

PERSONALITY DISORDERS

MH 6.1

Includes All Personality Disorders

For Obsessive-Compulsive Personality Disorder see Obsessive-Compulsive Disorder

INFORMATION REQUIRED

All Applicants:

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.
- Psychological testing, e.g., MMPI 2

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

A. History of Histrionic, Narcissistic, Avoidant, or Dependent Personality Disorder

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. Effective management of maladaptive personality pattern for <i>at least</i> the past 2 years. 2. Functioning well socially and occupationally during the past 2 years (corresponds to a GAF of 80 or above). 3. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only. 4. No history of suicide attempt, gesture, or ideation with plan. 5. No history of coexisting psychiatric disorders (Axis I and Axis II). 6. No history of psychosis. 		
Meets clearance criteria 1 - 6, AND <ul style="list-style-type: none"> • No use of psychotropic medications. 	RN	CLEAR
Meets clearance criteria 1 - 6, AND <ul style="list-style-type: none"> • If on psychotropic medications, stable for <i>at least</i> the past 1 year. 	RN	CLEAR WITH RESTRICTION 8B Accommodation
	PCMO FOLLOW-UP Medication monitoring every 3-4 month. Avoid mefloquine.	
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • Ineffective management of maladaptive personality pattern during the past 2 years. • Some impairment of functioning socially or occupationally during the past 2 year (corresponds to a GAF below 80). • Active phase of psychotherapy or counseling not complete. 	MHA	DEFER Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • History of suicide attempt, gesture, or ideation with plan. • History of coexisting psychiatric disorders (Axis I and Axis II). • History of psychosis 	MHA MED ADVISOR	DEFER/MNQ

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B. History of Borderline or Antisocial Personality Disorder.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. Effective management of maladaptive personality pattern for <i>at least</i> the past 5 years. 2. Functioning well socially and occupationally during the past 5 years (corresponds to a GAF of 80 or above). 3. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only. 4. No history of suicide attempt, gesture, or ideation with plan. 5. No history of coexisting psychiatric disorders (Axis I and Axis II). 6. No history of psychosis. 		
Meets clearance criteria 1 - 6, AND <ul style="list-style-type: none"> No use of psychotropic medications; OR If on psychotropic medications, stable for <i>at least</i> the past 1 year. 	MHA	<p>_____</p> <p>Risk varies - assess based on detailed history.</p>
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Some impairment of functioning socially or occupationally during the past 5 years (corresponds to a GAF below 80). Active phase of psychotherapy or counseling not complete. If on psychotropic medications, <i>not stable</i> for <i>at least</i> the past 1 year. 	MHA	DEFER Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Ineffective management of maladaptive personality pattern during the past 5 years. History of suicide attempt, gesture, or ideation with plan. History of coexisting psychiatric disorders (Axis I and Axis II). History of psychosis. 	MHA MED ADVISOR	DEFER/MNQ

C. History of Paranoid, Schizoid, or Schizotypal Personality Disorder

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. If history of one or more of the following Personality Disorders: 		
<ul style="list-style-type: none"> Paranoid Personality Disorder Schizoid Personality Disorder Schizotypal Personality Disorder 	MHA MED ADVISOR	DEFER/MNQ

DIAGNOSTIC CODES	
301.50	Histrionic Personality Disorder
301.60	Dependent Personality Disorder
301.81	Narcissistic Personality Disorder
301.82	Avoidant Personality Disorder
301.70	Antisocial Personality Disorder
301.83	Borderline Personality Disorder
301.00	Paranoid Personality Disorder
301.00	Schizoid Personality Disorder
301.70	Schizotypal Personality Disorder
Cross Reference DSM - IV	

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Definition: Personality disorders are enduring patterns of inner experience and behavior that markedly affect an individual's ability to function both individually and interpersonally with others in both social and occupational settings.

Dependent Personality Disorder: Individuals with Dependent Personality Disorder demonstrate a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation. Symptoms seen with this disorder include difficulty making everyday decisions; needing others to assume responsibility; difficulty expressing disagreement with others because of fear of loss of support or approval; difficulty initiating projects or doing things on his or her own; going to excessive lengths to obtain nurturance and support from others; feeling uncomfortable or helpless when alone; urgently seeking another relationship as a source of care and support when a close relationship ends; being preoccupied with fears of being left to take care of himself or herself. The treatment of choice is long-term insight-oriented psychotherapy. Medications are rarely used in the long-term treatment of this disorder.

Avoidant Personality Disorder: Individuals with this disorder demonstrate a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity. Symptoms include the avoidance of occupational activities that involve significant interpersonal contact, unwillingness to get involved with people, restraint in intimate relationships, and preoccupation with being criticized or rejected by others. These individuals view themselves as inadequate, socially inept, personally unappealing, and inferior to others. They are reluctant to take personal risks or to engage in new activities. This disorder appears to lessen or remit with age. The treatment of choice for this disorder is long-term insight-oriented psychotherapy. Medications are rarely used in the long-term treatment of this disorder.

Narcissistic Personality Disorder: These individuals demonstrate a pervasive pattern of grandiosity, the need for admiration, and a lack of empathy for others. Symptoms include a grandiose sense of self-importance; preoccupation with fantasies of unlimited success, power, brilliance, beauty or ideal love; the belief that he or she is "special" and can only be understood by other special people or individuals of high status. They demand excessive admiration, have a sense of entitlement, are interpersonally exploitative, lack empathy, are often envious of others, and appear arrogant or haughty. In more extreme forms, these individuals are extremely difficult to relate to both socially and occupationally. They are frequently intolerant to criticism or defeat. About 50% to 75% of those diagnosed with Narcissistic Personality Disorder are male. The treatment of choice tends to be long-term insight oriented psychotherapy. Medications are rarely used in the long-term treatment of this disorder.

Histrionic Personality Disorder: Patients with this disorder present with a pervasive pattern of excessive emotionality and attention seeking as indicated by 5 or more of the following: (1) trying to be the center of attention; (2) sexually seductive or provocative behavior; (3) rapidly shifting and shallow expression of emotions; (4) using physical appearance to draw attention to self; (5) speech that is excessively impressionistic and lacking in detail; (7) being easily influenced by others; (8) considering relationships to be more intimate than they actually are. These individuals can be difficult to work with in that they often present as shallow and unreliable. They quickly become depressed when they are not the center of attention and alienate friends with demands for constant attention. The treatment of choice tends to be long-term insight-oriented psychotherapy. Medications are not commonly used to treat this disorder.

Borderline Personality: These patients demonstrate a pervasive pattern of instability of interpersonal relationships, self-image, and affect, as well as marked impulsivity. This is seen in a variety of contexts as indicated by 5 or more of the following: (1) efforts to avoid real or imagined abandonment; (2) a pattern of unstable and intense interpersonal relationships; (3) unstable self-image and sense of self; (4) impulsivity in areas such as spending, sex, substance abuse, driving, binge eating; (5) recurrent suicidal behavior, gestures, threats or self-mutilating behavior; (6) affective instability and mood swings; (7) chronic feelings of emptiness; (8) inappropriate, intense anger and rage, difficulty controlling anger; (9) transient paranoid-ideation or dissociation. These patients typically present with long psychiatric histories that include multiple psychiatric hospitalizations and treatments. The moods of these individuals are extremely erratic and unpredictable, placing the patient at risk for frequent acting out behaviors. Suicidal thoughts, suicide attempts, and acts of self-mutilation are common. The diagnosis tends to wane or remit with age, particularly during the fourth decade. Therapy consists of long-term insight-oriented psychotherapy, cognitive-behavioral therapy, and/or group psychotherapy. These patients are treated with a variety of medications, including antidepressants, low-dose antipsychotics, and mood stabilizers, all with varying results.

Antisocial Personality: These patients demonstrate a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by 3 or more of the following: (1) failure to conform to social norms with respect to lawful behaviors; (2)

deceitfulness, repeated lying, conning others; (3) impulsivity or failure to plan ahead; (4) irritability and aggressiveness, repeated physical fights or assaults; (5) reckless disregard for safety of self and others; (6) consistent irresponsibility, repeated failure to sustain consistent work; (7) lack of remorse. There is evidence of Conduct Disorder before age 15 years. These individuals tend to have little regard for the rights of others and have a great deal of difficulty working with others. They are frequently involved in legal altercations. There is evidence that, with age, this disorder may lessen in severity or remit completely. Patients tend to be refractory to treatment. They rarely present for treatment unless ordered into treatment as a result of a legal infraction. Compliance with treatment tends to be very poor. Psychiatric medication, particularly antipsychotics, beta-blockers, and mood stabilizers are used to treat patients with extreme impulsivity and violent episodes.

Paranoid Personality Disorder: The patient has a pervasive distrust and suspiciousness of others and presents with 4 or more of the following: (1) suspects that others are exploiting, harming, or deceiving him/her; (2) has unjustified doubts about the loyalty or trustworthiness of friends or associates; (3) is reluctant to confide in others; (4) reads hidden meaning or threatening meanings into benign remarks or events; (5) persistently bears grudges; (6) perceives attacks on his or her character or reputation; (7) has recurrent suspicions, without justification, regarding fidelity of a spouse or sexual partner. Paranoid Personality disorder is more commonly diagnosed in males. It may first be apparent in childhood and adolescence. Many of these individuals never present for therapy or refuse psychiatric intervention. Therapies include individual long-term psychodynamically oriented psychotherapy. With extreme cases of paranoid ideation that seem to border on delusional ideation, low dose antipsychotic medication may be used.

Schizoid Personality Disorder: The patient has a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings as indicated by at least 4 of the following: (1) neither desires nor enjoys close relationships, including being a part of a family; (2) chooses solitary activities; (3) has little interest in sex; (4) takes pleasure in few, if any, activities; (5) lacks close friends or confidants; (6) is indifferent to criticism or praise; (7) shows emotional coldness, detachment, or flattened affectivity. These individuals usually appear cold, detached, and aloof. They have particular discomfort when experiencing warm feelings and few, if any activities, give them pleasure. Many of these individuals never present for therapy or refuse psychiatric intervention. Therapies include individual long-term psychotherapy; however, it is frequently difficult to engage the patient in any form of therapy. In patients with symptoms that seem to border on psychotic thinking, low dose antipsychotic medication may be used.

