Medical Examiners' – Medical Manual

Part 3 - Clinical Aviation Medicine

3.9 Mental Health

ICAO Annex 1:	6.2, 6.3.2, 6.4.2, and 6.5.2
Civil Aviation Act:	s27B
CAR Part 67:	67.103(b) & (c), 67.105(b) & (c), and 67.107(b) & (c)
GD:	Timing of Routine Examinations, Examination Procedures
ICAO Medical Manual:	Part III, Chapter 9

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3.9.1 Mental Health Problems - Interim Guidelines

3.9.1.1 Introduction

This section is intended to provide Medical Examiners with guidance for the clinical mental health screening of applicants while the detailed Mental Health chapter is being completed.

This section is based on a similar document published by the Civil Aviation Safety Authority (CASA Australia). That document, in turn, was based on (open usage) training material developed by the Federal Aviation Administration (FAA US). That training material referenced a 2001 report, 'Psychiatric Factors in Civil Aviation Medicine', written by eminent aviation psychiatrist Dr David R. Jones MD, MPH and initially delivered by Dr Jones prior to his retirement.

CASA and FAA have provided permission for their work to be used here.

3.9.1.2 Screening for Mental Health Problems During Routine Periodic Physical Examinations

Clues that may be available before the examination begins:

- You may know something of the reputation of the applicant in the community.
- You may learn something from the applicant's interaction with your office staff.
- Applicants with mental health problems may behave differently with office staff than with the examiner. Consider this if your staff points out behavioural problems or eccentricities.

Clues on Medical Certificate application form

- The applicant's form contains careless or missing marks.
- Obtain the correct or missing data and ask why the mistake was made.
- The class of certificate desired is not usual for this type of pilot.
- Find out how flying fits into the applicant's lifestyle and plans.
- The applicant does not live or work locally.
- Consider the type and stability of the applicant's occupation.
- Discuss how the applicant came to pick you to do this examination.
- Previous examinations were not completed.
- Was the applicant learning what to say or not say in order to pass?
- Previous problems prevented certification (medical or mental health history).
- Previous experience with health professionals was not adequately explained.
- Pilot has had personal counselling by mental health professionals or paraprofessionals.
- Pilot time is unusual or contains unexplained gaps.
- Ask for explanation from a high-time pilot with no date of last examination.

- Medication history suggests significant illnesses that pilot did not note on the history questionnaire.
- Obtain an adequate history.
- Explanations for any medical history or findings do not make sense or seem illogical.
- Remember Jones's Rule of Irrational Data: If you don't understand what a flier means, assume it's your problem. Ask again, clearly. If the flier tries hard to explain, you try hard to understand, and you still don't understand, it's probably the flier's problem. Find out what it is. Possibilities include simple misunderstandings, English as a second language, educational deficiencies, cultural differences, limited intelligence, neurological problems, or psychiatric problems.

Clues obtained during the physical examination

- Note anything markedly different from what you usually see in pilots: trust your instincts.
- Assess the nature of the applicant's motivation to fly (Jones, 1986).
- Watch for applicants who want to be fliers rather than who want to fly. Some see themselves as alienated from others, or inept, or weak, and wish to acquire the attributes they perceive to be those of fliers: gregarious, competent, and strong.
- Watch for applicants who want to fly in order to prove fearlessness.
- Watch for applicants whose only knowledge of flying is childish fantasy.
- Look for scars without explanation obtained by history. Palpate scalp and skull for evidence of old head injury.
- Watch for applicants whose collection of scars reflects personal recklessness.
- Watch for applicants who are evasive about surgical scars or head injury scars.
- Ask about significant loss of consciousness or amnesia if pilot did not report the injury on their medical certificate application.
- Observe other pertinent physical factors bearing on mental status (e.g., dress, grooming conduct, alcohol on breath, needle tracks, tattoos that suggest sociopathy, slash scars on wrists, spider nevi, hepatomegaly, blood pressure, heart rate, pupils).
- Talk with applicants before, during, and after the physical examination—inquire about home, work, education, military, or flying. Trust your judgment if you feel uneasy.
- Inquire about non-prescription medications, herbal remedies and dietary supplements.
- Such information may be aeromedically significant because of the nature of these remedies, or because of the symptoms for which the pilot feels they are necessary. Taking St. John's Wort may indicate the presence of depressive symptoms, for instance.

