Mental Health & Aviation Medical Clearances

Aviation Rulemaking Committee

Recommendation Report

April 1, 2024

I. Executive Summary

The Mental Health & Aviation Medical Clearances Aviation Rulemaking Committee (Mental Health ARC or the ARC) was chartered by the Federal Aviation Administration (FAA) on December 4, 2023. The ARC provided a forum for the United States (US) aviation community to discuss the barriers preventing pilots and air traffic controllers (controllers) from reporting and seeking care for mental health issues and provide recommendations to the FAA to address these barriers to mitigate potential aviation safety risks.

The ARC members, observers, and contributors consisted of a broad representation of people, including aerospace medicine, psychiatric and psychological medical experts from the FAA Office of Aerospace Medicine (AAM),[1] FAA Flight Standards Service (AFS), the National Transportation Safety Board (NTSB), US aviation industry trade associations, pilot/controller representative organizations, academia, and international aviation industry associations and civil aviation authorities (CAAs). The ARC established two working groups, Peer Support & Operations and Medical, to identify and provide recommendations to address the barriers to reporting mental

[1] AAM includes Designated Aviation Medical Examiners. *See* Aviation Medical Examiner (AME) Designee Information (faa.gov)

health concerns and the steps needed to mitigate aviation safety risks. The groups worked collaboratively to identify barriers and develop consensus recommendations.

The ARC working groups addressed the following major issues:

- The FAA's handling of mental health diagnoses,
- Current aeromedical mental health screening processes,
- Barriers preventing pilots/controllers from reporting mental health issues and seeking mental health care, and
- Education, training, and awareness of pilot/controller mental health issues.

In-person ARC plenary meetings were held in Fort Worth, TX (Jan 9-11), McLean, VA (Feb 5-7), and Seattle, WA (Mar 13-15). Virtual attendance options were also available for remote participants. Co-chair and working group meetings were held multiple times each week, and on an *ad hoc* basis in person or virtually throughout this ARC's compressed timeline.

A summary of the ARC's Recommendations is below:

- Create a non-punitive pathway for disclosing mental health conditions and treatments;
- Revise and evaluate the requirements for reporting and certification/qualification of psychotherapy (talk therapy), depression/anxiety; attention deficit hyperactivity disorder, and post-traumatic stress disorder;
- Ensure that aeromedical screening protocols and requirements are based on Safety Management System principles (i.e., proportionate, relevant, and risk-based), and appropriately communicated to applicants;
- Expand the use and promotion of Peer Support Programs;
- Develop mental health literacy, education, and awareness campaigns;
- Increase mental health training and improve quality assurance for Aviation Medical Examiners (AMEs); and
- Modernize the FAA's information management system/Aviation Medical Certification Subsystem.

Details and supporting text for all recommendations are in Section VIII.

II. Background

Pilots are required to obtain and maintain an FAA Medical Certification to operate aircraft, and for those in commercial operations, it is a condition of their employment. Similarly, controllers are required to obtain and maintain an FAA Medical Clearance, and for those working in Air Traffic Organization (ATO), it is a condition of their employment. The impact of mental health conditions on pilot/controllers' ability to obtain and maintain medical certification/clearance is a growing concern within the aviation community.

In 2015, the FAA established the Pilot Fitness ARC (2015 ARC) to assess pilot mental health following the Malaysia 370 and Germanwings 9525 incidents.[2] The 2015 ARC found that the primary

[2] Pilot Fitness ARC Recommendation Report (faa.gov), November 2015.

factors that discourage reporting of mental health conditions are the stigma associated with mental health, the potential impact on the person's career, and fear of financial hardship.

In the ensuing years, the FAA acted on several of the 2015 ARC's recommendations, including expanding coverage of mental health issues in the training provided to AMEs in basic and refresher seminars; and encouraging Peer Support Programs (PSPs) organized by airlines and unions to provide mental health training to peer support volunteers. However, there remained much work to do, as noted by the Department of Transportation's (DOT) Office of the Inspector General (OIG) in their July 2023 report. [3] The OIG report found that although the FAA has comprehensive procedures to evaluate pilots' psychological health, the FAA's ability to mitigate safety risks is limited by pilots' reluctance to disclose mental health conditions. In response to the OIG's report and recent events highlighting pilot mental health concerns,[4] the FAA established the Mental Health ARC in December 2023 with taskings aimed at supporting the FAA's efforts to implement the OIG's recommendations. Specifically, the OIG recommended that the FAA:

- Collaborate with airlines, airline pilot unions, and the aerospace medical community to assess ways to address barriers that discourage pilots from disclosing and seeking treatment for mental health conditions, based on the latest data and evidence; and
- Develop and implement policy and protocol revisions recommended in the assessment.

The establishment of the Mental Health ARC is the FAA's response to both the OIG's first recommendation and recent high-profile incidents[5] related to pilot mental health. The ARC's work will also inform the FAA's efforts to address the OIG's second recommendation.

III. Aviation Rulemaking Committee (ARC) Comments

A part of the FAA mission is to regulate aviation safety, which includes medical certification of pilots and medical clearance of controllers. Recent events have heightened awareness throughout society of the risk of untreated mental health concerns of aviation safety professionals, including pilots and controllers (pilot/controller). Concurrent with the attention on recent events, the aviation industry has been calling for a major change in how the FAA manages pilot/controller mental health conditions.[6] The ARC believes that this change must include risk-based processes and pathways to allow for the non-prejudicial reporting, treatment, and safe return to operation for both pilots/controllers experiencing or diagnosed with mental health conditions. Improvements should also include greater accessibility to mental health education, treatment, and resources.

The Mental Health ARC Charter might inadvertently imply a direct link between the ARC's work and the future ability to mitigate safety risks associated with pilot/controller mental health issues in the National Airspace System (NAS). The ARC's influence on reducing safety risks in the NAS is significant, but indirect. The ARC expects that breaking down barriers for pilots/controllers to acknowledge, seek care/treatment, and report mental health concerns, will lead to increased reporting and certifications/clearances for healthy pilots/controllers to remain or return to the

[3] OIG Report and Recommendations (dot.gov), July 12, 2023.
[4] Navigating Mental Health in Aviation (ntsb.gov), December 2023.
[5] Malaysia Airlines Flight 370 or Germanwings Flight 9525.
[6] NTSB Mental Health in Aviation-Aviation Safety Summit, Dec 6, 2023. The summit's purpose was to examine the unintended consequences of the current system for evaluating mental fitness in the aviation workforce, identify how to better support those in the aviation industry, and ultimately make aviation safer for all.

workforce. Breaking down these barriers will then reduce the risk that an untreated pilot/controller enters or remains in the workforce without needed mental health care. However, the ARC's focus is on pilot/controller mental health literacy, wellness, and performance, rather than solely focusing on mitigating safety risks associated with specific past incidents. The ARC sees its' primary goal is to provide a strategy to enhance pilot/controller wellness, which, in turn, can lead to providing more accurate information for health-related decision-making, an improved safety culture, and better operational outcomes.

Pilots/controllers have been avoiding treatment for a variety of reasons. The Mental Health ARC identified seven overarching barriers to reporting and seeking treatment for mental health concerns (See section VII). The ARC then developed a set of recommendations intended to address the identified barriers that pilots/controllers face when dealing with mental health concerns.

The ARC notes that airlines, the FAA, Air Navigation Service Providers (ANSP), labor unions, regulatory bodies, pilot advocacy groups, business aviation, general aviation, the Aerospace Medical Association,[7] academia, and many other organizations (collectively and hereinafter aviation stakeholders), in conjunction with the international community have taken steps over the last several years to address mental health issues and wellness initiatives in the aviation community. These efforts have included:

- Public outreach via articles, symposia, webinars, podcasts;
- Review of existing science and regulatory policy;
- Updating policy to streamline issuance of certificates and clearances;
- Expanding peer support and wellness programs across aviation;
- Synchronizing international policy where possible; and
- Increased research initiatives and collaboration.

The ARC includes representatives and resources from all these aviation stakeholders to ensure that solutions are the result of the contribution and buy-in of all parties. These recommendations should be considered collectively to positively impact safety culture and emphasize the well-being of pilots/controllers and aviation stakeholders.

IV. Current Regulatory Landscape

The FAA Office of Aerospace Medicine (referred to as AAM) is responsible for a broad range of medical programs and services for the US and international aviation communities. As part of these responsibilities, AAM manages the medical certification program that issues medical certificates to pilots, or medical clearances to controllers as evidence of medical fitness. The medical certification process, which includes a physical exam and may include a general mental status evaluation,[8] contributes to keeping pilots, controllers, air travelers, and the general public safe. During this process, AMEs[9] and AAM personnel issue, defer, or deny applications for medical

[7] The Aerospace Medical Association (AsMA) is organized exclusively for charitable, educational, and scientific purposes. It is the largest, most-representative professional membership organization in the fields of aerospace medicine and human performance.
[8] 2024 Guide for Aviation Medical Examiners Item 47. Psychiatric Conditions.
[9] 14 CFR 183.21(c).

certificates in accordance with the relevant statutes, regulations, and guidelines. Applications deferred or denied by an AME are reviewed by AAM's Medical Certification Division (AAM-300) or a Regional Flight Surgeon (RFS). These offices may refer applicants with a significant medical history to the Medical Specialties Division (AAM-200) to determine the applicants' qualifications on behalf of the Federal Air Surgeon.[10] This is typically done for "dual diagnosis"[11] cases that involve comorbidities, such as substance abuse and Attention Deficit Hyperactivity Disorder (ADHD) or substance abuse and the use of Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants. AAM-200 also maintains and updates guidelines for evaluating pilot/controller qualifications for obtaining a medical certificate or clearance.

V. Industry Overview

In any given year, about 1 in 5 US adults has a diagnosable mental health condition, and more than 50% will experience some occurrence over the course of their lifetimes.[12] Most of these events are not severe, but there is a very real stigma associated with mental health conditions, especially in aviation, which can make it difficult to ask for help. This difficulty is one of the many reasons mental health events go unreported. In the US, less than half of people with a diagnosable mental health condition ever receive treatment.[13] The ARC collectively acknowledges similar concerns about untreated diagnosable mental health conditions across the aviation workforce. There are many obstacles between needing help and getting it, such as lack of education, stigma, access to mental health support, financial concerns, and job security — all of which bring more stress to a person that may already be struggling.

For many years, being honest about mental health struggles has been viewed within the aviation community as a risky endeavor. There is a misconception that reporting a mental health issue will result in permanent grounding for pilots, or permanent removal from duties for controllers. The fact is that the initial disqualification rate for all mental health diagnoses is ~20%,[14] meaning the pilot/controller is without certification/clearance until the disqualification is resolved. Only about 0.1% of applicants who disclose *any* health issue and complete the process are ultimately denied a medical certificate, and then only after an exhaustive attempt to "get to yes." However, "getting to yes" can be very time consuming, which may result in a significant financial penalty for the applicant even if the certificate/clearance is ultimately granted. The widespread belief in aviation is that you are, in effect, disadvantaged for following the disclosure rules. A system that incentivizes people to remain silent will cause pilots/controllers to avoid seeking help, leading to unacceptable safety risks.