Schizotypal Personality Disorder: The patient demonstrates a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and a reduced capacity for, close relationships. These individuals also demonstrate cognitive and behavioral distortions and eccentricities of behavior as indicated by 5 or more of the following: (1) ideas of reference; (2) odd beliefs and magical thinking; (3) unusual perceptual experiences; (4) odd thinking and speech; (5) suspiciousness or paranoid thoughts; (6) inappropriate or constricted affect; (7) behavior or appearance that is odd, eccentric, or peculiar; (8) lack of close friends or confidants; (9) excessive social anxiety. Individuals with Schizotypal Personality Disorder are perceived as "odd" and different. These individuals frequently have marked difficulty relating to and working with others. In more severe presentations of this disorder the patient may appear mildly psychotic. As many as 1/3 of these individuals may develop psychotic symptoms. These individuals rarely present for therapy unless they are encouraged by relatives or significant others. Extreme forms of this disorder may appear mildly psychotic and may be treated with low dose antipsychotic medications.

Literature review available.

ALCOHOL RELATED DISORDERS

MH 7.1

Includes Acute and Chronic Alcohol Abuse, and Alcohol Dependence (Alcoholism).

INFORMATION REQUIRED <i>Any history</i>
<p>All Applicants</p> <ul style="list-style-type: none"> Report of Medical Examination <p>Applicants With a History of Alcohol Dependence:</p> <ul style="list-style-type: none"> Substance Abuse Evaluation <p>If History or Assessment Includes Chronic Alcohol Abuse or Alcohol Dependence:</p> <ul style="list-style-type: none"> Two reference letters verifying sobriety. Applicant Personal Statement with a written plan for maintaining sobriety in Peace Corps. <p>If Applicable:</p> <ul style="list-style-type: none"> Discharge summary for all in-patient and out-patient treatment. <p>If Currently Undergoing Treatment with Psychotropic Medications:</p> <ul style="list-style-type: none"> Statement from prescribing physician addressing: <ul style="list-style-type: none"> Diagnosis Medication history, i.e., dates, doses, response, adverse effects. Required monitoring over the next 3 years.

A. Acute or Chronic Alcohol Abuse; No Substance Abuse Evaluation Completed

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. Screening information reviewed.		
Meets clearance criteria, AND <ul style="list-style-type: none"> Current alcohol abuse concerns noted in requested evaluations. 	MED ADVISOR	<p>_____</p> <p>Risk varies - assess based on detailed history. Consider Substance Abuse Evaluation</p>

B. Acute or Chronic Alcohol Abuse; Substance Abuse Evaluation Complete

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. No drinking pattern suggestive of alcohol dependence. 2. If history of <i>acute</i> abuse: No <i>pattern</i> of abuse for at least the past 1 year. 3. If history of <i>chronic</i> abuse: No <i>pattern</i> of abuse for at least the past 2 years. 4. Understands issues and problems contributing to their alcohol abuse, i.e., has clear <i>insight</i> into their abuse. 5. Not dependent on Alcoholics Anonymous (AA) meetings for maintenance of sobriety. 6. No history of polysubstance use. 7. No alcohol related disease, e.g., cirrhosis, pancreatitis. 8. No coexisting psychiatric disorders (Axis I and Axis II). 9. No <i>current</i> alcohol, or substance, abuse concerns noted in references or physician evaluations.		
Meets clearance criteria 1 - 9, AND <ul style="list-style-type: none"> Risk of alcohol abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>low</u>. 	RN	<p>CLEAR</p> <p>If applicant attends AA, send "AA Availability" letter.</p>

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Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Risk of alcohol abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>high</u>. If history of <i>acute</i> abuse: Pattern of abuse <i>within</i> the past 1 year. If history of <i>chronic</i> abuse: Pattern of abuse <i>within</i> the past 2 years. Does not understand issues and problems contributing to their alcohol abuse, i.e., lacks <i>insight</i> into their abuse. 	RN	DEFER Deferral period begins at the end of the therapeutic phase of a formal treatment program; OR, if no treatment program completed, on the date of the last abusive episode.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Dependent on Alcoholics Anonymous (AA) meetings for maintenance of sobriety. 	MED ADVISOR	Review stability of recovery and resources required for accommodation. If applicant attends AA, send "AA Availability" letter
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Risk of alcohol abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>moderate</u>. History of polysubstance use. History of alcohol-related disease, e.g., cirrhosis, pancreatitis. Coexisting psychiatric disorders (Axis I and Axis II). <i>Current</i> alcohol, or substance, abuse concerns noted in references or physician evaluations. 	MED ADVISOR	Risk varies - assess based on detailed history.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Drinking pattern suggestive of alcohol <i>dependence</i>. 	RN	See Table B: Alcohol Dependence.

C. Alcohol Dependence (Alcoholism)

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. Demonstrates <i>stable recovery</i> , including sobriety, for at least the past 3 years. 2. Acknowledges, accepts, and understands their alcohol dependence, i.e., does not <i>deny</i> alcohol dependence. 3. Understands issues and problems contributing to their alcohol dependence, i.e., has clear <i>insight</i> into their disease. 4. Accepts that they can not drink safely again. 5. Realistic plan, as expressed in the Substance Abuse Evaluation and Applicant Personal Statement, for maintaining sobriety in Peace Corps. Plan includes reasonable steps to prevent relapse in an overseas environment. 6. Not dependent on Alcoholics Anonymous (AA) meetings for maintenance of sobriety. 7. No history of alcohol related disease, e.g., cirrhosis, pancreatitis. 8. No history of polysubstance use. 9. No coexisting psychiatric disorders (Axis I and Axis II). 10. No <i>significant</i> alcohol, or substance, abuse concerns noted in references or physician evaluations.		
Meets clearance criteria 1 - 10, AND <ul style="list-style-type: none"> Risk of alcohol abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>low</u>. 	RN	CLEAR If applicant attends AA, send "AA Availability" letter

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<p>Does not meet clearance criteria due to one or more of the following:</p> <ul style="list-style-type: none"> • Risk of alcohol abuse in Peace Corps, as stated in the Substance Abuse Evaluation is <u>high</u>. • Does not demonstrate <i>stable recovery</i>, including sobriety, for at least the past 3 years. • Does not acknowledge, accept, and understand their alcohol dependence, i.e., <i>denies</i> alcohol dependence. • Does not understand issues and problems contributing to their alcohol dependence, i.e., lacks <i>insight</i> into their disease. • Does not accept that they can not drink safely again. • Does not have a realistic plan, as expressed in the Substance Abuse Evaluation and Applicant Personal Statement, for maintaining sobriety in Peace Corps. Plan does not include reasonable steps to prevent relapse in an overseas environment. 	RN	<p>DEFER</p> <p>Deferral period begins at the end of the therapeutic phase of a formal treatment program; OR, if no treatment program completed, on the date of the last abusive episode.</p>
<p>Does not meet clearance criteria due to one or more of the following:</p> <ul style="list-style-type: none"> • Dependent on Alcoholics Anonymous (AA) meetings for maintenance of sobriety. 	MED ADVISOR	<p>Review stability of recovery and resources required for accommodation.</p> <p>If applicant attends AA, send "AA Availability" letter</p>
<p>Does not meet clearance criteria due to one or more of the following:</p> <ul style="list-style-type: none"> • Risk of alcohol abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>moderate</u>. • History of polysubstance use. • History of alcohol-related disease, e.g., cirrhosis, pancreatitis. • Coexisting psychiatric disorders (Axis I and Axis II). • <i>Current</i> alcohol, or substance, abuse concerns noted in references or physician evaluations. 	MED ADVISOR	<p>Risk varies - assess based on detailed history.</p>

DIAGNOSTIC CODES

303.90 Alcohol Dependence
 305.00 Alcohol Abuse
 Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current Substance Abuse Evaluation.
- If history of acute abuse: contract between Peace Corps and applicant requiring applicant to maintain nonabusive drinking pattern.
- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

COMMENTS

Background: Alcohol abuse and dependence are more common in males than in females with a ratio of 5:1. They are among the most prevalent mental disorders in the general population. Eight percent of the adult population meet criteria for Alcohol Dependence and 5% meet criteria for Alcohol Abuse at some time in their lives. The age of onset for Alcohol Dependence peaks in the 20s to mid-30s. The risk for Alcohol Dependence is 3 to 4 times higher in close relatives of people with Alcohol Dependence.

Substance Abuse Evaluation, e.g., Professional Guidance Associates (PGA), includes the following information:

- Assessment of drinking history
- Assessment of dependence on Alcoholics Anonymous (AA).
- Plan for managing alcohol in Peace Corps.
- Risk of future abuse
- Evaluator concerns and recommendations

PGA Assessment Categories

Acute Alcohol Abuse: Periodic abuse, environmentally related such as college, military, etc. The usual age range is 18-22, in the experimental phase of life, i.e., peer-related drinking. There is no significant abuse pattern which affects the individual's life situation or health. It may approach chronic abuse if a significant pattern develops.

Chronic Alcohol Abuse: Clear pattern of very heavy drinking, abuse, for at least 90 days. The abuse causes significant life problems and the individual begins to lose control of when, how much they drink, and how it affects them. It often has its base in unresolved emotional issues. Both acute and chronic abuse involve a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations.
- Recurrent substance use in situations in which it is physically hazardous.
- Recurrent substance-related legal problems.
- Continued substance use despite having persistent or recurrent social interpersonal problems caused or exacerbated by the effects of the substance.

Alcohol Dependence: Clear pattern of alcohol abuse leading to clinically significant impairment or distress. It is often related to serious life problems. The individual loses control of either when they drink, how much they drink, or what happens to them when they drink, i.e., disease process. Denial of a drinking problem is an inherent component of dependence. The maladaptive pattern is manifested by 3 or more of the following, occurring at any time in the same 12-month period:

- Tolerance: (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect, (b) Markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal: (a) The characteristic withdrawal syndrome for the substance, (b) The same, or a closely related, substance is taken to relieve or avoid withdrawal symptoms.
- The substance is often taken in larger amounts or over longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Medications/Therapy: Therapy in nearly all cases consists of total abstinence from the substances of abuse. There are no long-term medications used to treat Alcohol Abuse or Dependence. Many alcoholics attend 28 day treatment programs (inpatient or outpatient), followed by private counseling or group counseling. It is not, however, necessary to attend a formal treatment program to have a solid recovery from alcoholism. Participation in individual therapy, group therapy, and self-help groups such as Alcoholics Anonymous, however, may prove beneficial in maintaining abstinence. Individuals who have completed an inpatient treatment program and maintain regular AA attendance for an extended period of time may have fewer relapses.

