstinence for NO less than TWO years.
Substance Dependence (addiction)  
“Characteristics”

- Loss of Control
- Compulsive Use
- Continued Use in spite of Consequences -(3 C’s)
- Characteristic Symptoms- Family Discord & Problems, Tolerance, Blackouts, Legal Issues (DUI/ DWI, Public. Intox.), Excessive Sick Leave, Irritability, physical effects (heart, BP, liver, neurologic, etc.), seizures, withdrawal symptoms, withdrawal delirium, failure to fulfill expected roles, positive DOT or workplace test, variable performance, etc.
Course of Illness

- EARLY - episodic loss of control, occasional consequences, FAMILY ISSUES! (divorce, etc.), tolerance, blackouts, legal issues, job loss, etc.
- MIDDLE - increasing frequent loss of control, begin to see physical withdrawals, medical complications, further consequences.
- LATE - Worsening medical issues, neurological & cognitive impairment, cirrhosis/ liver failure, Cardiomyopathy, alcohol associated dementia (irreversible), Withdrawal seizures, etc.
- 4th stage = “Too Late”- death/ jails/ institutions
Substance Dependence (as far as the FAA goes) ONLY requires ONE or more of the following:

- Tolerance (DUI/ DWI with BAC > 0.149%)
- Withdrawal Symptoms
- Impaired Control of Use
- Continued Use (or return to use) despite damage to physical health or impairment of social/ personal/ occupational function.
Substance Dependence/ Abuse (per CFR 67.107)

- Two other Situations CAN lead to diagnosis.

1. Use of a substance in physically hazardous situation (DUI/ DWI, P.I., etc.) if there has EVER been another “episode” (arrest, etc.) of hazardous use. (Substance Abuse at a minimum)

2. Positive DOT test- (BAC 0.04 or higher) or positive drug test (Substance Abuse at a minimum).

So it is “pretty easy” to fit criteria as per the FAA!
Must Have’s for the Initial Appointment

- Inpatient record/ discharge summary/ labs/ physical exam, Arrests/ court records/ disciplinary reports, etc.
- Past treatment records, any medications, hospitalizations, Neuropsych. testing, etc.
- Any communications with the FAA or employer.
- Reports from ANY other treatment providers.
- If in doubt, bring it or have it sent!
- We WILL also need the FAA MEDICAL FILE to be sent to us, ESPECIALLY if “issues” with FAA (revocation, DUI, repeat entry into HIMS program, etc.)
Components of Report

- **Identifying Information** - Name, age, marital status, consent, confidentiality issues, referral source, company/position, etc.

- **History of Present Illness** - details of "incidents" -> treatment, arrest reports, DUI/DWI, COMPREHENSIVE substance history (chronological), past treatment experiences, compulsive behaviors especially if related to substance use (sex, gambling, etc.) "consequences" of use, as well as airman's "AWARENESS" of the consequences/disease.
Components of Report - cont.

- **History of Present Illness** - continued
  - Treatment History/ Records - progress, difficulties, etc.
  - Post Treatment Experience - Recovery activity - AA/ NA/ CA, 90 in 90?, Home Group?, sponsor?, Step Work?
  - Acceptance of Disease? (versus “Compliance” with monitoring)

- I typically end this section with “fits criteria ... as evidenced by ...”
Components - cont.

- **Past Psychiatric/ Substance Abuse history**
- **Past Medical History, Medications, OTC medications, allergies?**
- **Family History - substance & psychiatric.**
- **Social/ Developmental history - Childhood, family, school, education, relationships, hobbies/ interests, marriage/ children, trauma or abuse history, etc.**
Mental Status Exam

- Alert, oriented, dress, behavior, speech/language
- Mood and Affect, Vegetative Symptoms?
- Thought Form - logical/ goal directed???
- Thought Content - Any hallucinations/depressions, SI, HI, paranoia ???
- Memory/ Cognitive Functioning?? Any evidence cognitive dysfunction?
Diagnosis- Will be as per the C.F.R. Part 67.107. Diagnosis is based on Federal Air Regulations, NOT on the DSM V (our current psychiatric manual).

I typically include DSM V diagnosis.

Interestingly DSM V did away with “abuse” as diagnosis, now looks at disease as a “SPECTRUM”- Mild, Moderate, Severe.
Substance Dependence

CFR Title 14 Part 67.107- (1 or more required)
- Increased tolerance
- Withdrawal symptoms
- Impaired Control of Use
- Continued Use despite damage to physical health, impaired social/ personal/ occupational function

Substance Use Disorders

DSM 5 Textbook-at least 2-3
- Increased Tolerance
- Withdrawal Symptoms
- Consume more than intended, unable cut down, cravings/ urges, time spent recovering
- Continued use despite persistent physical/ psychiatric problems, use when physically hazardous, failure to meet important social/ occupational/ recreational activities, etc.
Discussion/ Recommendations

- Overall summary of individual- reason for referral, circumstances, diagnosis/ issues, recommendations (or NOT recommend due to...)

- Example- John Doe is a 49 year old DWM with a long history binge drinking, led to breakup marriage, excessive sick time, eventually had a DUI with elevated BAC -> referral.

- Recommend- Complete Abstinence, Treatment, 12 step meetings (AA/NA), IOP/ aftercare after primary treatment, AA sponsor, union & management sponsors, follow-up, any special issues (individual therapy, marital therapy, etc.)
When is the Pilot “READY” for the Psychiatric & Psychological Evaluation?