What to do when you have finished

- Ask enough questions to clarify troublesome issues.
- Obtain indicated medical data.
- If anything you encounter raises clinical questions about the applicant's mental status, or even if you find yourself feeling uncomfortable without knowing exactly why, perform a brief mental status evaluation, using some or all of the items in the Formal Mental Status Examination (MSE) that follows.
- Note that some clinical MSEs, such as the Mini-Mental Status Examination, assess only the Sensorium rather than the entire mental status of a person.
- If you find anything that indicates clinical problems, consider necessary specialty consultations. Again, trust your judgment as an examiner, even if you can't exactly define what's wrong.
- Mention equivocal items in "Comments" section of Original or Renewal form for the record, even if you grant the certificate. Your data will be on record if the item arises in future examinations.
- If in doubt, call the CAA medical unit for advice.
- If in serious doubt, defer; and let the CAA medical unit decide.
- As a last resort: make a "Don't quote me" call to the medical authority.

3.9.1.3 Formal Mental Status Examination

AMSIT (Appearance, Mood, Sensorium, Intelligence, Thought) is adapted from a formulation by David Fuller, MD, as presented in R.L. Leon, MD. Psychiatric Interviewing: A Primer. Ed 2, New York; Elsevier / Science Publishing Co. 1989.

Appearance, Behaviour, and Speech

- Physical Appearance: apparent age, gender, and other identifying features. Appearance of being physically ill or in distress; and a careful description of the patient's dress and behaviour.
- Manner of Relating to Examiner: placating, negativistic, seductive; motivation to work with examiner.
- Psychomotor Activity: increased or decreased, including jumpiness, jiggling, tapping, looking at watch, etc. Is the person hyperactive or lethargic?
- Behavioural Evidence of Emotion: tremulousness, perspiration, tears, clinched fist, turned-down mouth, wrinkled brow, etc.
- Repetitious Activities: mannerisms, gestures, stereotypy, "waxy flexibility," compulsive performance of repetitious acts.
- Disturbance of Attention: distractibility, self-absorption.
- Speech: description—volume, rate (pressured or slowed), clarity, spontaneity and disturbances—mutism, word salad, perseveration, echolalia, affectation, neologisms, clang speech.

Mood and Affect

Note: "Mood is to Affect as Climate is to Weather."

- Mood: use adjectives: mild (it's there), moderate (it needs treatment), or severe (it needs treatment today!). Consider depression, elation, or other sustained emotions such as anger, fear, or anxiety.
- Affect: its range, intensity, lability, and appropriateness to immediate thought. To describe a normal, stable emotional status, say something like "The examinee's mood is euthymic. Affect is unremarkable in range, intensity, and stability, and is appropriate to material being discussed."

Sensorium

- Orientation: for time, place and situation.
- Memory: immediate (digits recall), recent (three items for 10 minutes, current events) and remote (history).
- Calculating Ability: serial 7's, 11 times 13 out loud (valid only if patient is adequately educated).
- Concentration: spell WORLD backwards, then arrange its letters alphabetically. Repeat with EARTH.

Intellectual Function

- Estimate current level of function as above average, average, or below average based on general fund of information, vocabulary, and complexity of concepts. Do not confuse intelligence with education. Can the examinee handle abstract ideas, reason by analogy, "make the connection" in conversation? Is the examinee apparent intellect consistent with what is expected from a licence holder.