Regular or Frequent AA Attendance: Specific guidelines are used in the Substance Abuse Evaluation to assess a stable recovering alcoholic's use of AA (PGA Guidelines for AA Dependence Assessment, March 27, 1996). The evaluation attempts to determine if an individual's involvement in AA is of a dependent nature and at what point that individual would be at significant risk without regular attendance at AA meetings. This assessment recognizes the distinction between what is called the AA program and AA meetings. The AA program consists of the 12 steps of Alcoholics Anonymous, as outlined in the Big Book and the Twelve and Twelve. Meetings, sponsorship, and direct contact with other alcoholics support step work. The program, however, does not consist of meetings only, and does not depend on meetings to be operative or successful. An individual can "work the steps" of the AA program without benefit of meetings.

OMS Process and Rational on AA Attendance: Professional Guidance Associates, a group of clinical experts in this field, conduct a telephone interview with the applicant and make a recommendation to the Screening Team about the relative risk for relapse to abusive behavior under the stresses of Peace Corps service. We DON'T want to pull people prematurely or inappropriately away from a legitimate support system, such as AA, when it is clear that the support system is keeping the individual clean, sober and productive. When the risks outweigh the benefits, we will defer the applicant or, very rarely, MNQ.

However, there are some people who lean heavily on AA (meetings, peer support, social network, etc.) to maintain their sobriety. There is NO country in the PC world where OMS can GUARANTEE continued availability of AA meetings. We often find that a particular class of Volunteers starts a meeting, but when that class COSs, there go the meetings. The PCMOs are not charged with running support groups, no matter how laudatory, because of their direct responsibility for teaching illness prevention and treatment of acute medical needs. Neither can Placement and OMS together, working with Post, guarantee a site placement which lends itself to reasonable access to AA meetings, if they exist. Further, AA meetings which may be held in the local language have not been found to be particularly helpful, as the cultural environment is often so different.

For recovering applicants who do not DEPEND on AA to maintain sobriety, but use it rather as a reinforcement or adjunct to their sober lifestyles - and this is most of them - such a separation from regular AA attendance is rarely an issue. For those who NEED it, however, placing these people away from their main source of abstinence support, at best, risks their hard-won sobriety and, at worst, is dangerous and medically irresponsible. PGA explores the relationship between a recovering alcohol or substance abuser and his/her support group to determine the relative risk, and makes recommendations to OMS. OMS then makes the final determination about whether or not we have appropriate supportive resources.

AMA Policies

H-30.995 Alcoholism as a Disability

1. The AMA believes it is important for professionals and laymen alike to recognize that alcoholism is in and of itself a disabling and handicapping condition.
2. The AMA encourages the availability of appropriate services to persons suffering from multiple disabilities or multiple handicaps, including alcoholism.
3. The AMA endorses the position that printed and audiovisual materials pertaining to the subject of people suffering from both alcoholism and other disabilities include the terminology "alcoholic person with multiple disabilities or alcoholic person with multiple handicaps." Hopefully, this language clarification will reinforce the concept that alcoholism is in and of itself a disabling and handicapping condition. (CSA Rep. H, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97)

H-30.997 Dual Disease Classification of Alcoholism

The AMA reaffirms its policy endorsing the dual classification of alcoholism under both the psychiatric and medical sections of the International Classification of Diseases. (Res. 22, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed by CSA Rep. 14, A-97)

H-30.958 Ethyl Alcohol and Nicotine as Addictive Drugs

The AMA

1. identifies alcohol and nicotine as drugs of addiction which are gateways to the use of other drugs by young people;
2. urges all physicians to intervene as early as possible with their patients who use tobacco products and have problems related to alcohol use, so as to prevent adverse health effects and reduce the probability of long-term addiction;
3. encourages physicians who treat patients with alcohol problems to be alert to the high probability of co-existing nicotine problems; and
4. reaffirms that individuals who suffer from drug addiction in any of its manifestations are persons with a treatable disease. (Amended Res. 28, A-91; Reaffirmed by CSA Rep. 14, A-97)

Literature review available.

SUBSTANCE RELATED DISORDERS

MH 7.2

Includes Acute and Chronic Substance Abuse, and Substance Dependence.

If Information Consists of Drug Use History Only; See "Report of Previous Drug Use" Guideline.
For Alcohol Abuse and Dependence; See "Alcohol-Related Disorders" Guideline.

INFORMATION REQUIRED *Any history*

All Applicants

- Report of Medical Examination

All Applicants With a History of Substance Dependence: Substances Include Cannabis, Cocaine, Hallucinogens, Inhalants, Opioids, Phencyclidine (PCP), and Sedatives.

- Substance Abuse Evaluation

If History Includes Chronic Substance Abuse or Substance Dependence:

- Two reference letters verifying abstinence.
- Applicant Personal Statement with a written plan for maintaining abstinence in Peace Corps.

If Applicable:

- Discharge summary for all in-patient and out-patient treatment.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

A. Acute or Chronic Substance Abuse; No Substance Abuse Evaluation Completed

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. Screening information reviewed. 2. History of substance use <i>greater</i> than 3 years ago.		
Meets clearance criteria 1-2, AND <ul style="list-style-type: none"> • Current substance abuse concerns noted in requested evaluations. 	MED ADVISOR	<hr/> Risk varies - assess based on detailed history. Consider Substance Abuse Evaluation
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • History of substance use <i>less</i> than 3 years ago. 	RN	<hr/> See "Report of Previous Drug Use" Guideline

B. Acute or Chronic Substance Abuse; Substance Abuse Evaluation Complete

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. No pattern of substance use suggestive of substance dependence. 2. If history of <i>acute</i> abuse: <i>No abuse pattern</i> for at least the past 1 year. 3. If history of <i>chronic</i> abuse: <i>No abuse pattern</i> for at least the past 3 years. 4. Understands issues and problems contributing to their substance abuse, i.e., has clear insight into their abuse. 5. Not dependent on Narcotics Anonymous (NA) meetings for maintenance of abstinence. 6. No history of polysubstance use. 7. No history of suicide attempt, gesture, or ideation with plan. 8. No coexisting psychiatric disorders (Axis I and Axis II). 9. No <i>current</i> alcohol, or substance, abuse concerns noted in references or physician evaluations.		

(continued on next page)

Meets clearance criteria 1 - 9, AND <ul style="list-style-type: none"> Risk of substance abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>low</u>. 	RN	CLEAR If applicant attends NA, send "NA Availability" letter.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Risk of substance abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>high</u>. If history of <i>acute</i> abuse: Drug abuse <i>within</i> the past 1 year. If history of <i>chronic</i> abuse: Drug abuse <i>within</i> the past 3 years. Does not understand issues and problems contributing to their substance abuse, i.e., lacks <i>insight</i> into their disease. 	RN	DEFER Deferral period begins at the end of the therapeutic phase of a formal treatment program; OR, if no treatment program completed, on the date of the last abusive episode.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Dependent on Narcotics Anonymous (NA) meetings for maintenance of sobriety. 	MED ADVISOR	_____ Review stability of recovery and resources required for accommodation. If applicant attends NA, send "NA Availability" letter.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Risk of substance abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>moderate</u>. History of polysubstance use. History of suicide attempt, gesture, or ideation with plan. Coexisting psychiatric disorders (Axis I and Axis II). <i>Current</i> alcohol, or substance, abuse issues noted in references or physician evaluations. 	MED ADVISOR	_____ Risk varies - assess based on detailed history.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Pattern of substance use suggestive of substance <i>dependence</i>. 	RN	_____ See Table B: Substance Dependence.

C. Substance Dependence

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> Demonstrates stable recovery, with complete abstinence, for <i>at least</i> the past 5 years. Acknowledges, accepts, and understands their substance dependence, i.e., does not <i>deny</i> substance dependence. Understands issues and problems contributing to their substance dependence, i.e., has clear <i>insight</i> into their disease. Realistic plan, as expressed in the Substance Abuse Evaluation and Applicant Personal Statement, for maintaining sobriety in Peace Corps. Plan includes reasonable steps to prevent relapse in an overseas environment. Not dependent on Narcotics Anonymous (NA) meetings for maintenance of abstinence. No history of polysubstance use. No history of suicide attempt, gesture, or ideation with plan No coexisting psychiatric disorders (Axis I and Axis II). No <i>current</i> substance, or alcohol, concerns in references or physician evaluations. 		
Meets clearance criteria 1 - 9, AND <ul style="list-style-type: none"> Risk of substance abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>low</u>. 	RN	CLEAR If applicant attends NA, send "NA Availability" letter.

(continued on next page)

<p>Does not meet clearance criteria due to one or more of the following:</p> <ul style="list-style-type: none"> • Risk of substance abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>high</u>. • Has not demonstrated stable recovery, including abstinence, for at least the past 5 years. • Does not fully acknowledge, accept, and understand their substance dependence, i.e., <i>denies</i> substance dependence. • Does not understand issues and problems contributing to their substance dependence, i.e., lacks <i>insight</i> into their disease. • Does not have a realistic plan, as expressed in the Substance Abuse Evaluation and Applicant Personal Statement, for maintaining sobriety in Peace Corps. Plan does not include reasonable steps to prevent relapse in an overseas environment. 	RN	<p>DEFER</p> <p>Deferral period begins at the end of the therapeutic phase of a formal treatment program; OR, if no treatment program completed, on the date of the last abusive episode.</p>
<p>Does not meet clearance criteria due to one or more of the following:</p> <ul style="list-style-type: none"> • Dependent on Narcotics Anonymous (NA) meetings for maintenance of sobriety 	MED ADVISOR	<p>Review stability of recovery and resources required for accommodation</p> <p>If applicant attends NA, send "NA Availability" letter.</p>
<p>Does not meet clearance criteria due to one or more of the following:</p> <ul style="list-style-type: none"> • Risk of substance abuse in Peace Corps, as stated in the Substance Abuse Evaluation, is <u>moderate</u>. • History of polysubstance use. • History of suicide attempt, gesture, or ideation with plan. • Coexisting psychiatric disorders (Axis I and Axis II). • <i>Current</i> alcohol, or substance, abuse issues noted in references or physician evaluations. 	MED ADVISOR	<p>Risk varies - assess based on detailed history.</p>

DIAGNOSTIC CODES

305.70	Amphetamine Abuse	305.30	Hallucinogen Abuse
305.40	Amphetamine Dependence	304.50	Hallucinogen Dependence
305.20	Cannabis Abuse	305.90	Inhalant Abuse
304.30	Cannabis Dependence	304.60	Inhalant Dependence
305.60	Cocaine Abuse	305.90	Phencyclidine Abuse
304.20	Cocaine Dependence	304.90	Phencyclidine Dependence
305.50	Opioid Abuse	305.40	Sedative, Hypnotic, or Anxiolytic Abuse
304.00	Opioid Dependence	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
305.90	Other or Unknown Substance Abuse	304.80	Polysubstance Dependence
304.90	Other or Unknown Substance Dependence		
Cross Reference DSM - IV			

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current Substance Abuse Evaluation.
- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

COMMENTS

Background: During the first several years of treatment, most substance-dependent patients continue to relapse, although with decreasing frequency. Risk of relapse is highest in the first 12 months after the onset of a remission. The frequency, intensity and duration of treatment participation are positively correlated with improved outcome. The majority of patients treated for substance dependence (up to 70%) are eventually able to stop compulsive use and either abstain from abused substances entirely or experience only brief episodes that do not progress to abuse or dependence; only 15-20% of patients exhibit a pattern of chronic relapse. Of those who remain abstinent for 5 years or more, almost 95% are able to remain substance free. Relapse rates may be higher with Opioid-related Disorders.