Aviation is facing a challenging time. The effects of the pandemic still linger, and controllers and pilots in all types of operations are facing staffing issues, equipment, infrastructure, and technology issues, and increased overtime. The current strain on the aviation system and its workforce should not be underestimated. Everyone needs to feel safe seeking the mental health

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[10] 14 CFR Part 67.
[11] Dual diagnosis refers to the simultaneous presence of two or more diseases or medical conditions in a single patient.
[12] National Institute of Mental Health, Mental Health Statistics.
[13] The State of Mental Health America, 2023 Key Findings.
[14] *See* Appendix E Aeromedical Update. Remarks by Dr. Brett Wyrick, FAA Deputy Federal Air Surgeon. General Aviation Joint Safety Committee Meeting. August 30, 2023.

support that they need and deserve. Mental health issues do not affect those in aviation any differently than they affect others in safety-sensitive roles. The ARC intends its recommendations to be the foundation for a regulatory, policy, and cultural shift that will provide a safe space for pilots/controllers to seek treatment without the fear of losing their livelihoods.

The medical certification/clearance process, AME education and oversight, process timeline and transparency all need to be addressed. The ARC notes that there have been some recent improvements, such as expanding training in mental health issues provided to AMEs in the AME Basic and Refresher seminars and encouraging Pilot Peer Support programs organizations by airlines and unions,[15] but more needs to be done. The important thing to stress is creating an environment, a 'Culture of Wellness,' where aviation professionals seek help when any symptoms begin, and underlying conditions are treated before their health degrades.

US Healthcare System Concerns

The unique challenges in the US Healthcare System can make it more difficult to address the issues surrounding mental health in aviation. The paucity of mental health providers and their geographic dispersion present a significant challenge for those seeking mental health support. Depending on their specialty, some physicians may receive one month of psychiatry training in medical school and none after that. Similarly, depending on where they were educated, mid-level providers may be well-trained in treating mental health problems, while others will have no formal training. Even if an individual has a primary physician well-educated in treating mental health problems, the wait time for obtaining any health care appointments can be lengthy, with availability sometimes measured in weeks to months.

Furthermore, the US health insurance system typically only pays for "illness" if it pays at all. Parity for mental health care is still an issue, as outlined by the National Alliance on Mental Illness (NAMI).[16] Most typically, if someone seeks care for something that is not an "illness" (e.g., dealing with the death of a child, marriage counseling, or work stress), it is not covered by insurance. Consequently, individuals either need to pay out of pocket, or the provider ends up attaching a diagnosis code to an individual's bill so that the insurer will pay, resulting in the individual being labeled with an illness they may not actually have. This "upcoding" can be especially problematic for pilots/controllers with respect to recertification because they may have been "diagnosed" with a mental illness far more severe than what they were experiencing.

[15] Pilot Mental Fitness - Additional FAA Oversight (faa.gov).
[16] National Alliance on Mental Illness – What is Mental Health Parity?

VI. ARC Charter – Tasks and Objectives

The ARC was charged with several tasks in its Charter. Each task is briefly discussed below.

> ***TASK A – Identify factors that prevent individuals who hold FAA medical certificates or clearance from reporting mental health issues. Develop recommendations for actions that the FAA or other organizations should take to overcome or reduce the barriers.***

The ARC spent considerable time identifying the factors that hinder disclosure and developing recommendations to overcome or reduce them. These factors, or "Barriers," were consolidated into seven broad categories:

- Culture
- Trust
- Fear
- Stigma
- Financial
- Process
- Knowledge and Information Gap

The ARC membership recognizes that Culture, Trust, Fear, and Stigma are large overarching barriers that cannot be fixed with a single recommendation. These barriers and the associated recommendations are complementary and fundamentally interrelated. Implementing the recommendations associated with these barriers will set the stage for a seismic shift in how the industry perceives and manages the risks associated with mental health conditions. This shift in perception will take time and will only occur after the recommendations have been implemented, allowed to gain traction, and embraced by pilots/controllers. An awareness and education campaign with consistent and accurate messaging will be necessary to ensure we achieve our goals over time.

The ARC membership also recognizes that the Process, Financial, and Knowledge and Information Gap barriers can only be overcome with input, collaboration, education, and communication among all aviation stakeholders. The ARC notes that some of the work identified in these recommendations to address the barriers is already underway or can be implemented quickly. For example, the FAA has taken some steps to improve its electronic submission and transmission capabilities, but there remains a heavy reliance on hardcopy documentation and mailing packages of documents, so continued improvement of the electronic portals is needed. In other cases, implementing the recommendation will require significant time and effort, such as implementing the comprehensive recommendations for improved information systems described in REC 16. Most importantly, communication of such changes must be distributed throughout the aviation industry through every available avenue.

TASK B – Discuss and develop recommendations for how the FAA should address a mental health diagnosis.

Many of the barriers identified by the ARC involve the FAA's handling of mental health diagnoses. Fear of temporary or permanent certificate/clearance loss is the most prevalent and serious barrier identified. The ARC's view is that there is a widespread perception amongst pilots/controllers that the FAA's processes for adjudicating mental health cases are complicated, excessive, and inconsistent with accepted protocols and treatment practices. Moreover, in many cases, there does not appear to be an obvious relevant connection between the FAA's processes and flight safety. A recent study involving collegiate pilots showed that they have the perception that the FAA's current policies on mental health are restrictive and negatively impact their desire to seek out treatment.[17] These perceptions drive a lack of trust in the aeromedical certification process and present a barrier to pilots/controllers to seek and/or report treatment.

The ARC engaged the expertise of the operational community, academia, foreign CAAs, and the FAA to evaluate this tasking. A key theme of these discussions was creating a regulatory environment that encourages applicants to seek treatment while still assuring safety. The ARC recognized that in general, the overarching priority for the safety of the NAS should be to reduce the rate of healthcare-avoidant behavior. Although enhancements in message and culture can contribute to advancing this aim, they will lack effectiveness without substantial modifications to aeromedical standards and procedures.

The ARC is recommending several significant, risk-based reforms to aeromedical policy. These reforms are made with the recognition that treatment is the key benefit to the safety of the NAS, and that aeromedical evaluation is only one of many means of mitigating risks from a Safety Management System (SMS) perspective.

Among these recommendations are changes to reportability of treatment for certain conditions without fear of *immediate* revocation; reductions of the stabilization period for many medications; placing more decision-making authority in the hands of the AME; and allowing operational performance measurements to be used as part of certification assessments where appropriate.

The ARC also recommends that the FAA continually evaluate its standards and procedures against the latest research to ensure treatment practices are contemporary, and communicate the processes, expectations, and timelines to applicants in an easy and understandable manner.

The ARC recognizes AAM's important role in assuring the safety of the NAS via aeromedical evaluation of all safety-critical personnel in the system. The ARC's aim in addressing Task B is to utilize the authority and expertise of AAM within a system in which pilots/controllers feel secure in their ability to seek appropriate treatment, and in turn, trust the system to treat them fairly.

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[17]Stein, Laila, "Mental Health in Aviation: A Study of Aviation Students on Their Perceptions of the Federal Aviation Administration's Rules Governing Mental Health" (2023). *Honors Theses*, 3674.

TASK C – Develop recommendations for steps that the FAA may take to mitigate aviation safety issues during the time between the disclosure of a mental health diagnosis by a pilot or an FAA air traffic controller and the subsequent issuance of an aeromedical decision by the FAA.

To mitigate the safety risks that may arise between the identification, disclosure, and treatment of a mental health symptom/diagnosis, the ARC provides individual recommendations to address each barrier outlined in this report. Further, the ARC acknowledges that aeromedical certification is only one risk control among many that can limit the potential hazards related to pilot/controller mental health. Other risks are specific to operational environments, including automation, recurrent training, periodic flight reviews, multi-pilot operations, crew resource management, and other emergent technologies. The ARC recommends that the FAA investigate whether current control measures achieve acceptable levels of risk related to pilot/controller mental health and assess newer measures using SMS tools as outlined in many of the ARC's Recommendations.

The purpose of mental health screening is to ensure that hazards related to pilot/controller mental health do not create an undue risk or adverse event within the NAS. The FAA's aeromedical certification process is the primary tool currently employed to ensure medical hazards are controlled, including mental health hazards. This process where pilots/controllers report symptoms, diagnoses, or use of medical services could result in certificate/clearance loss and grounding/removal from operations. Task C focuses on mitigating safety hazards during the time between disclosure and certification/clearance. However, this assumes that the pilot/controller actually reported the mental health concern in the first place. The ARC contends that non-reporting of mental health concerns is also a risk to the NAS that must be addressed as there are several factors impacting non-reporting and ultimately safety. These include barriers related to pilot/controllers' ability to:

- Identify symptoms (i.e., Culture, Knowledge),
- Seek mental healthcare services to address those symptoms/diagnoses (Culture, Fear, Knowledge, Stigma); and
- Report symptoms/diagnoses during aeromedical certification (Fear, Financial, Process, Trust).

TASK D – Review how other civil aviation authorities address pilot and air traffic controller mental health issues and develop recommendations for best practices that the FAA should adopt.

The ARC reviewed aviation mental health practices from CAAs in Australia, Canada, China, Europe, India, New Zealand, Singapore, the United Arab Emirates (UAE), and the United Kingdom (UK). Additionally, the Chief Medical Officers from the Civil Aviation Safety Authority of Australia (CASA), Transport Canada (TC), the European Aviation Safety Authority (EASA), and the Civil Aviation Authority of New Zealand (CAA NZ) participated in the ARC's Medical Working Group with frequent and valuable inputs.

The ARC's Recommendations were developed with consideration of international policies on mental health from other CAAs, as well as guidance from the International Civil Aviation Organization's (ICAO) Standards and Recommended Practices (SARPs). Annex 1 of the ICAO SARPs delineates common standards,[18] and the ICAO Manual on Civil Aviation Medicine (Document 8984)[19] contains detailed descriptions of a spectrum of mental health conditions and the use of medications. Document 8984 was published in 2012 and is currently being rewritten. Several members, observers, and participants of the ARC's Medical Working Group are contributing to the new edition.

Chapter 9 of Document 8984 addresses the use of medication and provides that:

> *"States' certification of pilots and controllers taking medications accepted by the Licensing Authority should be conditional on the following:*
>
> a. *The applicant should be under the care of a medical practitioner experienced in the management of depression.*
> b. *The applicant should:*
>
> *1. be stable on an established and appropriate dose of medication for at least four weeks before returning to flying/controller duties and exhibiting:*
>
> *i. minimal, acceptable side-effects.*
> *ii. no medication interactions or allergic response.*
>
> *2. be subject to regular clinical review by the medical practitioner with progress reports provided to the medical section of the Licensing Authority. The applicant may be involved in other concurrent treatment (e.g. psychotherapy).*
> *3. have no other significant psychiatric co-morbidities.*
> *4. require no other psychoactive medications.*
>
> c. *demonstrate symptoms of depression being well controlled, without evidence of psychomotor retardation.*
> d. *have no suicidal ideation or intent.*

[18] ICAO SARPS Annex 1 – Personnel Licensing, Chapter 6, Medical Assessments.
[19] ICAO Manual of Civil Aviation Medicine (Document 8984), Chapter 9, Mental Fitness.

e. *have no history of psychotic symptoms*.
f. *have no features of arousal (e.g. irritability or anger)*.
g. *have a normal sleep pattern*.
h. *have resolution of any significant precipitating factors of depression*.
i. *ongoing cognitive-behavioral, rational-emotive or similar therapy is desirable, but not necessarily required for certification*.