Thought

- Coherence: clear thoughts may be expressed incoherently.
- Logic: even clear, grammatical speech may express illogical thoughts.
- Goal Directedness (has a point and makes it): tangential or circumstantial thought.
- Disturbance of Attention: distractibility (interrupts own sentences), self-absorption.
- Associations: loose associations, blocking of obvious ideas or connections, flight of ideas.
- Perceptions: hallucinations (false perceptions), illusions, depersonalisation, distortion of body image.
- Delusions: false interpretations of real situations.
- Other Content: noteworthy memories, thoughts and feelings; suicidal or homicidal intent.
- Judgement: formal (specific set-piece situations such as "mailing a letter you find on the street"), social (how examinee behaves with examiner, how he or she "reads" other people —predictable, reasonable, comfortable).

- Abstracting Ability: ask pilot to define similarities / differences between tree-bush, child-midget, king-president, character-personality. This is more reliable than interpreting proverbs (stitch in time, bird in the hand).
- Insight: understanding of any personal dysfunction affecting self or others, and its need for treatment. Insight is lacking if there is an unacknowledged problem, superficial if it is only acknowledged ("It is a problem."), moderate if it is personalized ("I have a problem"), and profound if "It's my problem, and it's up to me to fix it."

3.9.2 Alcohol and Other Drugs (AOD) - Interim Guidelines

ICAO Annex 1	1.2.7.1, 1.2.7.2, 6.3.2.2, 6.4.2, 6.5.2
Civil Aviation Act	s27B
CAR Part 67	Part 67.103 b, & e, 67.105 b, & e, 67.107 b, & e
General Directions	Timing of Routine Examinations, Examination Procedures
ICAO Medical Manual	Chapter 1: 1.2.35 – 1.2.37. 1.4 Definitions.
	9.12 Drug Use (Abuse and Dependence)

3.9.2.1 Introduction

Alcohol has the potential to interfere with aviation safety through reductions in functional capacity (e.g. impairment or intoxication), through increased likelihood of incapacitation, and through unsafe behaviour. Those adverse effects are not limited to periods of intoxication or 'being under the influence' but can, in some cases, be active for much longer periods of time.

The aviation implications of (AOD) on safety are not limited to the realms of hypothetical possibilities but take a very real toll in damage and lives lost. In 2015 the Transport Accident Investigation Commission (TAIC) recommended "regulatory changes to strengthen the management of alcohol and drugs in the aviation, rail, and maritime transport modes"[1]. This was in response to a number of transport safety investigations, including the 2012 Carterton Hot-air balloon accident[2]. Similarly the first edition of TAIC's safety monitoring publication, the *Watch List*, included, as one of its three highest priority transport safety issues: "The issue of people in safety-critical roles being impaired as a result of using drugs or alcohol. The Ministry of Transport has stated its zero tolerance of operator impairment where members of the public are being transported by sea, rail, and air."[1]

TAIC: "The detrimental effects of drugs and alcohol on cognitive abilities are well documented. International research suggests the likelihood and severity of accidents increase if people responsible for performing safety-critical tasks use drugs or alcohol. In the New Zealand air, rail, and marine accidents investigated by the Transport Accident Investigation Commission, consumption of alcohol or use of other performance impairing substances recurs as a contributing factor or a potential impediment to survival. We believe more can be done in the transport sector to prevent people who are in safety-critical roles being under the influence of performance-impairing substances."[3]

The Civil Aviation Authority's medical certification system has an important role to play in preventing community losses due to the effects of alcohol and other drugs in the aviation

1 New Zealand Transport Accident Investigation Commission Annual Report 2014 – 2015 (F.7 ANN)
2 New Zealand Transport Accident Investigation Commission Final report, Aviation inquiry 12-001 Hot-air balloon collision with power lines and in-flight fire, near Carterton, 7 January 2012.
3 New Zealand Transport Accident Investigation Commission *Watch List* 'Substance use: regulatory environment for preventing performance impairment' accessed online at http://www.taic.org.nz/WatchList/tabid/284/language/en-US/Default.aspx on 16 February 2016.

industry. Medical Examiners are at the forefront of this system, being in a position to identify and investigate AOD-related safety concerns as well as being well placed to educate and assist at-risk aviation industry participants. This section of the CAA Medical Manual deals only with the aviation medical certification considerations of AOD use.