Substance Abuse Evaluation, e.g., Professional Guidance Associates (PGA), includes the following information:

- Assessment of drinking history
- Assessment of dependence on Alcoholics Anonymous (AA).
- Plan for managing alcohol in Peace Corps.
- Risk of future abuse
- Evaluator concerns and recommendations

PGA Assessment Categories

Acute Substance Abuse: *Periodic abuse*, environmentally related such as college, military, etc. The usual age range is 18-22, in the experimental phase of life, i.e., peer-related substance use. There is no significant abuse pattern which affects the individual's life situation or health. It may approach chronic abuse if a significant pattern develops.

Chronic Substance Abuse: Clear *pattern* of very heavy substance use, *abuse for at least 90 days*. The abuse causes significant life problems and the individual begins to lose control of when, how much they use, and how it affects them. It often has its base in unresolved emotional issues. Both acute and chronic abuse involve a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations.
- Recurrent substance use in situations in which it is physically hazardous.
- Recurrent substance-related legal problems.
- Continued substance use despite having persistent or recurrent social interpersonal problems caused or exacerbated by the effects of the substance.

Substance Dependence: Clear pattern of substance abuse leading to clinically significant impairment or distress. It is often related to serious life problems. The individual loses control of either when they use substances, how much they use, or what happens to them when they use substances, i.e., disease process. Denial of a substance abuse problem is an inherent component of dependence. The maladaptive pattern is manifested by 3 or more of the following, occurring at any time in the same 12-month period:

- Tolerance: (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect, (b) Markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal: (a) The characteristic withdrawal syndrome for the substance, (b) The same, or a closely related, substance is taken to relieve or avoid withdrawal symptoms.
- The substance is often taken in larger amounts or over longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Epidemiology: Each category of substances has different prevalence and incidence rates. Individuals between ages 18 and 24 years have relatively high prevalence rates for the experimentation and use of virtually every substance. Dependence can occur at any age, but typically has its initial onset for most drugs of abuse in the 20s, 30s, and 40s. The course of Substance Dependence is variable. Although relatively brief and self-limited episodes may occur, the course of untreated Substance Dependence is usually chronic, lasting years, with periods of exacerbation and partial or full remission. Ten percent of individuals with Substance Dependence commit suicide.

Medications/Therapy: Therapy in nearly all cases consists of abstinence from the substances of abuse. There are few long-term medications used to treat Substance-Related Abuse or Dependence. Participation in individual therapy, group therapy, and self help groups such as Alcoholics and Narcotics Anonymous may prove beneficial in maintaining abstinence.

Literature review available.

REPORT OF PREVIOUS DRUG USE

MH 7.3

Guideline Applies to Applicant Report of Illegal Drug Use on PC-1790S "Report of Medical Examination" or Drug Use History Identified During Screening Process

For Substance-Related Disorder; See "Substance-Related Disorders" Guideline

INFORMATION REQUIRED *Any history*

Applicants Who Report Illegal Drug Use:

- If no substance-related medical complications or disease noted in Medical Record, refer to Volunteer Recruitment and Selection (VRS) for suitability assessment.

A. Applicant Report of Illegal Drug Use

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> No known substance-related medical complications or disease; May involve the pulmonary, cardiovascular, renal, neurological, or musculoskeletal systems (see comments). No coexisting alcohol or substance-related disorders, i.e., <i>chronic</i> alcohol or substance <i>abuse</i> or alcohol or substance <i>dependence</i>. No coexisting psychiatric disorders (Axis I and Axis II) 		
Meets clearance criteria 1 - 3, AND <ul style="list-style-type: none"> Applicant reports "Not Applicable (NA)" or leaves questions blank. 	RN	CLEAR
Meets clearance criteria 1 - 3, AND <ul style="list-style-type: none"> Applicant reports illegal drug use history. 	RN	CLEAR Refer to VRS for suitability assessment.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> Substance-related medical complications or disease; May involve the pulmonary, cardiovascular, renal, neurological, or musculoskeletal systems (see comments). Coexisting psychiatric disorder (Axis I and Axis II). 	MED ADVISOR MHA	Risk varies - assess based on detailed history. If cleared, consider Substance Abuse Evaluation
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> History of alcohol or substance-related disorder, i.e., chronic alcohol or substance abuse or alcohol or substance dependence (see comments). 	RN	See "Alcohol-Related Disorders" Guideline or "Substance-Related Disorders" Guideline.

DIAGNOSTIC CODES

Not Applicable

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Substance Abuse Evaluation.

COMMENTS

Epidemiology: Each category of substances has different prevalence and incidence rates. Individuals between ages 18 and 24 years have relatively high prevalence rates for the experimentation and use of virtually every substance. Dependence can occur at any age, but typically has its initial onset for most drugs of abuse in the 20s, 30s, and 40s. The course of substance dependence is variable. Although

relatively brief and self-limited episodes may occur, the course of untreated substance dependence is usually chronic, lasting years, with periods of exacerbation and partial or full remission. Ten percent of individuals with substance dependence commit suicide.

Substance Abuse Evaluation, e.g., Professional Guidance Associates (PGA), includes the following information:

- Assessment of drinking history
- Assessment of dependence on Alcoholics Anonymous (AA).
- Plan for managing alcohol in Peace Corps.
- Risk of future abuse
- Evaluator concerns and recommendations

PGA Assessment Categories

Acute Substance Abuse: Periodic abuse, environmentally related such as college, military, etc. The usual age range is 18-22, in the experimental phase of life, i.e., peer-related substance use. There is no significant abuse pattern, which affects the individual's life situation or health. It may approach chronic abuse if a significant pattern develops.

Chronic Substance Abuse: Clear pattern of very heavy substance use, abuse for at least 90 days. The abuse causes significant life problems and the individual begins to lose control of when, how much they use, and how it affects them. It often has its base in unresolved emotional issues. Both acute and chronic abuse involve a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations.
- Recurrent substance use in situations in which it is physically hazardous.
- Recurrent substance-related legal problems.
- Continued substance use despite having persistent or recurrent social interpersonal problems caused or exacerbated by the effects of the substance.

Substance Dependence: Clear pattern of substance abuse leading to clinically significant impairment or distress. It is often related to serious life problems. The individual loses control of either when they use substances, how much they use, or what happens to them when they use substances, i.e., disease process. Denial of a substance abuse problem is an inherent component of dependence. The maladaptive pattern is manifested by 3 or more of the following, occurring at any time in the same 12-month period:

- Tolerance: (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect, (b) Markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal: (a) The characteristic withdrawal syndrome for the substance, (b) The same, or a closely related, substance is taken to relieve or avoid withdrawal symptoms.
- The substance is often taken in larger amounts or over longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

DSM-IV Criteria for Substance Abuse

Statistical Manual of Mental Disorders, Fourth Edition. (pp182-183)

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 1 (or more) of the following, occurring within a 12-month period:
 - a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (eg, repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
 - b. recurrent substance use in situations in which it is physically hazardous (eg, driving an automobile or operating a machine when impaired by substance use)
 - c. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

- d. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
2. The symptoms have never met the criteria for substance dependence for this class of substance. *DSM-IV* indicates *Diagnostic and*

DSM-IV Criteria for Substance Dependence

Statistical Manual of Mental Disorders, Fourth Edition. (p181)

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by either of the following:
 - a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - b. markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either of the following:
 - a. the characteristic withdrawal syndrome for the substance
 - b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (eg, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Diagnosis: The diagnosis of substance abuse and addiction involves a thorough analysis of an individual's level of functioning in all major life domains (e.g., medical, psychological, social. Educational/vocational, legal, familial). Comprehensive assessment requires in-depth knowledge of the following: neuroanatomical and neurological considerations; brain chemistry and brain function, brain effects of single and multiple drug use; physiology, child and adolescent growth and development, the principles of detoxification, withdrawal, tolerance, sleep, appetite and memory disturbances; and symptoms of physical illness due to substance use. Any comorbid (co-existing) psychiatric disorders, particularly depression, must also be identified and typically require psychotherapeutic and/or psychopharmacological intervention.

Those who use and abuse substances frequently suffer from comorbid (co-existing) psychiatric conditions, complicating the assessment process. Therefore identifying any comorbid psychiatric disorders is a very important component of diagnosis. Some common comorbidities associated with substance abuse are attention deficit disorders, mood disorders, anxiety disorders, eating disorders, and suicidal, self-injurious and risk-taking behaviors [*American Academy of Child and Adolescent Psychiatry*].

Complications of Injection Drug Use

Adapted from Cherubin CE and Sapira JD. The medical complications of drug addiction and the medical assessment of the intravenous drug user: 25 years later. Ann Intern Med 1993;119:1017-46. National Institute on Drug Abuse (NIDA).