EASA's publications on Mental Health in Aviation Safety (ME SAFE)[20] published in 2023 and 2024 also contain extensive research, recommendations, and rationale regarding mental health diseases, assessment, treatment, certification, and surveys of pilot, controller, and aviation medical assessors' experiences with aviation mental health issues.

CASA and CAA NZ have also drafted a Safe Haven Pathway to encourage certificate holders to seek help and self-disclose mental health problems. The Safe Haven Pathway provides support and the opportunity to remain on duty while participating in the assessment process. The intent is to "develop a safety culture that enhances help-seeking for and self-disclosure of mental health and other problems."[21]

Tables 1 and 2 below illustrate evolving trends in the certification of pilots/controllers who use medication to treat mental health conditions. The ARC specifically notes there are significant differences between FAA requirements and other countries' CAAs for:

- Consideration and authorization of categories and types of medications.
- Observation periods to demonstrate stability once medication is started or dosage is changed (notably the US and Singapore CAAs observation times for anti-depressants exceed other referenced CAAs, see Table 1).
- Use of neuropsychological testing (e.g., other CAAs only use neuropsychological testing in cases of significant co-morbidities or operational deficiencies).
- The use of peer support committees with an independent mental health provider working directly with the pilot/controller to determine fitness to return to duty after initiation of treatment without prior clearance by the CAA.
- Operational observations to assist in safety and fit-to fly determinations.
- Mental health literacy training and education for safety sensitive personnel, especially those with self-identified mental wellness stressors.

The ARC also highlights some unique practices in the US and some recent changes to FAA policies. For example, under the original 2010 special issuance procedure, a minimum twelve-month period (later reduced to six months)[22] on a single dose of one of the allowed medications was required, along with satisfactory completion of annual neuropsychological testing and semi-annual psychiatric assessments (among other requirements). Similarly, a change in the medication dosage required an additional six-month observation period, during which certification was invalid,

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[20] European Union Aviation Safety Agency 2025 – Medical.
[21] *See* Appendix C – CASA and CAA NZ draft policy – Safe Haven Pathway.
[22] Durham, J., & Bliss, T. (2019). *Depression and Anxiety in Pilots: A Qualitative Study of SSRI Usage in U.S. Aviation and Evaluation of FAA Standards and Practices Compared to ICAO States*. Collegiate Aviation Review International, 37(2), 78-109. Retrieved from http://ojs.library.okstate.edu/osu/index.php/CARI/article/view/7908/7304.

and recertification could not be considered.[23] However, in 2023, the FAA removed the requirement for *annual* neuropsychological testing after initial certification for most cases. The FAA's decision was based on an internal follow up study[24] that showed that in the absence of clinical findings, repeat neurocognitive testing did not influence the ultimate decision to renew a special issuance. The FAA found that 20% of initial certifications in this sample were impacted by neuropsychological testing results in some way, but further study needs to be conducted reviewing a population of all-comers for initial certification. Also in 2023, the FAA allowed another antidepressant, that was not an SSRI,[25] to be used by pilots/controllers to treat depression. This newly approved medication is in addition to the four SSRIs that the FAA allowed in 2010 for depression and certain other medical and psychiatric conditions under the special issuance procedure requirements that were in place at that time. As illustrated below, these recent changes in policy regarding certain antidepressants are consistent with international trends.

[23] Guide for Aviation Medical Examiners Item 47. Psychiatric Conditions.

[24] The study was based on 12 years of clinical data and review. The FAA was resource limited, but the addition of specialist staff enabled completion of the study. The ARC commends the FAA in its efforts to proactively manage applicants with unique issues and notes that additional resources would be helpful in this regard, specifically with respect to initial certification as well as with recertification.

[25] *See* Airman Information - SSRI Initial Certification, FAA Certification Aid for SSRI Initial Certification, and FAA Certification Aid – SSRI Recertification/Follow Up Clearance.

Tables 1 and 2 - Differences in Approach for Pilot Antidepressant Use

Table 1 - FAA/CAA Approval Process*

Agency	Time Grounded	Initial Monitors	Additional Follow-Up	Neurocognitive Testing
FAA	Min. 6 months	HIMS AME + Board Certified Psychiatrist + Treating Physician (if not board cert psychiatrist) + Chief Pilot/Air Traffic Manger (1st & 2nd class only) + Additional providers	HIMS AME (every 6 months face-to-face / every 1-3 months virtual) + psychiatrist every 6 months) Chief Pilot/Air Traffic Manger (every 3 months) + Additional Providers	Initial Certification ALL Follow-up - every 12 months (limited number of cases if clinically indicated)
UK CAA	Min. 1 month (2 on fluoxetine)	GP and CAA Specialist Advisor in Psychiatry[1]. "Buddy" reports.	Initially every 3 months. Can change	None
CAA NZ	Min. 2-4 weeks	GP, Psychiatrist, or Psychologist. Chief pilot or fleet manager	Periodic follow-ups.	None*
CASA	Min. 2-4 weeks	GP. Psychologist, or Psychiatrist[1]	Not specified	None*
EASA	Min. 4 weeks. Realistiically 3 months	Mental health care provider and ocupational physician[2] Family member contact.	Not specified	None
TC	Min. 4 months	GP and Psychiatrist[1]	Every 6 months.	None
GCAA UAE	Min. 4 weeks	Treating Psychiatrist, Secondary Psychiatrist	Initially monthly. Can change.	Psychometric
CAA Singapore	Min. 6 months	Treating Psychiatrist, CAAS Physician	Every 3 Months	None

*Data accurate as of March 30, 2024

[1] If deemed necessary.

[2] If applicable/available.

Table 2 - FAA/CAA Antidepressant Medication Approvals*

Name	Type	FAA	CAA Singapore[1]	UK CAA	CAA NZ	CASA	EASA
Fluoxetine (Prozac)	SSRI						
Sertraline (Zoloft)	SSRI						
Citalopram (Celexa)	SSRI						
Escitalopram (Lexapro)	SSRI						
Paroxetine (Paxil)	SSRI						
Fluvoxamine (Luvox)	SSRI						
Bupropion (Wellbutrin)	Aminoketones				Not Licensed in New Zealand	Not Licensed in Australia	
Mirtazapine (Remeron)	Atypical Tetracyclic						
Venlafaxine (Effexor)[2]	SNRI						
Desvenlafaxine (Pristiq)[2]	SNRI						
Duloxetine (Cymbalta)[2]	SNRI						
Amitriptyline (Elavil)	Tricyclic						
MAO Inhibitor	MAO Inhibitor (All)						

*Data accurate as of March 30, 2024

[1]CAA Singapore considering Vortioxetine

[2] FAA Approval Expected April 2024

Green = Allowed

Yellow = Case-by-case basis

Red =Not Allowed

TASK E – Discuss and develop recommendations for mental health education programs for individuals who hold medical certificates or clearances that the FAA and the aviation industry could implement to improve awareness and recognition of mental health issues, reduce stigmas, and promote available resources to encourage voluntary self-disclosure in a confidential and protected environment, and assist with resolving mental health problems.

Task E provides the ARC its greatest opportunity to correct misinformation, narrow information gaps, improve the overall mental health literacy of pilots/controllers and begin the work to effect a change to the cultural barrier to mental health reporting. This task is widely seen as the direct continuation and development of Recommendation 4 from the 2015 Pilot Fitness ARC Report,[26] and is expected to have the most significant and lasting impact on the aviation ecosystem. Consistent with that effort, the Recommendations in this report are intended to expand mental health education beyond what is already occurring at Part 121 air carriers. The goal is for the Recommendations to be adapted to every type of aviation operation, coupled with increased efforts to better engage with multi-generational aviation stakeholders. Specific attention should be given to the various ways that different generations acquire, share, and use information to ensure effective outreach for a range of target audiences.

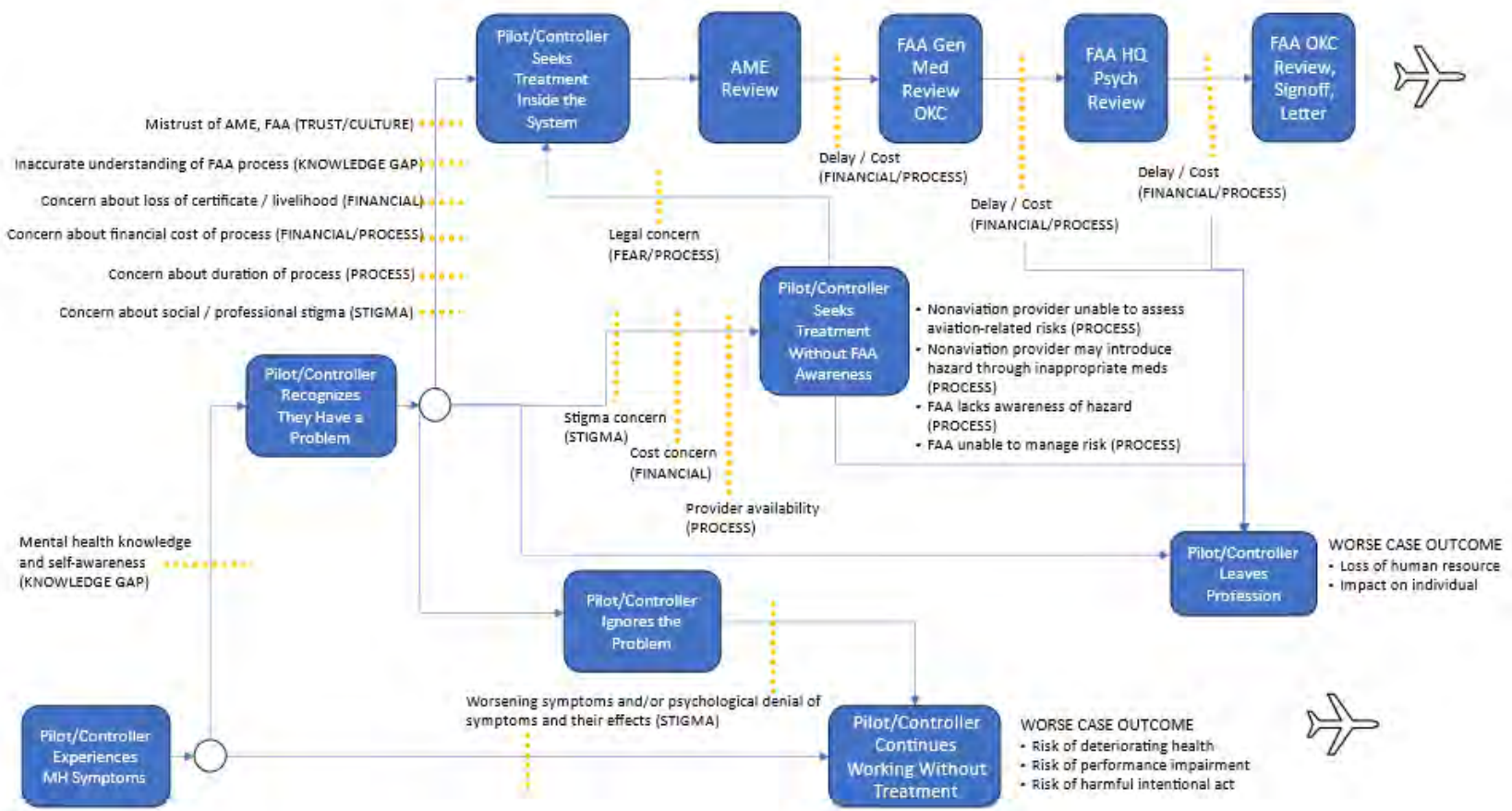
All aviation stakeholder groups should be party to the development, distribution, and marketing of this new aviation mental health education paradigm. This will require a coordinated effort to effectively address the different sectors of the aviation community and engage with its various member groups. Although this ARC does not detail the program specifics of this outreach, it remains ready to assist in the creation of a precise communication plan, cohesive strategy, and effective distribution methods of mental health education for aviation stakeholders. Continuing this work is crucial for the sustained success of transforming the mental health culture in the aviation sector.