3.9.2.2 Alcohol

Alcohol is a recreational drug and psychoactive substance that is widely and legally available. Alcohol is used safely and in moderation by many, but still takes a huge toll of damage on our community. The New Zealand Health Promotion Agency's published alcohol fact sheet[4] includes advice that:

- Alcohol consumption is an important risk factor for more than 60 different disorders (WHO 2007)[5];
- 3.8% of all global deaths and 4.6% of the global burden of disease (measured in disability-adjusted life-years) are estimated to be attributable to alcohol (Rehm et al 2009)[5];
- Between 600 and 800 people in New Zealand have been estimated to die each year from alcohol related causes (BERL 2009 and Connor et al 2013)[5]; and
- 14% of the population are predicted to meet the criteria for a substance use disorder at some time in their lives (Wells et al 2007)[5].

This Medical Manual section provides information and describes CAA's requirements for the medical certification of pilots who have, or may be at risk of having, an unsafe relationship with alcohol. It is beyond the scope of this Medical manual to address the wider public health management of AOD problems within the general community or the aviation community.

3.9.2.3 Alcohol - Considerations

For a wide range of reasons an individual's alcohol consumption patterns are not always accurately reported to safety regulatory agencies. Because of these imperfect reporting patterns a range of collateral information often needs to be considered if a medical certification system aims to reduce the likelihood of harm caused by an individual's unsafe relationship with alcohol.

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4 New Zealand Health Protection Agency alcohol.org.nz 'Alcohol Quick Facts' accessed online at http://alcohol.org.nz/sites/test.alcohol.ginger.sparksinteractive.co.nz/files/documents/Alcohol%20Quickfact%20Facts.pdf on 16 February 2016.

5 World Health Organization. WHO Expert Committee on Problems Related to Alcohol Consumption: Second report. Geneva: WHO. 2007.
Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y, & Patra J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. The Lancet, 373(9682), 2223 - 2233. 2009.
Business and Economic Research Limited (BERL) Report to: Ministry of Health and ACC, Costs of Harmful Alcohol and Other Drug Use. BERL ref #4577. July 2009.
Connor J, Kydd R, Shield K, & Rehm J. Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Research Report commissioned by the Health Promotion Agency. Wellington: Health Promotion Agency. 2013.
Law Commission. Alcohol in our lives: an issues paper on the reform of New Zealand's liquor laws. Wellington: Law Commission. 2099.

In general terms the CAA's approach to medical certification safety and alcohol:

1. Recognises a wide spectrum of alcohol use patterns and does not limit medical safety concerns to any particular defined diagnostic category or criteria;
2. Considers a range of 'red flags' in deciding whether an applicant may be at risk of having an unsafe relationship with alcohol;
3. Relies on multiple independent information sources to confirm safety in at-risk applicants;
4. Views severe alcohol disorders (e.g. addiction) as being chronic relapsing medical *illnesses* - not character flaws, moral failings, or personality defects - implying that after appropriate treatment, and adequately reassuring follow-up, pilot medical certification will be resumed, subject to stringent ongoing medical surveillance; and
5. Offers the benefit of any reasonable doubt to public safety.

Possible Unsafe Relationship with Alcohol

Sometimes a Medical Examiner is confronted with information that suggests the possible presence of an unsafe relationship with alcohol but is not adequate to either confirm or refute that suggestion. This should not be surprising given the alcohol consumption patterns observed in our wider community.

It is important to remember that a medical certificate should not be issued unless satisfied that there is not a safety problem. This is the approach required by our legislation and is consistent with the general principle to offer the benefit of any doubt to public safety.