Pulmonary complications

- HIV-related or increased in incidence with HIV infection
 - Pneumocystis
 - Bacterial pneumonias
 - Opportunistic infections, e.g., *Rhodococcus equi*, *Nocardia*
 - Tuberculosis, especially involving strains resistant to multiple drugs
- Cocaine-related
 - Focal air-space disease
 - Atelectasis
 - Alveolar hemorrhage

- Pneumothorax and mediastinum
- Bronchiolitis obliterans
- Pulmonary edema
- Focal infections and injection complications
- Pneumothorax
 - Hemothorax and pyopneumothorax
 - Cellulitis, abscess, or pseudoaneurysm
 - Septic thrombophlebitis with pulmonary emboli or endocarditis
- Microemboli, due to nonsoluble additives
 - Starch, talc-producing pulmonary granuloma and angiothrombosis and emphysema
- Complications of inhalation
 - Reduced pulmonary function in intravenous drug users who are cigarette smokers
 - Pulmonary aspergillosis in users of contaminated marijuana

Cardiovascular complications

- Cocaine-associated
 - Coronary artery constriction with angina and myocardial infarction
 - Cardiomyopathy
 - Rhabdomyolysis with chest pain mimicking anginal pain
- Endocarditis

Musculoskeletal

- Rheumatologic prodrome of hepatitis B antigenemia
- Chronic amyloidosis
- Bone and joint infections in injecting drug users (IDUs), especially due to *Candida* and gram-negative bacilli (particularly *Pseudomonas*)
- Muscle and skin infarction
- Rhabdomyolysis, sometimes accompanied by shock and renal failure
- Small-vessel angiitis

Septicemia and disseminated infections

- Group A, beta-hemolytic streptococci
- *Candida albicans* fungemia syndrome
- Fungal ophthalmitis
- Fungal brain abscess
- HIV-related
 - Aspergillosis
 - *Rhodococcus equi* infection
 - Listeriosis
 - Nocardiosis
 - Salmonellosis
 - Pyomyositis
 - *Borrelia* infection
 - Pericarditis due to *Bacillus cereus*
- Cocaine sinusitis
 - *Clostridium botulinum* infection

- Pott puffy tumor
- Syphilis
- Hepatitis
- Renal disease

AMA Policies

H-95.983 Drug Dependencies as Diseases

The AMA

1. endorses the proposition that drug dependencies, including alcoholism, are diseases and that their treatment is a legitimate part of medical practice, and
2. encourages physicians, other health professionals, medical and other health related organizations, and government and other policymakers to become more well informed about drug dependencies, and to base their policies and activities on the recognition that drug dependencies are, in fact, diseases. (Res. 113, A-87)

Harmful Effects of Commonly Used Illegal Drugs

American College of Emergency Physicians: June 2003

Heroin: After an initial rush, users experience alternately wakeful and drowsy states, often feeling drowsy for several hours. Due to the depression of the central nervous system, mental functioning becomes clouded, and breathing may become slowed to the point of respiratory failure. Chronic users may develop collapsed veins, infection of the heart lining and valves, abscesses, and liver disease. In addition, pulmonary complications, including various types of pneumonia, may also result. Heroin overdose may cause slow and shallow breathing, convulsions, coma, and possibly death. Heroin most often is injected, particularly low-purity heroin.

Cocaine: Cocaine use inflicts tremendous damage to American society, enslaving over 3 million hard-core addicts and sending 193,034 Americans to hospital emergency departments in 2001, a 10-percent increase over 2000 when 174,881 people ended up in the emergency department. People who use cocaine can experience increased heart rate, muscle spasms, and convulsions. They often don't eat or sleep regularly. Cocaine can cause heart attacks, seizures, strokes, and respiratory failure. If snorted, it can permanently damage nasal tissue. It also can make people feel paranoid, angry, hostile, and anxious, even when they're not high. Cocaine interferes with the way the brain processes chemicals that create feelings of pleasure, so users continue to need more of the drug to feel normal. People who become addicted start to lose interest in other areas of their life, such as school and friends. People who share needles can also contract hepatitis, HIV/AIDS, or other diseases. Cocaine may be snorted as a powder, converted to a liquid form for injection with a needle, or processed into a crystal form to be smoked.

Methamphetamine: Methamphetamine is highly addictive, and its effects include psychotic behavior and brain damage. Chronic methamphetamine use can cause violent behavior, anxiety, confusion, and insomnia. Users also can exhibit psychotic behavior including auditory hallucinations, mood disturbances, delusions, and paranoia, possibly resulting in homicidal or suicidal thoughts. The drug can cause damage to the brain detectable months after use, similar to damage caused by Alzheimer's disease, stroke, or epilepsy. Withdrawal symptoms include depression, anxiety, fatigue, paranoia, aggression, and intense cravings for the drug.

Marijuana: Marijuana contains toxins and cancer-causing chemicals, which are stored in fat cells for as long as several months. Users experience the same health problems as tobacco smokers, such as bronchitis, emphysema, and bronchial asthma. Some effects include increased heart rate, dryness of the mouth, reddening of the eyes, impaired motor skills and concentration, increased hunger, and a desire for sweets. Extended use increases risk to the lungs and reproductive system, as well as suppression of the immune system. Occasionally, hallucinations, fantasies, and paranoia are reported.

Inhalants: Inhalants affect the brain with great speed and can cause irreversible, physical and mental damage. Long-term use can result in loss of sense of smell; nausea and nosebleeds; short-term memory loss or impaired reasoning; slurred speech; clumsy staggering gait; escalating stages of brain atrophy; and liver, lung, and kidney problems. Inhalants can starve the body of oxygen, forcing the heart to beat irregularly and more rapidly. Chronic use can lead to muscle wasting and reduced muscle tone. Inhalants can be deadly, even with first-time use, causing death by suffocation, choking or vomiting, or heart attack. Inhalants include numerous household and commercial products (glue, paint thinner) that are abused by sniffing or "huffing" (inhaling through one's mouth). Users experience a short-lasting euphoria and dizziness, followed by headaches and loss of consciousness.

Club Drugs: Club drugs, such as Ecstasy (MDMA, methylenedioxymethamphetamine), Rohypnol (flunitrazepam), GHB (gamma hydroxybutyrate), and ketamine (ketamine hydrochloride) can damage neurons in the brain and impair senses, memory, judgment, and

coordination. The physical effects of Ecstasy include muscle tension, involuntary teeth clenching, nausea, blurred vision, rapid eye movement, faintness, and chills or sweating. Health risks include severe dehydration and death from heat stroke or heart failure. The drug suppresses the need to eat, drink, or sleep and subsequently allows people to stay up all night. Heavy users can have significant impairments in visual and verbal memory. Users may experience increases in heart rate and blood pressure, a special risk for people with circulatory or heart disease. Ecstasy also induces a state characterized as "excessive talking." Side effects including anorexia, psychomotor agitation, and profound feelings of empathy, result from the flooding of serotonin. Often used in conjunction with other drugs, a growing numbers of users are combining Ecstasy with heroin, a practice known as "rolling."

Steroids: The repercussions of steroid use are enormous. Among teenagers, steroid use can lead to an untimely halting of growth due to premature skeletal maturation and accelerated puberty changes. Steroid users risk liver tumors, high blood pressure, severe acne, and trembling.

Medications/Therapy: Therapy in nearly all cases consists of abstinence from the substances of abuse. There are few long-term medications used to treat substance-related abuse or dependence. Participation in individual therapy, group therapy, and self help groups such as Alcoholics and Narcotics Anonymous may prove beneficial in maintaining abstinence

Federal Policy and Programs

The National Drug Control Strategy 2002, issued by the White House Office of National Drug Control Policy, is the guiding policy document for all Federal agencies whose mission includes a role in reducing the supply of and demand for drugs in the United States. Dozens of Federal agencies have a role in reducing the supply of and demand for drugs in the United States. Some of the more prominent include:

The Department of Health and Human Services includes the Substance Abuse and Mental Health Services Administration, which consists of three centers: Center for Substance Abuse Prevention; Center for Substance Abuse Treatment; and Center for Mental Health Services.

The Department of Health and Human Services also includes the National Institutes of Health, which includes the National Institute on Drug Abuse and the National Institute on Alcoholism and Alcohol Abuse.

The Department of Labor addresses substance abuse issues in the employment setting through its Substance Abuse Information Database (SAID) and Working Partners programs.

The Department of Justice includes the Drug Enforcement Administration, which has the unique mission of enforcing the nation's drug laws and also addresses employment and Workplace issues through its Demand Reduction Section.

Under the Drug-Free Workplace act of 1998, the Small Business Administration awards grants to help small businesses learn the benefits of a Workplace free from alcohol and drug abuse through the establishment of Drug-Free Workplace programs.

General Information and Resources about Substance Abuse

The National Clearinghouse for Alcohol and Drug Information is the Substance Abuse and Mental Health Service Administration's primary site for information dissemination.

The Partnership for a Drug-Free America provides a database of drug information, parental resources, and a news center.

INFORMATION REQUIRED**All Applicants:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. Single psychotic episode. 2. Etiology of psychotic episode due to one or more of the following: medication, drug or substance, medical condition. 3. No psychotic episode for at least the past 1 year. 4. Antipsychotic medications required for 1 month or less during the psychotic episode. 5. Functioning well socially and occupationally <i>before and after</i> the psychotic episode (corresponds to a GAF of 80 or above). 6. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only. 7. No history of suicide attempt, gesture, or ideation with plan. 8. No history of coexisting psychiatric disorders (Axis I and Axis II). 		
Meets clearance criteria 1 - 8, AND <ul style="list-style-type: none"> • No use of psychotropic medications for at least the past 1 year. 	MHA	CLEAR
	PCMO FOLLOW-UP Mefloquine contraindicated.	
Meets clearance criteria 1 - 8, AND <ul style="list-style-type: none"> • If on psychotropic medications, stable for at least the past 1 year. 	MHA	CLEAR WITH RESTRICTION 8A Accommodation.
	PCMO FOLLOW-UP Medication monitoring every 3-4 months. Mefloquine contraindicated	
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • Psychotic episode within the past 1 year. • Some impairment of functioning socially or occupationally <i>before or after</i> the psychotic episode (corresponds to a GAF below 80). • Active phase of psychotherapy or counseling not complete. • If on psychotropic medications, not stable for at least the past 1 year. 	MHA	DEFER Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • Etiology of psychotic episode: other than listed in criteria 2 or unknown. • Antipsychotic medications required for <i>more than 1 month</i> during the psychotic episode. 	MHA	_____ Risk varies - assess based on detailed history.

(continued on next page)

Does not meet clearance criteria due to one or more of the following:

- History of two or more psychotic episodes.
- History of suicide attempt, gesture, or ideation with plan.
- History of coexisting psychiatric disorders (Axis I and Axis II).

MHA
MED ADVISOR

DEFER/MNQ

DIAGNOSTIC CODES

298.8 Brief Psychotic Disorder
Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Background: This is a relatively uncommon disorder in which 50% of persons with the disorder either do not relapse or go on to develop long-term psychosis. There is no way to predict who will relapse or when a relapse will occur. The onset tends to occur in the late 20s and early 30s. There are no reliable data available for sex, race or social class associations. About 50% of patients who have received this diagnosis go on to a long-term course and are re-diagnosed with a different psychotic disorder or a mood disorder, the other 50% retain the diagnosis of Brief Psychotic Disorder on long-term follow-up. Good prognostic features include: acute onset, good premorbid functioning, the presence of affective symptoms, a short duration of symptoms, and confusion during the episode of psychosis.

Key Symptoms: The patient has a sudden onset of at least one of the following psychotic symptoms: delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior. The episode lasts at least one day but less than one month, with a full return to premorbid functioning.