[26] *See* Pilot Fitness ARC Recommendation Report (faa.gov) Recommendation 4. AIR CARRIER EDUCATION Air carrier operators should be encouraged to implement mental health education programs for pilots and supervisors that improve awareness and recognition of mental health issues, reduce stigmas, and promote available resources to assist with resolving mental health problems. Rationale: Improved mental health literacy is associated with earlier reporting and improved treatment outcomes.

VII. Barrier Narratives

The following section contains narratives that help define the full meaning of each identified barrier that pilots/controllers face as they confront the challenges of a mental health condition.

Figure A: Mental Health Process Flowchart & Identified Barriers



A. Culture

There exists a prevailing culture within the aviation industry that contributes to the problem of not reporting medical disorders, particularly those linked to mental health. This cultural barrier feeds off fear and distrust. The fear of losing one's job, career, income, certification, professional reputation, potential prosecution, and bearing the associated stigma of these outcomes can push aviation professionals to hide mental health symptoms or conditions. Pilots/controllers are specifically trained to deal with complex emergencies as a team; however, when faced with a mental health issue, they often try to handle it alone.

Another facet of aviation Culture further exacerbating the problem with reporting is distrust in the FAA's aviation medical process. Much of the distrust is fueled by a lack of information or misinformation about FAA policies and processes. This is manifested, not only through a lack of reporting, but also through individual healthcare-avoidance and/or firewalling of physical and mental health information. Firewalling is a term used when medical concerns, treatment, and records are kept separate and not reported to the FAA on an individual's medical application or discussed with the AME. There is also a lack of mental health literacy within the aviation community that creates a sense of apprehension and further contributes to a culture of healthcare avoidance. Many people believe the FAA requires extreme evaluations and assessments for any disclosed mental health issue. Some of that distrust is understandable given the current concerns with the medical certification program; and those concerns are heightened by anecdotal tales of pilots/controllers that have experienced long and complicated journeys to return from an injury or illness. Moreover, pilots/controllers are apprehensive to talk about conditions related to mental health issues across their entire spectrum of professional interactions. Whether they're talking with fellow pilots/controllers, friends, managers, AMEs, or other medical professionals, fear tends to drive these conversations underground, resulting in non-reporting and a reluctance to seek help.

The culture of the professional aviator and controller has evolved over multiple generations to be one of strength, resilience, and decisiveness; but multiple generations of pilots/controllers have also encouraged firewalling of information, perpetuating a culture of healthcare avoidance for new aviators. Moreover, many pilots/controllers' sense of self-worth is attached to their job, position, and professional reputation. Anything that suggests or even hints at a potential weakness may be met with a lack of acceptance within the aviation community and further discourages one from seeking help.

The Culture barrier to mental health reporting is the most wide-ranging barrier that will require the greatest effort to overcome. All aviation stakeholders will need to work together to make sustainable and meaningful change. To overcome the Culture barrier, all other barriers must be removed. As challenging as this may seem, the aviation industry has repeatedly demonstrated the ability to affect culture change through programs designed to benefit the overall safety of the NAS.[27]

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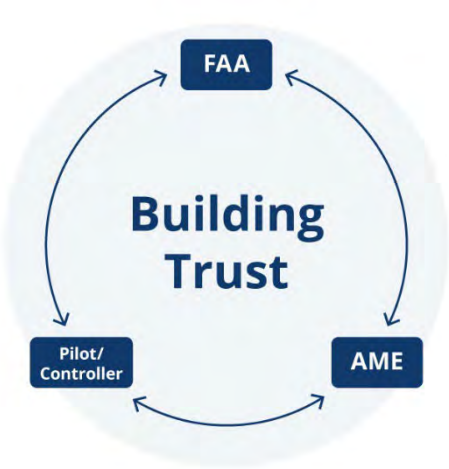
[27] *Examples include*: NASA Aviation Safety Reporting System, FAA Aviation Safety Action Program, FAA Human Intervention Motivation Study. These programs have greatly increased the aviation reporting culture and benefited the safety of the NAS.

B. Trust



Trust requires open communication, shared expectations, transparency with a commitment to reliability, and credibility by all parties. Justified or not, pilots/controllers lack trust that the FAA will manage the medical certification application process fairly and in a timely manner. This lack of trust is largely attributed to a perceived broad criterion for what is considered a safety risk related to mental health (i.e. imprecision), the inconsistent application of those criteria, and administrative inefficiencies. The current FAA aeromedical process is a principal barrier impeding healthcare-seeking behaviors and the reporting of mental health conditions. The Trust barrier, however, is a much larger systemic issue involving the FAA, AMEs, and aviation medical certificate/clearance holders.

Trust is built over time through consistent behavior, and if not carefully guarded, can easily be destroyed. Stories of pilots/controllers who have come forward to report a mental health concern or diagnosis when the FAA, the AME, the pilot/controller's doctor, or employer did not handle the situation in an effective manner spread quickly throughout the aviation community. These stories contribute to the lack of trust in the medical certification system, and further serve as a barrier to pilots/controllers getting the help they need and reporting mental health issues during FAA medical evaluations.

<u>FAA</u>

With respect to the ARC's work, the largest trust issue exists between pilots/controllers and the FAA. In many cases, there is an overlap between trust and other barriers identified in this report, including: the perception that FAA excessively scrutinizes a particular medical condition (Stigma), the costs involved with FAA-mandated procedures or testing to achieve recertification/clearance (Financial), and the time required to resolve a medical issue to the FAA's satisfaction and return to duty (Process). The challenges, complexities, and lack of transparency with the FAA-defined processes for a given mental health condition contribute to a lack of trust in the relationship between pilots/controllers and the AME, further straining the interface between the pilot/controller and the FAA.

Aviation Medical Examiner

Similar to the FAA concerns stated above, a pilot/controller's lack of trust in the AME is demonstrated by a reluctance to report symptoms or conditions due to concerns about how the AME's response might impact their medical certificate/clearance. The lack of trust is due to variations in AMEs' experience, administrative capability, application and understanding of FAA policy and procedures, and an unwillingness to engage with harder cases. Additionally, AMEs who need guidance or have questions during an appointment, are often unable to reach the FAA physician on duty during the exam, which can lead to a delay in issuance of a certificate/clearance or a deferral.

FAA technological limitations and AMEs limited administrative capabilities can slow the certification or recertification process due to the extensive documentation required. An AME presented with a mental health case must be prepared and willing to take the additional time required to navigate the application process. AME duties are typically only a fraction of most AMEs primary medical practice as most AMEs have other clinical practices. Any additional time required to process a complicated pilot/controller case involving mental health concerns comes at a cost to the primary practice, which the AME may not be willing to absorb.

This AME variability creates a challenge for the applicant in finding and choosing a suitable AME. Each time an application is deferred, or a pilot/controller must find a new AME, the associated Fear, Stigma, Financial, and Process barriers again come into play.

The Medical System

There is an underlying patient trust challenge in the US healthcare system. For many reasons, some people do not like meeting with a medical provider, and research has shown that when encountering a mental illness, most people opt for self-help or turn to friends and family, rather than mental health professionals.[28] In addition, concerns about affordability, payment options, healthcare inequities, and lack of access to timely, high-quality care negatively impacts patient trust in the US healthcare system. [29]

Trust is highest between a patient and provider with an established therapeutic relationship. In the aviation framework, the pilot/controller has the highest level of trust with their personal treating provider, be that a primary care physician or mental health provider. The primary care provider is also likely to have had greater patient contact with the applicant and is best positioned to observe how the applicant is responding to medication.

A pilot/controller may have, or gain, a limited level of trust with their AME depending upon the reputation of the AME, the experience of a pilot/controller during their visits, and the relationship developed during the certification/clearance visits. Trust can be difficult to establish between a pilot/controller and a HIMS psychiatrist or HIMS trained neuropsychiatrist performing an evaluation on behalf of the FAA.

[28] Lien YJ, Chen L, Cai J, Wang YH, Liu YY. The power of knowledge: How mental health literacy can overcome barriers to seeking help. Am J Orthopsychiatry. 2024;94(2):127-147. doi: 10.1037/ort0000708. Epub 2023 Nov 2. PMID: 37917500. (Lien et al., 2023).

[29] *See* discussion above at Section V. – Industry Overview.

The most challenged relationship for Trust is between the regulator (FAA) and the individual pilot/controller due to the lack of a physician-patient relationship or in-person interface, and the inherent conflict between the applicant and the agency that judges the application.

Primary care providers (e.g., family physicians, internists, physician assistants, or nurse practitioners), undergo mental health training and are authorized to treat patients, including prescribing antidepressant medications. Pilots/controllers have the most Trust in these providers and often seek help on these issues. However, current FAA policies on antidepressant use require a clinical finding summary from both the primary care provider and a board-certified psychiatrist.[30] Having to meet with a new and unfamiliar healthcare provider (psychiatrist) can increase the applicant's apprehension or anxiety.

Misdiagnosis of mental health conditions by medical, paramedical, or mental health professionals, as well as diagnostic escalation to support better insurance reimbursement for treatment providers, create many problems for aviation professionals. Moreover, the FAA's approach to clarifying a diagnosis involves seeking a second assessment from a mental health specialist with acceptable qualifications. This approach frequently entails a substantial financial burden for the pilot/controller or company and creates delays in receiving proper treatment or useful medications that could help alleviate symptoms and improve performance.

In addition, the FAA's certification standards stipulated in 14 CFR Part 67 are different from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). As a result of these differences, the FAA encourages, and occasionally requires, pilots/controllers to seek evaluation from mental health professionals who have completed specialized FAA training to render a complete psychological diagnostic evaluation, according to accepted standards of clinical care and regulatory requirements. In some cases, diagnoses can get lost in translation between 14 CFR Part 67 and DSM-5-TR, and errors and omissions can occur in testing and documentation. Sometimes mental health professionals attempt to provide a regulatory diagnosis and/or safety recommendation that is outside of their scope of practice or experience. If an accurate DSM-5-TR diagnosis is provided, the FAA then continues with the regulatory diagnosis and safety risk assessment. It is common for mental health professionals to provide both clinical and regulatory diagnoses along with safety recommendations that may conflict with each other. These situations lead to greater time spent reviewing the case file, often requiring an FAA psychiatrist to 'correct the record'. These issues often result in delays in recertification/clearance that further compromise the trust between the pilot/controller and the specialist.

Employer

Trust issues can also arise between a pilot/controller and their employer over the management of the medical certificate/clearance holder's interests. An employer may have an inherent conflict between prioritizing the well-being of the individual and ensuring safety and operational responsibilities. Unlike pilots, the FAA is most often an air traffic controller's employer and medical clearance authority, making that relationship unique. This dynamic creates a challenging balance for the FAA as an employer.

[30] *See* FAA Certification Aid for SSRI Initial Certification.