Red Flags

There are many observations that may, in isolation or in conjunction with other observations, reasonably suggest the possibility of an unsafe relationship with alcohol. The presence of any such red flags does not mean that an alcohol problem exists, but they do mean that further information should be sought before concluding that there is not an unsafe relationship with alcohol. The red flags most often seen by the CAA include:

- Drink driving offences;
- Other offences related to, or in association with, alcohol;
- Alcohol consumption in excess of recommended safe limits;
- The presence of health problems that have a strong association with alcohol consumption and no other more likely cause;
- Mental health problems where alcohol troubles can be a co-morbidity;
- Accidental or non-accidental injuries where the circumstances suggest contribution of alcohol;
- Problems with other drugs or addictions;
- Abnormal blood test results;
- Reports from community members;
- Clinical findings suggestive of elevated alcohol consumption levels; and

- Failure to comply with previous requirements concerning alcohol consumption or monitoring / surveillance.

Previously Identified Unsafe Relationship with Alcohol

When a pilot with a previously identified unsafe relationship with alcohol is returned to flying a range of ongoing medical surveillance is usually implemented. The role of that surveillance is to provide reassurance, over time, that no unsafe recurrence has occurred.

Generally those surveillance requirements are gradually stepped-back over time, usually by reducing their frequency, as safety confidence grows. Because of the wide range of individual circumstances many medical surveillance regimens are tailored for a particular applicant, usually via the detailed consideration of an Accredited Medical Conclusion (AMC).

Medical surveillance requirements are usually implemented by conditions placed upon a medical certificate. If the holder of a medical certificate fails to comply with any such condition they are not permitted to exercise the privileges associated with the medical certificate (See Civil Aviation Rule 61.35).

If an individual is subject to ongoing medical surveillance because of an alcohol problem and an abnormal result occurs (e.g. a rising CDT titre when it has been in the normal range for a long time) then that result should be weighted highly as suggesting the likelihood of a returned or relapsed unsafe relationship with alcohol.

3.9.2.4 Alcohol - Information to be provided

Possible Unsafe Relationship with Alcohol

When faced with the presence of any red flag, or others not listed above, the CAA's approach is to gather additional information in an effort to adequately mitigate the red flag(s). The additional information sought, on top of the detailed history and examination findings of the Medical Examiner (ME), may include any of the following:

- Detailed written explanation from the applicant concerning the matter;
- AUDIT questionnaire administered by the applicant's GP or ME;
- Up-to-date Ministry of Justice offences report or / and similar from relevant overseas jurisdictions;
- GP notes, or similar, over a period of time;
- Biochemical assays - e.g. Liver Function Tests (LFTs) and Full Blood Examination (FBE / FBC), Gamma Glutamyl Transferase (GGT), Carbohydrate Deficient Transferrin (CDT), Ethyl Glucuronide assays (EtG);
- Reports from AOD practitioners;
- Review reports from Addiction Medicine Specialists (FAChAM);
- Reports from 'sponsors' or other non-medical support persons;
- Information from other aviation safety regulatory authorities.

Reports or References from aviation or community members.Isolated, single, first-time red-flag

This situation most often occurs in the form of a single drink-drive offence in a first-time medical certificate applicant. If the ME interview and examination does not disclose any additional alcohol red flags some additional confirmatory information should be sought, but a medical certificate can be issued while that additional information is being gathered.

Typically the following would be sought as a minimum:

- Detailed written explanation from the applicant concerning the red-flag matter; and
- AUDIT questionnaire administered by the applicant's GP or ME; and
- Up-to-date Ministry of Justice offences report or / and similar from relevant overseas jurisdictions.