Medications: Antipsychotic medications are most commonly used to treat this disorder. These medications are frequently associated with extrapyramidal symptoms and Tardive Dyskinesia, a permanent, disfiguring movement disorder. Antipsychotics require frequent clinical and laboratory monitoring of the patient. Psychiatric hospitalization is frequently necessary during the psychotic episode. Medication is most commonly discontinued within a year of the psychotic episode.

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review available.

Includes Schizophreniform Disorder and Schizoaffective Disorder

INFORMATION REQUIRED**If Mental Health Consultant Requests:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.
- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Applicant presents with a history of one or more of the following disorders:		
1. Schizophrenia	MHA MED ADVISOR	DEFER/MNQ
2. Schizophreniform Disorder		
3. Schizoaffective Disorder		

DIAGNOSTIC CODES

	<i>Schizophrenia</i>
295.30	Paranoid Type
295.10	Disorganized type
295.20	Catatonic type
295.90	Undifferentiated type
295.60	Residual type
295.40	Schizophreniform Disorder
295.70	Schizoaffective Disorder
	Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Schizophrenia: A severe, frequently unremitting syndrome with a greater than 50% relapse rate. The onset of schizophrenia typically occurs in late adolescence to early 20s. Earlier age of onset is associated with greater morbidity. The first-degree biological relatives of individuals with Schizophrenia have a risk for Schizophrenia that is about 10 times greater than that of the general population.

Symptoms include hallucinations, delusions, disorganized speech, and/or disorganized behavior. These symptoms must be present for a period of at least one month, and either preceded or followed by a period of continuous signs of the disturbance that persist for at least 6 months. Residual symptoms affecting occupational and social interactions are common and complete remission of this disorder is rare. Suicide occurs in 10%-15% of individuals with Schizophrenia and suicide attempts occur in up to 40%.

Schizophreniform Disorder: There is little information available on the long-term course of this disorder. True Schizophreniform Disorder is rare. It is estimated that 1/3 of the individuals with this disorder recover within the 6-month period and receive Schizophreniform Disorder as their final diagnosis. Approximately 2/3 will progress to a diagnosis of Schizophrenia or Schizoaffective Disorder. There is no way to predict relapse or whether an acute episode will become chronic. There is also no reliable way of determining when a relapse may occur. Longitudinally, prognosis is better than individuals with Schizophrenia, but worse than individuals with mood disorders.

Symptoms include hallucinations, delusions, disorganized speech, and/or disorganized behavior. Suicidal ideation and suicide attempts are common. The essential features of this disorder are identical to Schizophrenia with 2 exceptions: the total duration of the illness is at least 1 month but less than 6 months, and impaired social or occupational functioning during some part of the illness is not required (but may occur). The age of onset is most commonly adolescence or early adulthood.

Schizoaffective Disorder: Schizoaffective Disorder is a severe, frequently unremitting disorder with a greater than 50% relapse rate. There is no reliable way of determining when a relapse will occur. The chronicity of this disorder is not as severe as Schizophrenia, but more severe than the Mood Disorders. Residual symptoms affecting occupational and social interactions are common. Suicidal ideation and suicide attempts are common.

Symptoms: There is a period of illness during which there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode, concurrent with symptoms that meet criteria for Schizophrenia. During the same period of illness there are delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms. Onset is in late adolescence or early adulthood.

Medication: Medications used to treat these disorders include the full range of both antipsychotics and antidepressants. Antipsychotic medications are frequently associated with extrapyramidal symptoms and Tardive Dyskinesia, a permanent, disfiguring movement disorder. Antipsychotics require frequent clinical monitoring of the patient. Breakthrough episodes of psychosis are common. Tricyclic antidepressant medications, selective serotonin reuptake inhibitors, monoamine oxidase inhibitors, and mood stabilizers used to treat the affective symptoms associated with Schizoaffective Disorder also require frequent monitoring. Electroconvulsive therapy may also be used to treat this condition. Psychiatric hospitalization is frequently necessary.

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review available.

INFORMATION REQUIRED**If Mental Health Consultant Requests:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.
- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Applicant presents with a history of one of the following disorders:		
1. Delusional Disorder	MHA	_____
2. Shared Psychotic Disorder (Folie A Deux)		
3. Psychotic Disorder Not Otherwise Specified		
4. Substance Induced Psychotic Disorders		
5. Psychotic Disorder Due to a General Medical Condition	MHA MED ADVISOR	_____
		Risk varies - assess based on detailed history.

DIAGNOSTIC CODES

297.10	Delusional Disorder
297.30	Shared Psychotic Disorder (Folie A Deux)
293.81	Psychotic Disorder Due to a General Medical Condition / Psychotic Disorder with Delusions
293.82	Psychotic Disorder Due to a General Medical Condition / Psychotic Disorder with Hallucinations
297.10	Psychotic Disorder Not Otherwise Specified
	<i>Substance-Induced Psychotic Disorders:</i>
291.50	Alcohol, with delusions
291.30	Alcohol, with hallucinations
292.11	Amphetamines, with delusions
292.12	Amphetamine, with hallucinations
292.11	Cannabis, with delusions
292.12	Cannabis, with hallucinations
292.11	Cocaine, with delusions
292.12	Cocaine, with hallucinations
292.11	Sedative, Hypnotic, or Anxiolytic with delusions
292.12	Sedative, Hypnotic, or Anxiolytic with hallucinations
292.11	Hallucinogen, with delusions
292.12	Hallucinogen, with hallucinations
292.11	Inhalant, with delusions
292.12	Inhalant, with hallucinations
292.11	Opioid, with delusions
292.12	Opioid, with hallucinations
292.11	Phencyclidine, with delusions

292.12	Phencyclidine, with hallucinations
292.11	Other or Unknown Substance with delusions
292.12	Other or Unknown Substance with hallucinations
Cross Reference DSM - IV	

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Delusional Disorder: This is a relatively uncommon disorder in which the patient has very little insight regarding the disorder. The course is extremely variable, ranging from chronic and refractoriness to treatment, to full periods of remission followed by subsequent relapses, to full remission in a few months without subsequent relapse. The percent of individuals who relapse is estimated at 40% to 50%. There is no reliable way to determine when an individual will relapse. Delusional Disorder can significantly adversely affect a person's relational, social and occupational functioning. Onset is generally in middle or late adult life. Symptoms include nonbizarre delusions of at least 1 month's duration. These delusions most often involve situations that occur in real life. Common examples include being followed, poisoned, infected, loved at a distance, deceived by a spouse or lover, or having a disease.

Patients frequently do not see any difficulty with their behavior and are resistant to treatment. There is no proof that psychotherapy is particularly effective. Antipsychotic medications, particularly pimozide, are most frequently used to treat this disorder. Most patients with this disorder are treated as outpatients unless they are potentially dangerous to another person.

Shared Psychotic Disorder (Folie A Deux): Shared Psychotic Disorder is rare. A delusion develops in a person who is involved in a close relationship with another person who already has a Psychotic Disorder. The delusion is similar in content to that of the person who already has the established delusion. It tends to be more common in women and the age of onset is variable. Without intervention the disorder tends to become chronic because the disorder most commonly occurs in relationships that are long-standing and resistant to change. With separation from the primary case, the individual's delusional beliefs disappear over time. The submissive person frequently moves back in with the dominant person after hospitalization. Antipsychotic medications are commonly used to treat the submissive person as well as the dominant person. Medication is often discontinued within the first year after the psychotic episode has remitted.

Psychotic Disorder Not Otherwise Specified: The patient has psychotic symptoms that do not meet criteria for any specific Psychotic Disorder or for which there is inadequate information to make a specific diagnosis, e.g., postpartum psychosis, persistent auditory hallucinations in the absence of other features, culturally bound psychotic disorders. Antipsychotic medications are commonly used to treat these disorders, and may be used on either a short-term or long-term basis. Psychotherapy is most often supportive in nature. Hospitalization during the psychotic episode is common.

Substance Induced Psychotic Disorders: The patient has prominent hallucinations or delusions that develop during, or within a month of, Substance Intoxication or Withdrawal and is etiologically related to the disturbance. Relapse depends on the extent of damage resulting from the substance abuse. This varies from full remission to permanent psychosis. Therapy includes the identification and treatment of the underlying cause of the psychosis. Antipsychotics may provide symptomatic treatment of the psychosis, although secondary psychotic disorders often prove to be refractory to antipsychotic medications.

Psychotic Disorder Due to a General Medical Condition: The patient has prominent hallucinations or delusions that are a direct physiological consequence of a general medical condition. The course and prognosis frequently vary depending on the etiology and the medical condition. Recovery varies from permanent psychosis to full remission. Therapy includes the rapid identification and treatment of the underlying cause. Antipsychotics may provide symptomatic treatment of the psychosis, although secondary psychotic disorders often prove to be refractory to antipsychotic medications. Antipsychotic medications are commonly used to treat these disorders, and may be used on either a short-term or long-term basis. Psychotherapy is most often supportive in nature. Hospitalization during the psychotic episode is common.

Literature review available.

INFORMATION REQUIRED**If Mental Health Consultant Requests:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.
- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Applicant presents with a history of one or more of the following disorders:		
1. Dissociative Amnesia	MHA	_____ Risk varies - assess based on detailed history.
2. Dissociative Fugue		
3. Dissociative Identity Disorder (Multiple Personality Disorder)		
4. Depersonalization Disorder		
5. Dissociative Disorder Not Otherwise Specified		

DIAGNOSTIC CODES

300.12	Dissociative Amnesia
300.12	Dissociative Fugue
300.14	Dissociative Identity Disorder (Multiple Personality Disorder)
300.60	Depersonalization Disorder
300.15	Dissociative Disorder Not Otherwise Specified
Cross Reference DSM - IV	

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Dissociative Amnesia: These patients presents with one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness. Most typically, patients are unable to recall any of the events that have occurred during a specific period of time extending over a few hours to days. Patients typically appear remarkably unconcerned about the deficit. Dissociative amnesia can vary in severity from 1 episode to frequent, unremitting episodes. The amnesia is frequently preceded by an emotional trauma and these individuals may be a risk for further episodes of amnesia with subsequent stressors.

Dissociative Fugue: These patients have a history of sudden, unexpected travel away from home or work, with an inability to recall their past. They demonstrates confusion about personal identity or assumption of the new identity. These patients are typically unaware that any dramatic changes have taken place. The fugue can be short-term (a few hours or days) or long-term (months to years). Dissociative

Fugue is rare. Many episodes occur only once and never recur. There is debate as to whether a person who experiences one episode of Dissociative Fugue is at a greater risk for subsequent episodes.