The Process

Lastly, the medical certification process can also breed distrust. The process disincentivizes honesty due to the often-immediate grounding/removal from duty until recertification/clearance from the FAA is received. The *MedXPress* User's Guide[31] and the 8500 Form Help Instructions[32] have conflicting guidance regarding when medical professional visits must be reported (e.g., family/marital counseling, or life coaching).[33] Individuals may also have privacy concerns about sharing personal information with the government, their employer, or a training organization that may be required for mental health visit reporting. Likewise, the requirement to report conditions that "have you ever in your life"[34] had, as opposed to reporting the transient nature of mental health symptoms, can seem excessively conservative to a pilot/controller. Psychological avoidance[35] is common in pilots/controllers' action-oriented culture making them less likely to address known mental health issues. The perceived or actual consequences of reporting a mental health condition/medication that was not previously reported can make the process seem unfair and punitive, which further erodes trust.

C. Fear

Fear is the driving emotion behind both pilots/controllers' decisions to not disclose a mental health issue. Current data suggest that fear, anxiety, and avoidance in seeking health care is due to the fear of loss of medical certification/clearance.[36] This is common in pilots/controllers, which can negatively impact individual health, aeromedical screening, and ultimately the safety of the NAS.[37]

The pilot/controller's fears are further fueled by aeromedical decisions that appear to be subjective. Pilots/controllers are aware of the small numbers/percentages of individuals who are not recertified and are often left without a clear understanding of 'why' a medical certification/clearance was not granted. For the individual, certain questions can be daunting and may stoke fear that it's too risky to disclose the condition or treatment, such as, *Can I fly with this diagnosis? What treatments are allowed? Will they work? If I disclose my condition and my medical was deferred, what would be required, how much would it cost, and how long would it realistically take to return to duty?* As stated previously, pilots/controllers often see themselves and their profession as inseparable. Thus, losing their medical certification/clearance is a loss of both career and identity. This would be devastating for anyone, and even more so for goal-driven individuals like pilots/controllers.

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[31] *See* FAA *MedXpress* Users Guide.
[32] *See* FAA *MedXpress* Instructions for Completing the Airman Medical Certificate Application, FAA Form 8500-8.
[33] *See also* Appendix D.
[34] *Supra* note 32.
[35] Definition of *Psychological Avoidance*: by admitting a mental health concern, there is a personal realization that one must address it, therefore leading to the natural defense mechanism of denial of the issue.
[36] Hoffman WR, Aden J, Barbera RD, Mayes R, Willis A, Patel P, Tvaryanas A. (2022). *Healthcare Avoidance in Aircraft Pilots Due to Concern for Aeromedical Certificate Loss: A Survey of 3765 Pilots*. J Occup Environ Med. 64(4):e245-e248. doi: 10.1097/JOM.0000000000002519. Epub 2022 Feb 15. PMID: 35166258.
[37] *Id.*

While we tend to look at pilots/controllers as a homogeneous group, healthcare avoidance behavior due to fear of loss of certification is not uniform. In fact, the data[38] suggest unique subpopulations within these groups face uniquely high rates of healthcare anxiety and avoidance, including young, female, and student pilots, when compared to other populations. These data suggest subpopulations may face unique barriers, which may become more pressing as the aviation workforce becomes increasingly diverse.[39]

Further, if a pilot/controller chose to conceal a mental health condition, the fear of potential certificate action, enforcement, or disciplinary action may further deter the individual from future disclosure. The specter of criminal or civil penalties because of a legal enforcement action, the possibility of certificate actions or permanent medical disqualifications, and/or the threat of disciplinary actions for violations of employer policies create a fraught landscape and plays a key role in pressing the pilot/controller to keep any underlying mental health condition hidden.

One tool to combat Fear is education, and an overarching goal of the ARC's Recommendations is to combat misinformation, improve transparency surrounding the aeromedical certification process, and build a culture of Trust so that pilots/controllers will report their mental health concerns and seek the help they need without Fear of negative impact to their livelihood and careers. This will place a priority on wellness and enhance the overall safety of the NAS.

D. Stigma

Stigma refers to the notion of having a defect or imperfection due to a personal or physical trait that is considered socially unacceptable, leading to feelings of embarrassment, shame, and fear of judgement.[40] Internalized stigma and public stigma associated with mental health issues have contributed to unfavorable attitudes about seeking psychological help.[41] Particularly within the aviation community, mental health stigma is a pervasive barrier that often has profound implications for pilots, controllers, and other aviation professionals.[42] Research suggests that stigma is associated with lower intentions to seeking help, decreased rates of accessing information about resources and services, and lesser use of counseling services.[43]

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[38] Hoffman WR, Barbera RD, Aden J, Bezzant M, Uren A. (2021). *Healthcare related aversion and care seeking patterns of female aviators in the United States*. Arch Environ Occup Health. 2022;77(3):234-242. doi: 10.1080/19338244.2021.1873093. Epub 2021 Feb 3. PMID: 33533702.

[39] *Id*.

[40] Corrigan P. *How stigma interferes with mental health care*. Am Psychol. 2004 Oct;59(7):614-625. doi: 10.1037/0003-066X.59.7.614. PMID: 15491256. (Corrigan, 2004); Vogel, D. L., Wade, N. G., & Haake, S., *Measuring the self-stigma associated with seeking psychological help*. Journal of Counseling Psychology, 53(3), 325–337. (Vogel et al. 2006).

[41] Williston SK, Vogt DS. *Mental health literacy in veterans: What do U.S. military veterans know about PTSD and its treatment?* Psychol Serv. 2022 May;19(2):327-334. doi: 10.1037/ser0000501. Epub 2021 Mar 18. PMID: 33734727. (Williston & Vogt, 2022).

[42] Santilhano, Wendy, Robert Bor and Lia M.M. Hewitt. (2019). *The Role of Peer Support and Its Contribution as an Effective Response to Addressing the Emotional Well-Being of Pilots*. Aviation Psychology and Applied Human Factors.

[43] Vogel et al. *Stigma of Seeking Psychological Services: Examining College Students Across Ten Countries/Regions*, The Counseling Psychologist, sagepub.com/journalsPermissions.nav, doi: 10.1177/0011000016671411 journals.sagepub.com/home/tcp. (Vogel et al. 2017)

Pilots/controllers often worry that disclosing mental health concerns will jeopardize their careers or stunt career growth and professional credentialing, leading to discrimination, loss of employment opportunities, or damage to their standing within the industry. This could result in a pilot/controller not seeking help and/or reporting until after their symptoms are already moderate or higher in severity. The phenomenon known as reverse malingering, which is presenting oneself as healthy as possible or "faking good," further complicates the psychological assessment of what true impairment the applicant had or is having. Research has also shown that individuals with mental illness may internalize stigma leading to reduced self-esteem, reduced self-efficacy, and lower confidence in their future.[44] Promotion of mental health concerns, such as a Pilot/Controller Mental Fitness campaign, can further intensify Stigma, especially if this promotion is not part of broader awareness and educational efforts. Additionally, the existing FAA regulations tend to address mental health problems using a standardized approach that is more appropriate for severe psychiatric disorders. The current aeromedical screening process does not account for varying levels of impairment associated with different mental health conditions, which can be problematic for a pilot/controller seeking help with only mild or mild/moderate mental health concerns. Moreover, the current understanding of disqualifying mental health issues among pilots/controllers is limited, leading to anxiety and the perpetuation of Stigma within the sector.[45]

Under current FAA policy, AMEs are limited in the types of mental health conditions where they are allowed to issue a medical certification/clearance. There are FAA standards and guidelines regarding when an AME may issue; however, these standards/guidelines lack sufficient specificity for them to be applied in a uniform manner. This can result in different outcomes for pilots/controllers based upon the willingness of an AME to issue versus deferring a medical certificate/clearance.

The FAA has made some progress by defining several mental health-related situations where an AME can issue a certificate during the exam via the FAA's **C**onditions **A**MEs **C**an **I**ssue (CACI) process. The ARC believes the FAA could expand use of CACIs for mental health concerns, where appropriate. The FAA should recognize the spectrum of mental health conditions and the varying degrees of impairment they may cause. Additional measures should be implemented to prevent any undue and disproportionately adverse impact on pilots/controllers. Transparency from the FAA may include developing clarity within a disease spectrum to identify impairment issues that lead to medical certification deferrals and/or loss of license. This can lead to reduced Stigma by differentiating severe symptoms/states from transient/temporary symptoms.

The disparity in social perception and medical treatment between physical and mental health issues further contributes to Stigma. Pilots/controllers are also aware of the vast difference in the way mental health issues are treated in aviation when compared to other safety sensitive industries. As an example, other high-risk, high-reliability occupations do not face mandatory wait

[44] Corrigan. (2004).
[45] *See also* Knowledge and Information Gap Barrier discussion at Section VII.G. below.

times following the disclosure of mental health conditions or when starting/changing antidepressant medications.[46]

Moreover, the FAA mandates a six-month wait time when starting/changing an approved antidepressant or following a change in dose. While it is true that other professions have requirements to reveal mental health conditions, treatment, or the use of medications (usually for initial or recurrent state board licensing, or occupation-specific regulations and standards), this disclosure typically does not result in an interruption to the person's ability to remain in an active work status. Even if it does, a return to normal duties is based on the person's behaviors (not a specified timeline), and typically occurs within a much shorter window than six months. In some cases, the person may be given an alternate temporary assignment while addressing the mental health condition or medication. These arrangements are handled on a case-by-case basis, but these options are not always available to pilots/controllers. These examples highlight the extent to which pilots/controllers perceive that they are held to a much more stringent standard and may feel stigmatized by their mental health condition.

The ARC recognizes that managing conditions associated with anxiety and/or depression are challenging. This affects many pilots/controllers, particularly younger applicants who are more likely to acknowledge anxiety and depression due to generational changes, greater awareness and social acceptability. The ARC also notes the increasing number of young people that have been diagnosed with neurodevelopmental disorders[47] like ADHD who are considering careers in aviation. Specifically, the diagnosis, and perhaps over-diagnosis, of ADHD and the subsequent medication for that diagnosis is an issue of concern. Under current FAA regulations, pilots/controllers are disqualified when being treated for ADHD or taking any ADHD medication. The ARC encourages the FAA to explore how safety can be maintained while allowing pilots/controllers managing an ADHD diagnosis with medication to maintain their certification/clearance.

Addressing mental health Stigma in the aviation community requires a multifaceted approach that includes education, advocacy, and policy reform. Future initiatives should come from an institutional and organizational structure that encompasses all aspects of aviation and promotes improvement processes throughout the sector. One such approach may include peer-led mental health literacy education. Peer educators (PE) offer a mechanism for working directly with pilots/controllers. By providing relevant information from a trusted source and improving attitudes about mental health treatment, PEs may serve to reduce the impact of internalized stigma as a

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[46] Henderson, Williams, *Mental Health and Final Security Clearances*, Mar 29, 2022, noting that federal form SF-86 (Questionnaire for National Security Positions) states that *"[m]ental health treatment and counseling, in and of itself, is not a reason to revoke or deny eligibility for access to classified information or for holding a sensitive position, suitability or fitness to obtain or retain Federal or contract employment, or eligibility for physical or logical access to federally controlled facilities or information systems. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably to decisions about your eligibility."*

[47] Mullin AP, Gokhale A, Moreno-De-Luca A, Sanyal S, Waddington JL, Faundez V. Neurodevelopmental disorders: mechanisms and boundary definitions from genomes, interactomes and proteomes. Transl Psychiatry. 2013 Dec 3;3(12):e329. doi: 10.1038/tp.2013.108. PMID: 24301647; PMCID: PMC4030327. Neurodevelopmental disorders (NDDs) are multifaceted conditions characterized by impairments in cognition, communication, behavior and/or motor skills resulting from abnormal brain development. Examples include ADHD and autism spectrum disorder.

significant barrier to service utilization.[48] In addition, reducing Stigma can be achieved by offering a confidential, caring, and trustful relationship with peer volunteers, who provide accurate and reliable information through credible mental health resources.[49]

Further Stigma reduction can be accelerated by anti-Stigma campaigns and clear messaging to differentiate between mental illness and pilot/controller mental fitness. Research suggests that implementation of strategies to decrease mental health stigma should include educational videos that provide information about mental illness, its symptoms, and treatment options.[50] A thematic analysis of TED Talks featuring personal experiences with mental illness highlighted the need for first-person narratives to reduce stigma.[51] Hence, the use of video testimonies from first person narratives of recovery should incentivize pilots/controllers to proactively engage in an enhanced level of mental fitness and well-being.