Previously Identified Unsafe Relationship with Alcohol

The particular suite of surveillance requirements is tailored on a case-by-case basis in recognition of the individual situation and circumstances. The alcohol-related surveillance obligations placed upon CAA medical certificate holders, include the following:

- Self-monitoring diaries;
- Periodic Biochemical assays - e.g. Liver Function Tests (LFTs) and Full Blood Examination (FBE / FBC), Gamma Glutamyl Transferase (GGT), Carbohydrate Deficient Transferrin (CDT), Ethyl Glucuronide assays (EtG);
- Periodic reports from aviation or community members;
- Updated GP notes, or similar, over a period of time;
- Reports from 'sponsors' or other non-medical support persons;
- Reports from AOD practitioners or / and AOD specialist medical practitioners.

Two or more unresolved red-flags

Typically such cases involve a drink drive conviction, new or in a first time applicant, and some other feature suggesting the possibility of potentially unsafe alcohol consumption patterns.

Typically the following would be sought:

- Detailed written explanation from the applicant concerning their alcohol consumption;
- AUDIT questionnaire administered by the applicant's GP or ME;
- Up-to-date Ministry of Justice offences report or / and similar from relevant overseas jurisdictions;
- GP notes, or similar, over a period of time; and
- Biochemical assays (Typically LFT, FBE / FBC, GGT and CDT).

3.9.2.5 Alcohol - Disposition

Civil Aviation regulatory medical practitioners encounter a wide range of alcohol problems, from barely a problem at all through to a severe, chronic, relapsing condition with other associated medical problems. For this reason it is not possible to provide specific detailed guidelines that cover every situation likely to be encountered.

If the ME assesses a case that is not easily decided by considering this information then the ME should discuss the details with a CAA Medical Officer.

An ME should not issue a medical certificate until he / she is satisfied that no alcohol-related problem exists and that the applicant does not have an *unsafe relationship with alcohol*.

An ME should not issue a medical certificate on an assumption that if CAA sees a problem they will intercede. The ME's primary and over-riding responsibility must be towards public safety.

Isolated, single, first-time red-flag

- If the further information discloses no additional concerns then it would be reasonable to assess the condition as not being of aeromedical signficance.

Non Isolated red-flag

If any of the information sought discloses additional red flags, such as additional drink drive convictions or potentially unsafe alcohol consumption patterns, then further information should be sought before concluding the applicant safe for the issue of a medical certificate.

Such cases should be handled by immediate liaison directly with CAA Medical Officers.

- Applicants with additional red flags should be assessed as having a condition that is of aeromedical significance and handled via the statutory flexibility route, requiring an Accredited Medical Conclusion (AMC).

Previously Resolved Red-Flags

Typically this applies to an applicant who has previously been worked-up as outlined above, with red flag(s) having been identified and investigated.

In such a case the applicant may be considered as meeting the relevant medical standards only if:

- The red-flags had been clearly worked up and no actual unsafe situation identified; and
- No further red-flags or concerns have been raised.

Otherwise an ME should not assess the applicant as meeting the medical standards, should consider seeking further information (along the lines outlined above), and should consider seeking for the application to be processed via the statutory flexibility (AMC) process.

Previously Identified Unsafe Relationship with Alcohol

Severe

- Applicants with a history of addictive or other severe alcohol disorders should not be assessed as meeting the medical standards.
- If such an applicant continues to comply with ongoing medical surveillance obligations, and if none of those results raises additional concerns, then the ME should consider seeking for the application to be processed via the statutory flexibility (AMC) process.
- If the applicant has failed to comply with medical surveillance obligations, or if some other feature raises additional concerns, the CAA medical unit should be advised immediately and no CAA medical certificate should be issued or extended.

Intermediate

- Generally, applicants with an 'intermediate' severity alcohol-related history - neither severe (above) nor minor (below) - should be assessed as not meeting the medical standards. The application shoud be referred for further consideration via the statutory flexibility (AMC) process.
- Such applicants with an 'intermediate' severity alcohol-related history may in exceptional circumstances be assessed as meeting the medical standards.
- Care is essential in making such an assessment and an ME considering this action should have a long-term medical involvement with the applicant and their alcohol problem and should liaise directly with CAA Medical Officers beforehand.