Dissociative Identity Disorder (Multiple Personality Disorder): The patient presents with the presence of two or more distinct identities or personality states that recurrently take control of the person's behavior. There is an inability to recall important information that is too extensive to be explained by ordinary forgetfulness. Dissociative Identity Disorder is a long-term (frequently lifelong) chronic, relapsing, disorder requiring on-going psychotherapy, pharmacotherapy, and multiple hospitalizations.

Depersonalization Disorder: The patient has persistent or recurring experiences of feeling detached from, as if one is an outside observer of, one's mental processes or body. Reality testing remains intact. Occasional isolated episodes of depersonalization are common and are not considered pathological. Individuals with Depersonalization Disorder feel this way much of the time and the disorder causes clinically significant impairment in social, occupational, or other important areas of functioning. The level of psychosocial functioning in patients with Depersonalization Disorder can vary greatly from essentially "normal" day-to-day functioning to severe, chronic impairment.

Literature review available.

INFORMATION REQUIRED**If Mental Health Consultant Requests:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.
- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Applicant presents with a history of one or more of the following disorders:		
1. Factitious Disorder	MHA	<hr/> Risk varies - assess based on detailed history.
2. Factitious Disorder Not Otherwise Specified		

DIAGNOSTIC CODES

	<i>Factitious Disorder</i>
300.16	with Predominantly Psychological Signs and Symptoms
300.19	with Predominantly Physical Signs and Symptoms
300.19	with Combined Psychological and Physical Signs and Symptoms
300.19	Factitious Disorder Not Otherwise Specified
	Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Factitious Disorder: Patients with Factitious Disorder present with intentional production or feigning of physical or psychological signs or symptoms with the motivation of assuming the sick role. This is not the same as Malingering in which the patient feigns illness for a secondary gain such as economic gain or avoiding legal responsibility. Factitious Disorder is most commonly severe and unremitting. The patient's do not readily accept that they have a psychiatric disorder and tend to avoid psychiatric intervention.

Literature review available.

INFORMATION REQUIRED**If Mental Health Consultant Requests:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.
- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Applicant presents with a history of one or more of the following disorders:		
1. Intermittent Explosive Disorder	MHA	Risk varies - assess based on detailed history.
2. Kleptomania		
3. Pyromania		
4. Pathological Gambling		
5. Trichotillomania		

DIAGNOSTIC CODES

- 312.24 Intermittent Explosive Disorder
 312.32 Kleptomania
 312.33 Pyromania
 312.31 Pathological Gambling
 312.39 Trichotillomania
 Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Intermittent Explosive Disorder: The patient has a history of discrete episodes of violence that resulted in serious assaultive acts or destruction of property. The degree of aggressiveness is grossly out of proportion to any precipitating psychosocial stressors. This disorder is rarely diagnosed as most episodes of violence can be traced to other factors, e.g. mental disorders, antisocial personality disorders, head injuries, etc. This disorder is difficult to successfully treat.

Kleptomania: The patient has a recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value. There is an increasing sense of tension immediately before committing the theft, with pleasure, gratification or relief at the time of committing the theft. This disorder is difficult to treat and is associated with frequent relapses. The prognosis tends to be poorer if the patient has a history of associated legal difficulties.

Pyromania: The patient has demonstrated deliberate and purposeful episodes of firesetting on more than one occasion. There is an increase in tension or arousal before the act, with pleasure, gratification, or relief when setting the fires, or when witnessing or participating in their aftermath. These individuals have a fascination with, interest in, curiosity about, or attraction to fire and its situational contexts. The firesetting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment. This disorder is difficult to treat and is associated with frequent relapses. The prognosis tends to be poorer if the patient has a history of associated legal difficulties.

Pathological Gambling: The patient demonstrates a persistent and recurrent maladaptive gambling behavior associated with 5 or more of the following symptoms: (1) they are preoccupied with gambling; (2) there is a need to gamble with increasing amounts of money; (3) there have been repeated efforts to control, cut back, or stop the gambling; (4) the patient is restless or irritable when attempting to stop gambling; (5) he/she gambles as a way of escaping from problems or a dysphoric mood; (6) after losing money gambling, they will return another day to "get even"; (7) the patient lies to family members, therapist, or others about the extent of their gambling; (8) the patient has committed illegal acts to finance gambling; (9) the patient has jeopardized or lost significant relationships, jobs, etc. because of gambling; (10) the patient relies on others to provide money to relieve a desperate financial situation caused by gambling. This disorder can have devastating financial effects on the individual and his/her family, resulting in interpersonal conflicts, loss of jobs, and legal difficulties. The disorder is chronic and requires ongoing maintenance treatment, particularly in the form of participation with Gamblers Anonymous.

Trichotillomania: The patient presents with recurrent episodes of pulling out his/her hair resulting in noticeable hair loss. There is an increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior and a sense of pleasure, gratification, or relief when pulling out the hair. This disorder can result in significant, disfiguring, baldness and can be stigmatizing for the patient. In adults, this disorder is frequently chronic and is commonly associated with psychiatric comorbidity.

Literature review available.

INFORMATION REQUIRED**If Mental Health Consultant Requests:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.
- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Applicant presents with a history of one or more of the following disorders:		
1. Somatization Disorder 2. Undifferentiated Somatiform Disorder 3. Conversion Disorder 4. Pain Disorder Associated With Psychological Factors 5. Pain Disorder Associated With Both Psychological Factors and a General Medical Condition 6. Body Dysmorphic Disorder	MHA MED ADVISOR	Risk varies - assess based on detailed history.

DIAGNOSTIC CODES

300.81	Somatization Disorder
300.81	Undifferentiated Somatiform Disorder
300.11	Conversion Disorder
307.80	Pain Disorder Associated With Psychological Factors
300.89	Pain Disorder Associated With Both psychological Factors and a eneral Medical Condition
300.70	Body Dysmorphic Disorder
300.81	Somatiform Disorder Not Otherwise Specified
Cross Reference DSM - IV	

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Somatization Disorder: Somatization Disorder is a severe chronic psychiatric disorder with no effective treatment. The patient presents with many physical complaints, with at least one of the complaints beginning before age 30 years. The symptoms persist over several years and result in treatment being sought and significant social and occupational impairment. Each of the following criteria must be present: 4 pain symptoms, 2 gastrointestinal symptoms, 1 sexual or reproductive symptom, and 1 pseudoneurological symptom (e.g., paralysis, difficulty swallowing, blurred vision, etc.). After medical evaluation, these symptoms cannot be explained by a medical

condition or the direct effects of a substance. If there is a related general medical condition, the physical complaints or resulting impairment are in excess of what would be expected. It is important to note that these symptoms are not intentionally produced or feigned. Common comorbid conditions include Mood Disorders, Conversion Disorder, Social and Specific Phobias, Panic Disorder, Generalized Anxiety Disorder, Histrionic Personality Disorder, and Antisocial Personality Disorder. These individuals rarely present to a psychiatrist initially, and can be very resistant to psychiatric intervention. They commonly go from one primary care provider to another seeking "relief" for their symptoms. Suicide threats are common in this population but the actual suicide rate is no greater than the rate for the general population.

Undifferentiated Somatoform Disorder: The patient presents with one or more physical complaints that cannot be fully explained by a medical condition or the effects of a substance. The complaints are severe enough to effect social or occupational functioning. The duration of the disturbance is at least 6 months. Undifferentiated Somatoform Disorder is more common than Somatization Disorder and ranges in severity from mild to disabling. Like Somatization Disorder, this disorder is frequently resistant to treatment, resulting in multiple medical visits.

Conversion Disorder: The patient presents with one or more symptoms or deficits affecting motor or sensory function. These symptoms suggest a neurological or general medical condition, but after investigation, cannot be fully explained by a general medical condition or the direct effects of a substance. Psychological factors are judged to be associated with the symptoms or deficits because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.

Pain Disorder: The patient presents with pain in one or more anatomical sites that causes clinically significant distress or impairment. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. The pain may be purely psychological in origin or may be associated with a medical condition. Pain Disorder is considered to be a mental disorder only if psychological factors are judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain. Pain Disorder typically is chronic and unremitting. These individuals can be difficult to treat, particularly if litigation is involved.

Body Dysmorphic Disorder: The patient is preoccupied with an imagined defect in appearance. The preoccupation is severe enough that it results in significant distress or psychosocial impairment. Facial flaws (e.g., too large a nose) are the most common defect in body dysmorphic disorder. Other body parts that may be a focus include hair, breasts, and genitalia.

Literature review available.

Includes Counseling for Acute Stress Disorder.

If Applicant Has Diagnosis of *Acute Post Traumatic Stress Syndrome* (PTSD), see PTSD Guideline.
 If Applicant is Attending an Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) Support Group;
 See "Alcohol-Related Disorders" or "Substance-Related Disorders".

INFORMATION REQUIRED**All Applicants:**

- Report of Medical Examination
- Applicant Personal Statement

If Applicable:

- Mental Health Treatment Summary Form

If Mental Health Consultant Requests:

- Review of functional status as documented in the Mental Health Treatment Summary.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection:
- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. No history of psychotherapy. 2. Reviewer notes no significant mental health issues on the Applicant Personal Statement. 3. Reviewer notes no significant mental health issues on the Report of Medical Examination. 4. No identified psychiatric disorders (Axis I and Axis II). 		
Meets clearance criteria 1 - 4, AND <ul style="list-style-type: none"> • No use of psychotropic medications. 	RN	CLEAR
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • History of psychotherapy. • Reviewer notes significant mental health issues on the Applicant Personal Statement. • Reviewer notes significant mental health issues the Report of Medical Examination. • Use of psychotropic medications. 	MHA	_____ Risk varies - assess based on detailed history.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • Identified psychiatric disorders (Axis I and Axis II). 	RN	_____ See specific Disorder-Related Guideline.

DIAGNOSTIC CODES

308.30 Acute Stress Disorder
 Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Academic, Family, and Support Group Counseling: Short-term individual or group counseling to deal with well-defined, isolated, situational problems such as vocational issues, divorce, separation, death or illness of a significant other, marital problems, end of a difficult relationship, adolescence, college assertiveness, expression of feelings, rape, assault, school problems, and social problems.

Acute Stress Disorder: Following a traumatic event a high percentage of persons experience Acute Stress Disorder (ASD). Symptoms of ASD are similar to acute PTSD. The symptoms are experienced during or immediately after the trauma, last for at least 2 days, and resolve within 4 weeks after the conclusion of the traumatic event. When symptoms persist beyond 1 month, a diagnosis of PTSD may be appropriate if the full criteria for PTSD are met. After one month 70% to 90% may show the full symptoms picture for PTSD.