Fostering a culture of openness, understanding, and support will create an environment where aviation professionals feel empowered to prioritize their mental health without Stigma or fear of discrimination.

E. Financial

Financial concerns are a significant barrier to reporting. Under the current process the pilot/controller faces an uncertain financial future once a mental health condition/diagnosis is reported with the immediate loss of medical certification/clearance. This can include potential loss of income, as well as the costs of testing and treatment. The use of sick leave, insurance coverage, or transitioning to disability benefits can provide some financial relief, but it may not cover the entire time between the loss of medical certification/clearance and the return to work. Sick leave varies by employer and is typically limited in duration, so the disruption or loss of income may be immediate or may slowly erode over time. Individuals with the benefit of a disability program have a financial safety net that preserves some income after sick leave ends. However, this is typically at a reduced level of income that may not sufficiently cover living expenses. For those with no ability to transition to a disability program, or a guarantee of alternative work, income can cease entirely when sick leave ends. Moreover, the duration of disability coverage varies, and many policies offer only limited benefits for mental health conditions. The ARC also notes that personal or supplemental disability coverage can be cost prohibitive for individuals seeking to mitigate the potential financial impact of a mental health-related job loss. Therefore, financial concerns play a significant role in the decision to withhold reporting a mental health condition.

The cost of treatment and testing for recertification/clearance is another financial barrier to reporting a healthcare concern. Some mental health providers accept insurance for treatment, while others do not, requiring the pilot/controller to pay out-of-pocket for services. Providers that accept health insurance must issue a diagnosis following the initial evaluation and treatment to receive continued payment from the insurance provider. Providing escalating levels of diagnosis

[48] Connor et al. (2015).
[49] *Id*.
[50] Morton et al. (2024).
[51] Lien et al., (2023), p. 172 noting that "recognition of mental disorders may eliminate mental health stigma or improve help-seeking efficacy, thereby increasing positive help-seeking attitudes".

are usually required to continue insurance payments for the prescribed treatment plan. This can complicate FAA medical certification by leaving pilots/controllers to pay for treatment directly to avoid this undesirable scenario.

Moreover, the cost of required testing to return to duty is often not covered by insurance. In many cases, the required treatment and testing cannot be performed close to the pilot's/controller's home. This can result in additional expenses for travel and lodging to and from the testing site or to visit a specialist outside of their local area. This further exacerbates the financial impact on the individual, most often at a time when their income has already been reduced. It can also be difficult to find, and schedule required appointments and treatment with the necessary medical specialist. This can further extend time on reduced income or without pay.

Aspiring aviation professionals also face similar financial implications related to the cost and time for treatment, testing, and certification/clearance. Treatment costs, testing required by the FAA's certification process, and travel costs for treatment/testing are borne by the aspiring aviation professional, who likely does not have the financial resources and protections as someone already in the industry. This may delay starting or progression through training, which ultimately delays completion of training and entry into the workforce. This can also lead to the loss of the G.I. Bill or other financial aid to cover the cost of training, as well as costs incurred on servicing loans, and loss of income and earning potential.

In the rare event of permanent medical disqualification, pilots/controllers choosing to appeal the decision would likely incur significant additional medical and legal costs as they move through that process. To a greater extent than many professions, pilots/controllers develop highly specialized skills and are generally compensated well for their years of technical experience. Industry employment interruptions (furlough, strike, lockout, cessation of operations) have shown that pilots/controllers are not as readily successful in transferring their skills to another industry at a similar level of compensation. Thus, the possibility of a significant loss of income while awaiting treatment, testing, and completion of the FAA process for medical recertification/clearance presents a daunting potential financial risk to pilots/controllers. It is understandable why many aviation professionals see these financial considerations as a significant factor in their decision to seek help or report. Simply stated, if aviation professionals feel forced to choose between maintaining their family's financial viability or seeking help for a mental health issue, many will choose the former.

F. Process

The ARC identified the Process of obtaining a medical certificate/clearance as an obstacle to reporting a mental health condition. The FAA Aeromedical Certification Division's (AMCD) processes are unclear, complex, and sometimes overly conservative. The ARC believes that a broad process flow description would be helpful in explaining the certification/clearance requirements to applicants. The current system could also benefit from an incorporated feedback loop to provide information to end users during the process, as well as after a decision has been

made. The ARC also notes the extremely slow pace of the process[52] due to the FAA's heavy reliance on the US Mail and limited ability to receive/submit documentation electronically. For professionals accustomed to making time critical decisions, waiting weeks to months for feedback is demoralizing and can adversely impact many mental health issues. Other obstacles discussed in more detail below include access to AMEs and clarity around the documentation required and standards for aeromedical approval.

Access to AMEs

Lack of access to medical professionals trained and qualified in aviation medicine is another component of the Process barrier. Across the US, there can be vast distances between experienced AMEs willing to work complex mental health cases. Access and availability to HIMS AMEs, who are required for certifying pilots/controllers using acceptable antidepressant medications, can be equally challenging. FAA policies requiring testing or evaluations from FAA-approved neuropsychologists and psychiatrists pose yet another access issue in many locations. Also, mental health professionals in general, especially those familiar with the FAA processes, are limited in quantity and location. Across the industry, a variability of financial resources, mobility, and time impedes access to the required healthcare resources.

Documentation & Standards

The documentation required for recertification following a medical diagnosis can be extensive and difficult to navigate. Moreover, the documentation required seems skewed towards the severest disease state, and does not appear to consider the individual case, varying degrees of impairment, or previous history of certification. For example, many pilots that previously served in the US Uniformed Services with a mental health diagnosis and were subsequently re-certified, faced deferral as civilians pending FAA review of documented treatment, and verification they are symptom free. This results in the appearance that the FAA standards are overly conservative both in the treatment protocols and in the timelines in returning to wellness. Moreover, the process for reconsideration/appeal is ambiguous, and there can be variations in the outcomes of similar cases that make the process appear arbitrary and unfair.

To a pilot/controller, there also appears to be a specious link between a diagnosis and how the condition may adversely affect flight safety. Under the FAA's current requirements, applicants are required to report *any* visit to a mental health professional. From the laymen's perspective, many of these types of therapies have little to no impact on aviation safety, making the requirement to report feel like an invasion of privacy. This is often perceived as excessive reporting of non-safety related information, which stands in stark contrast to most pilot/controller's experience with SMS programs that rely on affirmative reporting of self-identified safety hazards or threats. Lastly, pilots/controllers have limited knowledge of any available quantitative mental health self-assessment tools that could help in the decision-making process to self-ground or continue operating. In sum, the FAA's current process is an overly complicated system that would benefit from simplification, increased relevance, and transparency.

[52] *See also* Figure C below, a *Notional Timeline for FAA Initial Authorization for Antidepressant Medication Use*, illustrating a timeline of more than 500 days for assessment and decision of pilots/controllers using antidepressant medications.

G. Knowledge & Information Gap

The ARC has identified the Knowledge and Information Gap pertaining to pilots/controllers' mental health literacy as a barrier to reporting a mental health condition. Mental health literacy has been defined as "knowledge about mental disorders which aid in their recognition, management, and prevention,"[53] including knowledge related to:

- the ability to recognize disorders,
- sources of information,
- risk factors and causes,
- self-treatment,
- availability of professional help, and
- attitudes that promote recognition or appropriate help seeking behaviors.[54]

Pilots/controllers and the FAA share responsibility for closing the Knowledge and Information Gap. Pilots/controllers are responsible for accessing and assimilating guidance material, while the FAA is responsible for providing accurate, clear, and timely information.

Misunderstandings exist throughout society regarding mental health conditions, knowledge, and stigmatization. Research shows that the variables of self-stigma and mental health literacy have a significant and distinct impact on help-seeking attitudes and behaviors among the general population.[55] Within the aviation community, inaccuracies and misconceptions persist surrounding mental health. Pilots/controllers often share FAA medical certification 'war stories,' which can perpetuate misinformation about the mental health certification/clearance process. Thus, it is essential to provide factual, positive personal narratives to counter misinformation, reduce stigma, and increase help-seeking attitudes.[56]

Peer Support Programs & Expanded Communication Methods

Usually, the first misstep in a mental health journey by a pilot/controller is to consult non-peer support trained co-workers to gather information on the regulations, processes, and potential pitfalls. These conversations include topics such as: exploring ways to navigate the landscape of mental health treatment options, information on the medical certification/clearance process, and the ability to return to flight/duty. Anecdotal knowledge shared within the pilot/controller networks may create misconceptions that are widely believed to be accurate. Exposure to these mistaken beliefs can be experienced as early as initial flight training where inaccuracies are passed among

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[53] Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. *"Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment.* Med J Aust. 1997 Feb 17;166(4):182-6. doi: 10.5694/j.1326-5377.1997.tb140071.x. PMID: 9066546, p. 182.

[54] O'Connor M, Casey L. *The Mental Health Literacy Scale (MHLS): A new scale-based measure of mental health literacy.* Psychiatry Res. 2015 Sep 30;229(1-2):511-6. doi: 10.1016/j.psychres.2015.05.064. Epub 2015 Jul 16. PMID: 26228163.; (Williston & Vogt, 2022).

[55] Cheng, H.-L., Wang, C., McDermott, R. C., Kridel, M., & Rislin, J. L. (2018). S*elf-stigma, mental health literacy, and attitudes toward seeking psychological help*. Journal of Counseling & Development, *96*(1), 64–74. Kitchener BA, Jorm AF. (2002). *Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behavior.* BMC Psychiatry. 2002 Oct 1;2:10. doi: 10.1186/1471-244x-2-10. PMID: 12359045; PMCID: PMC130043.

[56] Lien et al., (2023).