Relatively Minor

- Applicants with a history of relatively minor alcohol problems (e.g. a single drink drive conviction and , or demonstrated occasional only excessive binge drinking consumption pattern), who have effectively managed the problem and successfully complied with all medical surveillance obligations, may be assessed as having a condtion that is not of aeromedical significance, thus meeting the CAA medical standards.

3.9.2.6 Other Drugs - Considerations

A wide range of recreational drugs, legal and illegal, are available and used within the wider community. For example the 2012 / 2013 Ministry of Health drug use survey identified over 10% of the adult population as self-reporting the use of cannabis during the previous 12-months, with 6% of those users reporting harmful effects on work, studies or employment opportunities, and 8% reporting mental health harm due to cannabis use[6]. That same survey identified approximately 1% the adult population as self-reporting the use of amphetamines during the previous 12-months[7]. The previous nationwide drug use survey[8], which did not consider synthetic cannabinoid use, identified approximately 15% of adults as using cannabis during the previous 12-months followed, respectively, by stimulants (including methamphetamine) 3.9%, ecstasy 2.6%, LSD and synthetic hallucinogens 1.3%, prescription sedatives 1%, injected drugs 0.3%, and opiates 0.1%. The rapid emergence of use of synthetic cannabinoids is of grave concern given their potency and difficulties in detecting them.

“It is totally unacceptable for anyone in a safety-critical transport role, such as a pilot, to be working while impaired by a substance, whether legal or not”, Chief Commissioner John Marshall QC told a media briefing.

CAA considers the use of other recreational drugs to be totally unacceptable, even when abstaining at times of duty. This is because of the multiple pyscho-social consequences and circumstances usually associated with drug use.

3.9.2.7 Other Drugs - Information to be provided

On the first occasion that an applicant presents with a history of drug use.

- A point of contact screening drug test;
- A laboratory confirmatory drug test in case the point of contact drug test in non-negative;
- A Ministry of Justice report or equivalent, on the first occasion that an applicant presents with a history of use of psychoactive recreational drug use;
- A detailed written description by the applicant of their use of drug over time.

3.9.2.8 Other Drugs - Disposition

- A first time applicant with a remote history of drug use (more than five years), no evidence of addictive behaviour (drug, medication, smoking, alcohol), a negative point of contact drug test and no other red flag, may be considered as not having a condition that is of aeromedical signicance, thus meeting the medical standards.

6 New Zealand Ministry of Health. 2015. Cannabis Use 2012/13: New Zealand Health Survey. Wellington: Ministry of Health.

7 New Zealand Ministry of Health. 2013. Amphetamine Use 2012/13: Key findings of the New Zealand Health Survey. Wellington: Ministry of Health.

8 New Zealand Ministry of Health. 2010. Drug Use in New Zealand: 2007/08 New Zealand Alcohol and Drug Use Survey. Wellington: Ministry of Health.

- A first time applicant with a history of drug addiction, recent or prolonged use of drugs, multiple drug use, or a recent non-negative drug test may not be considered as meeting the medical standards. The application to be processed via the statutory flexibility (AMC) process.
- An applicant, who has been previously been issued a certificate and continues to comply with ongoing surveillance obligations should be considered as having a conditon that is of aeromedical significance unless a previous AMC has concluded that the condition is no longer of aeromedical significance.
  The applicant should be considered under the flexibility process. If none of the surveillance results raises additional concerns, the applicant is likely to be issued a medical certificate. Surveillance is likely to decrease over time.
- An applicant, who has been previously been issued a certificate and who has failed to comply with medical surveillance obligations, or returns a non-negative drug test, or if some other feature raises additional concerns should not be issued a certificate or an extension of the certificate.
  The CAA medical team should be advised immediately and no CAA medical certificate should be issued or extended. The application should be processed via the statutory flexibility (AMC) process or declined.