Self-Help Groups: Self-Help groups can be organized by anyone. They do not constitute therapy. They can be support groups for people with common problems, e.g., herpes, mastectomy, rape-survivors, diabetics, etc. Twelve step groups, or the "anonymous" groups, are based on the "12 steps" of Alcoholics Anonymous. Common groups include the following:

- Alcoholics Anonymous (AA): for recovering alcoholics
- Alanon: for families of recovering alcoholics
- Alateen: for teenagers with alcoholics in their families
- Narcotics Anonymous (NA): for recovering drug addicts
- Naranon: for families of recovering drug addicts
- Overeaters Anonymous (OA): for addictive eaters, anorexics and bulimics.
- Adult Children of Alcoholics Anonymous (ACAA): for people raised in alcoholic homes
- Co-Dependents Anonymous: for people raised in dysfunctional homes
- Gamblers Anonymous: for recovering addictive gamblers
- Survivors of Incest Anonymous
- Debtors Anonymous (DA)
- Sex and Love Addicts Anonymous

Subclinical References to Mental Health Problems that Present in Counseling.

INFORMATION REQUIRED**All Applicants:**

- Mental Health Treatment Summary Form

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. Reviewer notes no significant mental health issues on the Mental Health Treatment Summary Form. 2. No history of coexisting psychiatric disorders (Axis I and Axis II). 		
Meets clearance criteria 1 - 2 <ul style="list-style-type: none"> • Active phase of counseling complete. Continuing counseling sessions for normative issues only. 	RN	CLEAR
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • Reviewer notes significant mental health issues on the Mental Health Treatment Summary Form. 	RN	_____ Risk varies - assess based on detailed history.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • Active phase of counseling not complete. 	RN	DEFER Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • History of coexisting psychiatric disorders (Axis I and Axis II). 	RN	_____ See Specific Disorder-Related Guideline.

DIAGNOSTIC CODES*V Code Classifications*

- Relational Problems
- Problems Related to Abuse or Neglect
- Additional Condition That May Be A Focus of Clinical Attention
- Other V71.09 No Diagnosis of Condition on Axis I or Axis II
- 799.90 Diagnosis Deferred on Axis I or Axis II

Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

None

Does not meet clearance criteria due to one or more of the following:

- History of repeated, severe, panic symptoms.

MHA
MED ADVISOR

DEFER/MNQ

DIAGNOSTIC CODES

300.01 Panic Disorder without Agoraphobia
300.21 Panic Disorder with Agoraphobia
Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Background: Panic Attacks can range in intensity from mild, infrequent attacks that minimally effect a person's psychosocial and occupational functioning, to severe, unremitting attacks that completely disable a person. The ability to function socially, occupationally, and relationally with the Panic Attacks is a key concept in determining an applicant's ability to function in a Peace Corps environment.

Key Symptoms: The individual experiences recurrent Panic Attacks in which he/she has at least 4 of the following symptoms: palpitations, increased heart rate, sweating, trembling, shaking, shortness of breath, feelings of choking, chest pain, nausea, gastrointestinal distress, dizziness, fainting, feelings of unreality, feelings of being detached from oneself, fear of losing control, fear of going crazy, fear of dying, paresthesias, chills, or hot flashes. One or more of the attacks has been followed by at least one month of worrying about additional attacks or changes in behavior related to the attacks.

Agoraphobia: Fear of being in particular places or situations. Travel becomes restricted. Common situations that produce symptoms are, being outside the home, being in a crowd, traveling on a bus or plane, and riding in car. Agoraphobia ranges from mild to severe.

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review available.

PANIC DISORDER

MH 2.3

Includes Panic Disorder With or Without Agoraphobia
For Performance Anxiety; See "Social Phobia".

INFORMATION REQUIRED

All Applicants:

- Mental Health Treatment Summary Form to include a full description of panic attacks.
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. No history of panic attacks for at least the past 1 year, i.e., acute onset of <i>moderate to severe</i> panic symptoms. 2. Symptom free, or effective management of <i>mild</i> panic symptoms, for <i>at least</i> the past 6 months. 3. Functioning well socially and occupationally during the past 1 year (corresponds to a GAF of 75 or above). 4. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only. 5. No history of suicide attempt, gesture, or ideation with plan. 6. No history of coexisting psychiatric disorders (Axis I and Axis II). 7. No history of psychosis. 		
Meets clearance criteria 1 - 7, AND <ul style="list-style-type: none"> • No use of psychotropic medications for <i>at least</i> the past 6 months. 	RN	CLEAR
Meets clearance criteria 1 - 7, AND <ul style="list-style-type: none"> • Continuous or intermittent use of psychotropic medications <i>within</i> the past 1 year. • If on continuous psychotropic medication, stable for <i>at least</i> the past 3 months. 	RN	CLEAR WITH RESTRICTION 8B Accommodation
	PCMO FOLLOW-UP Medication monitoring every 3-4 months. Avoid Mefloquine.	
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • Ineffective management of <i>mild</i> panic symptoms during the past 6 months. • Some impairment of functioning socially or occupationally during the past 1 year (corresponds to a GAF below 75). • Active phase of psychotherapy or counseling not complete. • Not stable on psychotropic medication for <i>at least</i> the past 3 months. 	RN	DEFER Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • History of panic attacks <i>within</i> the past 1 year, i.e., acute onset of <i>moderate to severe</i> panic symptoms. • History of suicide attempt, gesture, or ideation with plan. • History of coexisting psychiatric disorders (Axis I and Axis II). • History of psychosis. 	MHA	Risk varies - assess based on detailed history.

(continued on next page)

Includes Specific Phobias, Social Phobia, and Agoraphobia Without History of Panic Disorder.

INFORMATION REQUIRED**All Applicants:**

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Treatment summaries for all in-patient and out-patient phobia treatment programs.
- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
 - Diagnosis
 - Medication history, i.e., dates, doses, response, adverse effects.
 - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
<ol style="list-style-type: none"> 1. If history of a <i>severe</i> phobic disorder, successfully completed a desensitization or exposure-based treatment program. 2. If history of a <i>mild</i> phobic disorder, effective management of mild anxiety or panic symptoms, when exposed to the specific phobia, for <i>at least</i> the past 1 year. 3. Avoidance of the specific phobia is not required for effective symptom management. 4. Functioning well socially and occupationally during the past 1 year (corresponds to a GAF of 75 or above). 5. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only. 6. No history of suicide attempt, gesture, or ideation with plan. 7. No history of coexisting psychiatric disorders (Axis I and Axis II). 8. No history of psychosis 		
Meets clearance criteria 1 - 8, AND <ul style="list-style-type: none"> • No use of psychotropic medications for <i>at least</i> the past 6 months. • If on medication other than psychotropics, e.g., beta-blockers, stable for <i>at least</i> the past 3 months. 	RN	CLEAR
Meets clearance criteria 1 - 8, AND <ul style="list-style-type: none"> • Continuous, or intermittent, use of psychotropic medications <i>within</i> the past 6 months. • If on <i>continuous</i> psychotropic medication, stable for <i>at least</i> the past 6 months. 	MHA	CLEAR WITH RESTRICTION 8B Accommodation
	PCMO FOLLOW-UP Medication monitoring every 3-4 months. Avoid Mefloquine.	
Does not meet clearance criteria due to one or more of the following: <ul style="list-style-type: none"> • If history of a severe phobic disorder: Has not successfully completed a desensitization or exposure-based treatment program. • If history of a mild phobic disorder: Ineffective management of mild anxiety or panic symptoms, when exposed to the specific phobia, during the past 1 year. • Some impairment of functioning socially or occupationally during the past 1 year (corresponds to a GAF below 75). • Active phase of psychotherapy or counseling not complete. • Not stable on psychotropic medications for <i>at least</i> the past 6 months. • Not stable on medications other than psychotropics for <i>at least</i> the past 3 months 	MHA	DEFER Deferral period consistent with clearance criteria.

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<p>Does not meet clearance criteria due to one or more of the following:</p> <ul style="list-style-type: none"> • Avoidance of the specific phobia is required for effective symptom management. • History of suicide attempt, gesture, or ideation with plan. • History of coexisting psychiatric disorders (Axis I and Axis II). • History of psychosis. 	MHA	<p>_____</p> <p>Risk varies - assess based on detailed history.</p>
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DIAGNOSTIC CODES

- 300.29 Specific Phobia
 300.23 Social Phobia (Social Anxiety Disorder)
 300.22 Agoraphobia Without History of Panic Disorder
 Cross Reference ICD.9.CM

NOTES AND INSTRUCTIONS FOR REVIEWERS**Reviewers to Consider:**

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Background: Although phobias are common in the general population, they rarely result in sufficient impairment or distress to warrant a diagnosis of Specific Phobia. Many individuals with Specific Phobias function well relationally, socially, and functionally as long as they are not exposed to the Specific Phobia. These individuals tend to present for treatment only when they are no longer able to avoid the phobia. In general, phobias are more common in women. Phobias that persist into adulthood remit only infrequently (around 20% of cases).

Specific Phobia: The individual has a persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Exposure to the phobic stimulus results in an immediate anxiety reaction or panic attack. The DSM-IV lists 5 types of Specific Phobias: (1) Animal type: cued by animals or insects; (2) Natural Environment Type: examples include fear of storms, heights, water, etc.; (3) Blood-Injection-Injury Type: cued by seeing blood or receiving an injection or other invasive medical procedures. This type is characterized by a strong vasovagal response.; (4) Situational type: the cue is a specific situation, e.g., public transportation, tunnels, bridges, elevators, flying, enclosed spaces; and, (5) Other type, e.g., fear of choking, vomiting, contracting an illness.

Social Phobia: These individuals have a persistent fear of one or more social or performance ("stage-fright") situations in which they are exposed to unfamiliar people or to the possible scrutiny of others. This exposure provokes severe anxiety and possible panic attacks. Typically, the feared situations are avoided, thus interfering with an individual's social and occupational functioning. At times, these fears can generalize to include most social situations, making this disorder difficult to distinguish from Agoraphobia or Avoidant Personality Disorder.

Agoraphobia Without History of Panic Disorder: The individual presents with Agoraphobia related to the fear of developing panic-like symptoms; however, the criteria have never been met for Panic Disorder. Agoraphobia consists of anxiety about being in places or situations from which escape might be difficult or in which help may not be available in the event of having panic-like symptoms. Common Agoraphobic fears include being outside the home alone; being in a crowd or standing in a line; being on a bridge; or traveling in a bus, train, or car. It is unlikely that an individual with Agoraphobia would present as an applicant to the Peace Corps unless she/he has been successfully treated for this condition. This condition, like Panic Disorder, tends to wax and wane, and relapse is common. There is very little research literature available on the outcome and prognosis of Agoraphobia.

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review available.