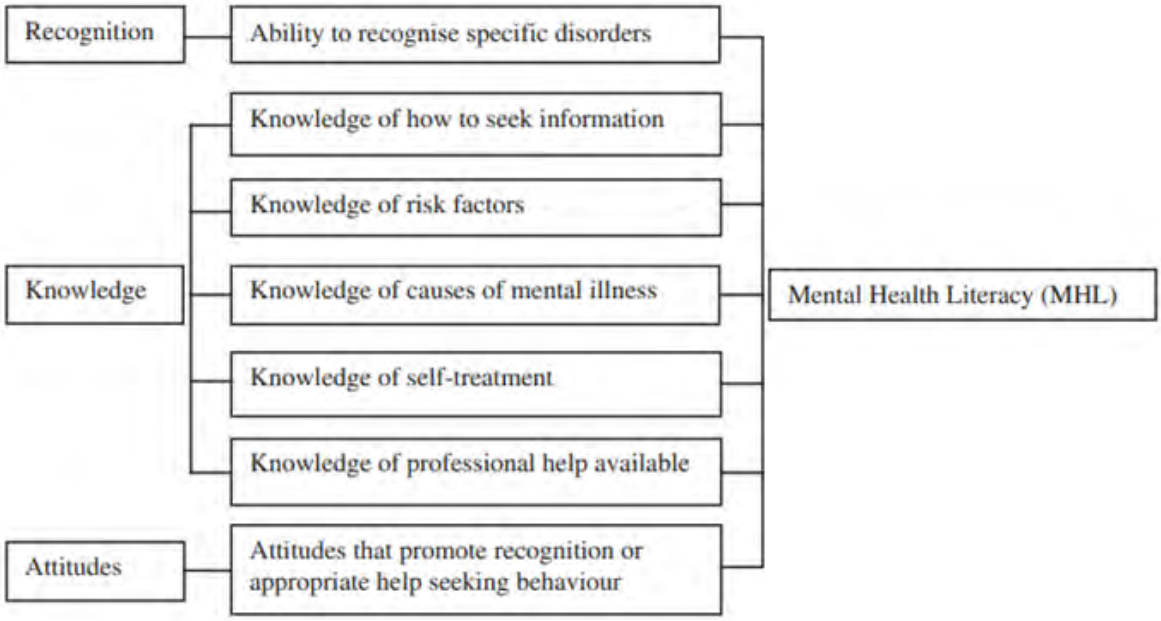
fellow students and their instructors and subsequently perpetuated throughout their aviation career. Proper education and well-trained peer support programs are needed to disseminate truths about mental health reporting and treatment, and reduce false perceptions from gaining traction and causing mental health care avoidance.

Current methods of disseminating FAA information on mental health (e.g., Pilot Minute, presentations at industry events, aviation magazine articles, mental health forums, or changes to the AME Guide), while frequent and thoughtful, are, for the most part, not viewed or well understood by most of the pilot/controller population. FAA communications are even less likely to reach younger generations of pilots/controllers who use social media outlets for their information gathering. The role of electronic communications/social media in reaching and appealing to all generations of aviation professionals should not be underestimated. Using social media outlets to disseminate factual, unambiguous, relatable information about mental health issues, treatment options, requirements for certification/clearance, and timelines associated with the journey may allow for the narrative around this topic to be discussed with honesty and transparency.

There is significant evidence that sharing narrative-driven accurate information is an effective approach to educating and communicating with others in aviation.[57] Peer-to-peer programs are an effective means to provide pilots/controllers with a forum to share knowledge in a reliable and trusting way.[58] Transparency of the process by which medical certification/clearance decisions are made will also help improve the Knowledge and Information Gap. This transparency should be evident at every stage of the process, from application to appeal. When pilots/controllers understand and have reliable information about the requirements and timeline of the process, their worry and distrust will be lessened, as will their reliance on the inaccurate narratives that they lean on today. *See Figure B below for more information on the Mental Health Literacy Framework*.

[57] Hoffman WR, McNeil M, Tvaryanas A. (2024). The Untapped Potential of Narrative as a Tool in Aviation Mental Health and Certification. Aerosp Med Hum Perform. 2024 Mar 1;95(3):165-166. doi: 10.3357/AMHP.6281.2024. PMID: 38356134.
[58] Santilhano et al. (2019).

Figure B: Mental Health Literacy Framework[59]



[59] O'Connor, M., Casey, L., & Clough, B. (2014). *Measuring mental health literacy – a review of scale-based measures. Journal of Mental Health, 23*(4), 197-204. doi:10.3109/09638237.2014.910646.

Increased Knowledge to Reduce Healthcare Avoidance Behaviors or Treatment Modification

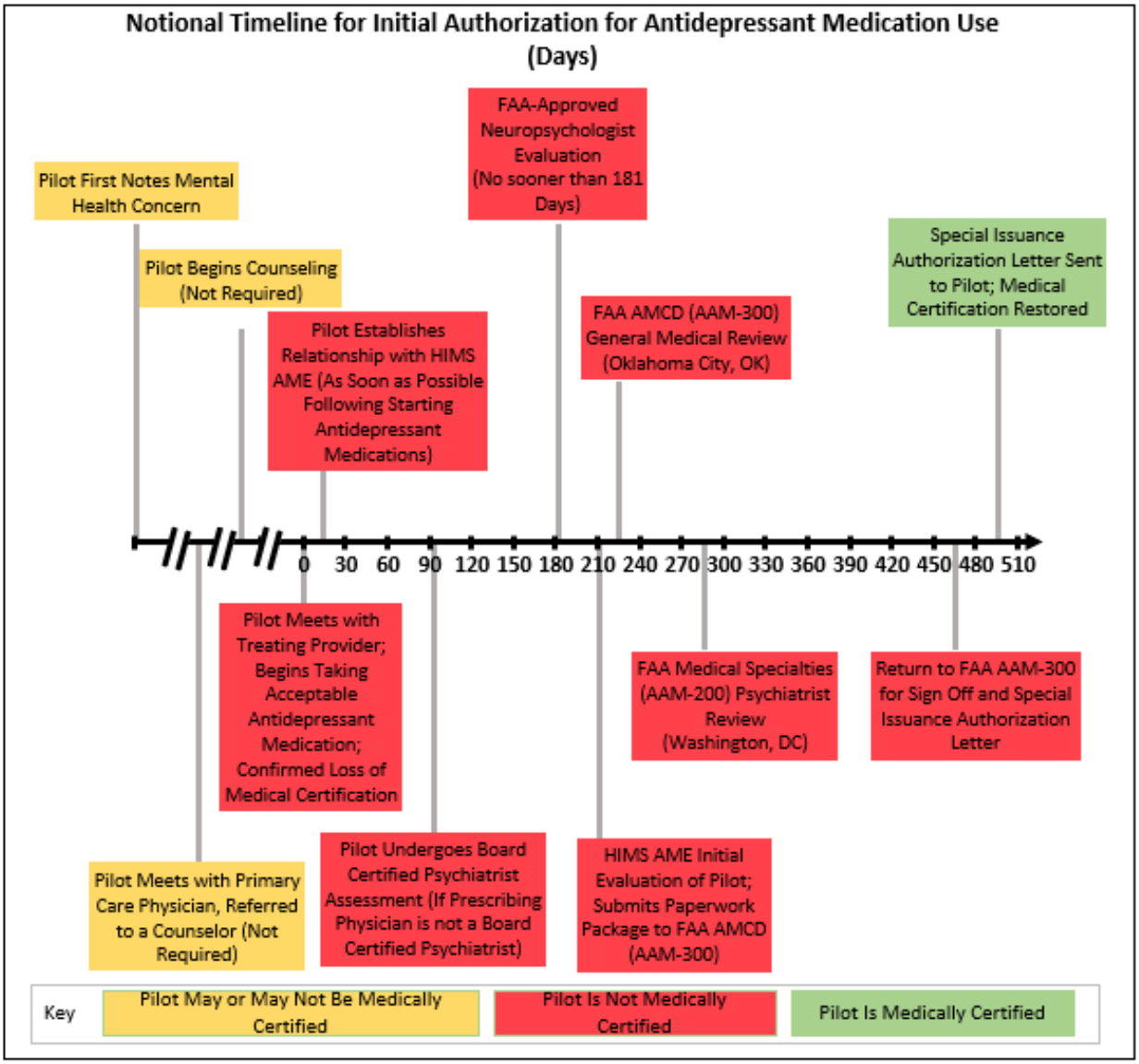
The FAA depends on pilots/controllers to self-report physical and mental issues, but pilots/controllers are often unaware of an existing problem, its severity, or the most effective treatment. Increasing pilot/controller's mental health literacy contributes to a better awareness which in turn may lead to earlier reporting and help-seeking behavior. Likewise, early intervention can effectively mitigate more serious mental health conditions. Therefore, increased mental health literacy will ultimately lead to better outcomes for the pilot/controller.

Pilots/controllers should educate themselves with aviation medical terminology as there is often a misunderstanding of the terminology. Moreover, in some cases, the differences between the clinical definitions in the DSM-5-TR and the FAA definitions used for regulatory determinations under 14 CFR Part 67 can be significant. Typically, the regulatory definition is more conservative because of the aviation context. For example, under the Federal Aviation Regulations, substance dependence is defined as meeting at least one of four criteria defined in Part 67. In contrast, under the DSM-5-TR, mild substance use disorder requires meeting at least 2 of 11 criteria; and moderate and severe substance use disorders require meeting at least 4 and 6 criteria respectively.

Confusion around aeromedical standards can also cause some applicants with mental health diagnoses to self-modify pharmacological treatment due to real or perceived differences in how their application will be handled. For example, there are currently no ADHD medications allowed by the FAA. Therefore, many applicants with ADHD discontinue taking medication for the condition in the hopes of being certified/cleared. What these individuals seemingly misunderstand is that ADHD in and of itself is a disqualifying condition, regardless of the use of medication. Therefore, discontinuing the medication does nothing to increase the applicant's chances of being certified/cleared and may only serve to worsen their symptoms if the ADHD diagnosis is correct. Similar behaviors regarding changes in pharmacological treatment are also seen in applicants with other commonly diagnosed mental health conditions, such as anxiety, depression, and PTSD. Many applicants with anxiety or depression will voluntarily discontinue use of approved SSRIs because they believe it will lead to a more streamlined approval. This is reinforced (perhaps unintentionally) by FAA literature that appears to show a truncated approval pathway when a person is off medication for a specified period.[60] *See Figure C below for more information on the approval process for applicants taking antidepressants*.

[60] The ARC notes that whether on or off antidepressant medications, the timeline for certification/approval is excessive and inconsistent with international standards. *See* Tables 1 and 2 above in Section VI. Task D discussion.

Figure C: Notional Timeline for Initial Authorization for Antidepressant Medication Use



Notes: Timeline assumes first medication used and dosage remains stable for 180 days, an FAA-defined minimum. Medication or dosage changes restart the 180-day observation period.

FAA review process timeline is variable, e.g. FAA Psychiatrist Review in DC (AAM-200) currently ranges between 150-180 days. The FAA aims for psychiatry review within 30 days of receipt at FAA AAM-200. This chart is based on current timeline estimates.

Air Traffic Controllers experience a similar process and timeline for initial authorization of antidepressant medication use.

Taking care of one's mental health is an important element to overall health and wellness and improving mental health literacy will enhance proactive mental health service use.[61]

[61] Corrigan. (2004); Kitchener & Jorm. (2002); Shields et al. (2023); Williston & Vogt. (2022).

VIII. ARC Recommendations – Intent, Rationale, and Approach

The following section contains detailed information on each recommendation, including the ARC's intent, supporting rationale, research, examples, and suggested regulatory approach. The ARC would like to reemphasis that the following recommendations are interdependent and all need to be implemented to fully overcome the barriers identified earlier.

REC1 – Disclosure Requirements for Psychotherapy

The FAA should change its policy and medical application instructions to allow pilots/controllers to participate in psychotherapy (talk therapy)[62] without requiring disclosure during aeromedical screening.

INTENT: To minimize barriers to obtaining non-pharmacological based mental health therapy for mental health concerns.