- Primary Treatment is done, finished IOP and established in aftercare (best).
- Home situation stable, AA home group, sponsor, comfortable in aftercare group.
- Minimum 90 days after treatment! (120 days better!) Many pilots, with heavy alcohol/sedative hypnotic use will “flunk” the neuropsychological tests if tested too early. Then they may need 6-12 months (or more) “clean” time. Finished Fifth Step w/ sponsor!!!.
- Acceptance of disease concept!!!
Monitoring the Pilot
Monitoring the pilot in Recovery

- AA meeting attendance - VERY IMPORTANT!
- MINIMUM of 1/ week, in addition to aftercare!
- I always “push” them to go to 4 meetings/ week
- Sponsorship is highly correlated with sobriety.
- Acceptance (vs. Compliance with monitoring)!!!
- Do they FULLY believe the first step???-
  “powerless over alcohol, life unmanageable”
- All the other steps are “goals” that we are trying to achieve, but we HAVE to accept Step One completely!!!
Monitoring - cont.

- **Work situation**- return to work/ Special Issuance, stressors, cravings/ urges, able to make meetings?, any problems?
- **Home situation**- relationship/ S.O., family, children, financial situation, free time/ hobbies,
- **Social Life**- how are they handling it?
- **Overnights??** How are they handling it?
- **Specific Stressors**- spouse drinking?, legal, separation/ divorce, affairs, financial, children, etc.
- Ideally I would like to see/ talk with the spouse!
Stages of Recovery

1. **Containment** - safe environment, contain the addiction/behaviors, (hospital/ PHP/ IOP)

2. **Early Cognitive Insight** - begin to (occasionally) see behaviors as “dangerous” & “harmful”. Pilot often still sees recovery as a “checklist to get back to work”.

3. **Emotional Integration** - painful place in recovery where one reviews the past, experiences feelings, beginning to take responsibility for own behaviors. (Steps 4 & 5)
Recovery Stages - cont.

4. **Transformational Experience** - “spiritual awakening”, sometime comes quickly (“burning bush”), other times can take many years to develop - very slow gradual process. They accept that they have the disease, must work a “good” program to have good “quality” of life & “meaning” in their life. ➔ “Sober because they truly want to be, not because they have to be”.

- This can take a **LONG TIME** (often 3-5 years or more) to develop!
My Views of Addiction

- Primary Illness - we drink too much because we’re alcoholic - heavy genetic “predisposition”.
- Complete Abstinence is essential!
- Recovery -> much more than “just not drinking”.
- Recovery (12 Steps) give us tools to live life on life’s terms, adapt, grow as human beings.
- We are either growing in recovery or sliding towards relapse, you can’t “coast forever”.
- Old AA saying - “Once a pickle, you can NEVER go back to a cucumber”. → Once you cross “invisible line” - can never return to drinking “safely”.
Ways to “fail” Your Initial (or Follow Up) Evaluations

- LIE! Sooner or later, We’ll catch the “lies”.
- “Forget” to tell me about another DUI arrest, even when I ask “any other arrests for anything in your entire life?”
- Don’t know the fundamentals of the 12 steps & have a poor working knowledge of basic recovery concepts.
- Don’t provide all the information, especially if you try to “cover” something up.
- Can’t remember the last time you went to a meeting, or called your sponsor, etc.
“Goal” of Psychiatric Evaluation

- We are looking at Airmen from a RECOVERY (and Psychiatric) standpoint, NOT their “flying ability”.
- Generally if they were able to fly safely before, while actively drinking, they are MUCH SAFER after they become sober.
- The reason people “fail” is they RELAPSE, not because of their “aviation abilities”.
- Try to intervene BEFORE a relapse occurs!!!
Neuropsychological Testing
Neuropsychological Testing- “Core” Battery

- Cogscreen- Aeromedical edition (Cogscreen AE)
- Wechsler Adult Intelligence Scales (WAIS- III)
- Trail Making Tests- parts A & B (or Reitan Trails)
- Tests of “executive functioning”- Booklet category test OR Wisconsin card sorting and STROOP color word test.
- Paced Auditory Serial Addition Test (PASAT)
- A Continuous Performance test- several available, tests attention/ concentration.
Neuropsychological Testing “Core” battery - cont.

- Tests of Verbal memory- (WMS IV, Rey, or California verbal learning II)
- Tests of Visual Memory- (WMS IV, Brief Visuospatial Memory Test - Revised, or Rey Complex Figure test)
- Language Tests- (Boston Naming, Verbal Fluency, etc.)
- Psychomotor Tests- Finger tapping, Grooved Pegboard or Purdue Pegboard, etc.
- Personality Testing- MMPI-2, etc.
Neuropsychological Testing - Assess

- Attention/ Concentration
- Ability to “multi-task”, shift attention rapidly
- Verbal & Visual memory, Immediate/ Recent/ Remote memory,
- Language/ Fluency, Naming, Visuospatial abilities
- Executive Functioning- higher levels
- Personality “style”, looking for “risky” things- impulse control, poor judgement, etc.
Neuropsychological “Tidbits”

- Abstinence Time → VERY important!!!
- Effects of Alcohol/ Sedative Hypnotics, etc. can take a LONG time to recover.
- Practice with lumosity.com, BrianHQ.com, or happy-neuron.com may help.
- Get a good nights sleep before test!!!
- Cognitive Rehabilitation “might help” also?
The End!

Questions?