RATIONALE: The FAA requirement to disclose talk therapy has had unintended consequences. Presumably, the requirement was based on the FAA's view that the use of talk therapy served as a marker for identifying an operational hazard or an impairment to work performance. However, not only is there limited data to support this view, but there is also robust data to the contrary. [63]

Studies show that barriers to seeking mental health care can produce additional stressors and anxiety, which can ultimately create aviation safety hazards that would not otherwise exist. For example, a pilot/controller desiring to engage in talk therapy to manage a life event (e.g., divorce), could be deterred from doing so due to the requirement to report it to the FAA. In these instances, the pilot/controller has recognized the need for help and has the desire to obtain it but may be concerned about the potential adverse impact on their livelihood and career. Consequently, not only is the person not obtaining help with the mental health issue related to the triggering event (i.e., the divorce), but the person is now also managing the stress and anxiety surrounding the decision to either:

- get help and disclose to the FAA (risking loss of certification pending the FAA review process),
- get help and **not** disclose to the FAA (risking loss of certification, civil/criminal penalties, and most likely an unnecessary financial burden of having to self-pay for mental health care because the person cannot access insurance benefits without disclosing); or
- not get help risking the development of a more serious mental health issue because the person was unable to take advantage of early intervention when the symptoms were mild or mild/moderate in nature and linked to a transient life event.

[62] Psychotherapy is an approach for treating mental health issues by talking with a psychologist, psychiatrist, or another mental health provider. It also is known as "talk therapy," counseling, psychosocial therapy or, simply, therapy. It can include cognitive behavioral therapy, supportive therapy, family, marital, life coaching, or bereavement counseling.

[63] Hoffman WR, Aden J, Barbera RD, Mayes R, Willis A, Patel P, Tvaryanas A. (2022). Healthcare Avoidance in Aircraft Pilots Due to Concern for Aeromedical Certificate Loss: A Survey of 3765 Pilots. *J Occup Environ Med*. 2022 Apr 1;64(4):e245-e248. doi: 10.1097/JOM.0000000000002519. Epub 2022 Feb 15. PMID: 35166258.

It is indisputable that the requirement to disclose talk therapy leads to healthcare avoidance and/or non-disclosure.[64] This alone should be sufficient to support a change in FAA policy because many pilots/controllers go without care, leaving their symptoms untreated, which poses its own aviation safety risks. Moreover, seeking talk therapy is a poor hazard identification tool from an aviation safety perspective. Thus, if the FAA is going to assign it any significance, it should view it as a marker of safety, wellness, and self-awareness instead of a marker for risk. Medical guidelines[65] advise evidence-based talk therapy as first line therapy, and many people participate in talk therapy, even in the absence of any acute stressors or triggering events, for preventive mental health purposes. Given the barriers identified above and the fact that work related stress is common and increasing among pilots/controllers,[66] the ARC recommends that talk therapy should no longer require disclosure.

APPROACH: The FAA should amend the instructions on medical applications to exclude mental health talk therapy services as a required reportable medical professional visit.[67] While the three examples of the instructions in Appendix D differ on what is reportable, it should be noted that the Guide for Aviation Medical Examiners-Version 03/27/2024 does state "The applicant should list visits for counseling only if related to a personal substance abuse or psychiatric condition." During a periodic health assessment, pilots/controllers should be asked by the AME about personal, social, and occupational issues to identify relevant mental health hazards. Obtaining this information, directly from the pilot/controller, instead of a mental health provider, will reduce the behavior of non-reporting and increase safety. If the AME senses a mental health concern during the screening process, additional information will be requested.[68]

Barriers Addressed: Trust, Fear, Stigma, Process

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[64] Hoffman WR, Patel PK, Aden J, Willis A, Acker JP, Bjerke E, Miranda E, Luster J, Tvaryanas A. (2023). *Multinational comparison study of aircraft pilot healthcare avoidance behaviour.* Occup Med (Lond). 2023 Oct 20;73(7):434-438. doi: 10.1093/occmed/kqad091. PMID: 37658781.

[65] https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf.

[66] Cahill, J., Cullen, P., Anwer, S., Wilson, S., & Gaynor, K. (2021). *Pilot Work Related Stress (WRS), Effects on Wellbeing and Mental Health, and Coping Methods*. The International Journal of Aerospace Psychology, 31, 87 - 109.

[67] *See* Appendix D.

[68] *See* Flowchart at Appendix A and Sample Checklist at Appendix B.

REC2 – Regulatory Pathway - Reporting Mental Health Conditions & Medications

The FAA should develop a non-punitive[69] pathway for reporting previously undisclosed mental health conditions, treatments, or medications.

INTENT: To increase trust in the FAA medical certification/clearance process by establishing a non-punitive pathway for applicants to report previously undisclosed conditions and medications. The process should incentivize compliance, minimize financial and occupational jeopardy, and encourage pilots/controllers to seek appropriate mental health care, which will improve the safety of the NAS.

RATIONALE: As explained in the barrier narratives, Fear inhibits reporting of previously identified or diagnosed conditions and medications. Individuals undergoing *unreported* mental health treatment are not subject to monitoring by the FAA AAM. Without monitoring, it is impossible to gather data regarding the magnitude, severity, and operational impact of mental health conditions. This creates a potential safety hazard within the NAS, as well as for the individual who may not be receiving appropriate treatment and adequate support for their condition.

The FAA does not have the authority to offer immunity from criminal prosecution under 18 USC 1001 for making any materially false, fictitious, or fraudulent statement or entry on the medical application form because immunity can only be offered by the Department of Justice. However, the FAA and the OIG (the office through which the FAA makes referrals for possible criminal prosecution), can agree that the FAA will not refer cases of apparent intentional falsification or misrepresentation for criminal investigation or prosecution. The ARC recognizes the need for a sunset clause to this non-referral period, but the period must be of sufficient duration to allow trust to be developed and culture to change. The ARC believes that a program of this type will allow the greatest number of individuals to come forward.

APPROACH: The FAA should create a process whereby pilots/controllers who currently hold a medical certificate/clearance are encouraged to report previously undisclosed mental health conditions, diagnoses, and/or treatment. The person should be able to disclose without fear of immediate revocation or referral for disciplinary or administrative/criminal prosecution for falsification, misrepresentation, or omission of information on the required disclosure documents. The non-revocation protections should extend to the *medical* certificate/clearance, as well as to any other certificates, ratings, clearances, or qualifications the person holds. This process should also allow pilots/controllers to maintain aeromedical certification/clearance, with appropriate restrictions as needed, when the condition/treatment is aeromedically acceptable, and there is evidence of present ability to function well.

Any pathway developed would require a good faith effort by the certificate/clearance holder to provide all information required by the FAA to render a determination on the status of the medical clearance/certificate. To be eligible for this pathway, the certificate/clearance holder must disclose the information prior to the FAA discovering the withheld information through other means.

[69] Non-punitive implies relief from both civil and criminal penalties, including medical/pilot certificate action, loss of medical clearance for controllers, referral to OIG for criminal prosecution, and/or any other disciplinary action.

The ARC recommends that the 'grace period' be at least two years from date of recommendation implementation. The certificate/clearance holder should report within the two-year period or in the case of the 3rd Class Medical Certificate holder at the time of the next medical application if it falls outside the end of that two-year 'grace period.' This would allow time for the promotion and training of the proposed mental health awareness initiatives described in Recommendations 17,18, 20 & 21 below to reach the widest possible group of aviation professionals. The ARC clarifies that this pathway does not guarantee continued issuance of the medical clearance/certificate if the person is unable to meet aeromedical standards either through the standard application process or through special issuance or special conditions.[70]

Caveats to the Guarantee of Non-Revocation and Non-Referral:

- the pilot/controller provides all medical and pharmacy records of treatment;
- the self-disclosure must be made before any FAA investigation. If the FAA discovers the undisclosed condition or treatment before self-disclosure, there is no guarantee of non-revocation or non-referral for prosecution; and
- if a currently disqualifying medical condition is identified, the medical certificate/clearance may be revoked until the person meets the conditions for medical certification or special issuance/special conditions, but the person's employment and the person's *non-medical* certificates, clearances, ratings, or other qualifications should not be in jeopardy.

This approach incentivizes widespread self-disclosure while allowing the FAA to adequately assess the individual's current medical status, and preserving the FAA's authority to prosecute those who continue to conceal/falsify medical applications despite the opportunity to self-disclose with protection.

The ARC reiterates that pilots/controllers will remain reluctant to disclose during the 'grace period' unless there is meaningful effort among all aviation stakeholders to address the identified barriers. The ARC notes that previous attempts at encouraging disclosure were met with minimal engagement due to lack of Trust in the aeromedical system.[71] The ARC strongly encourages the FAA to modify its previous approach if it decides to institute a grace period. This will instill confidence in pilots/controllers that the system has changed and that disclosures will be fairly assessed and not result in automatic loss of medical certification/clearance in every case.

Barriers Addressed: Trust, Fear, Stigma, Process

[70] *See* CASA and CAA NZ – Safe Haven Draft Policy Appendix C.

[71] *See* FAA Compliance and Enforcement Bulletin No. 2010-1. 75 FR 17200 (2010) announcing the FAA's policy to forgo enforcement action for persons who disclose previous falsification on medical certification applications of the use of antidepressant medication, the underlying condition for which the antidepressant was prescribed, and visits to health professionals in connection with the antidepressant use or underlying condition. *See also* Special Issuance of Airman Medical Certificates to Applicants Being Treated With Certain Antidepressant Medications, 75 FR 17047 (2010).

REC3 – Expanded Use of Peer Support Programs

Aviation stakeholders should develop, implement, and participate in effective Peer Support Programs (PSP) or enhance other existing programs.

INTENT: To establish and enhance PSPs throughout the aviation community.

RATIONALE: Pilots/controllers should feel comfortable disclosing mental health issues. PSPs should provide the opportunity for a pilot/controller to disclose a mental health concern and if appropriate, receive temporary relief from operational duties, and/or be referred to a mental health professional. It should be noted that an Employee Assistance Program (EAP) is different than a Peer Support Program. EAP employs accredited mental health care workers, not peers.

The successful implementation of PSPs requires commitment and support from all stakeholders, including senior management, pilot/controller representative organizations, and peer volunteers. The trusting relationship with a fellow pilot/controller in a peer-supported program may provide the best opportunity to identify and engage an individual requiring assistance. To encourage use, pilots/controllers must be handled in a confidential, non-stigmatized, and safe environment. If a culture of mutual trust and cooperation is maintained, pilots/controllers are less likely to conceal a condition, and more likely to report and seek help for mental health concerns.

APPROACH: Aviation stakeholders should consider best practices from mature PSPs and adapt them to meet their individual and organizational needs. These programs should include protocols based on the type of operation, the number of employees involved, the ability to consult with professional mental health service providers, and escalation processes where additional support is warranted. The ARC recognizes that for solo or smaller operators, 'peers' may not be readily available in-house. In these cases, the ARC recommends pooling resources with similarly situated individuals or organizations to create an effective network of support. Simply put, the program should provide adequate training and include access to peers and mental health professionals.

The ARC notes that many professional organizations have mental health PSPs for pilots with varying degrees of support from employers, and although the FAA has a Critical Incident Stress Management (CISM) program for post-traumatic workplace event counseling and a Professional Standards Committee to deal with performance and conduct issues in the workplace, no mental health PSP exists for controllers for issues not involving traumatic workplace events. The ARC encourages these entities to explore opportunities to expand and improve these PSP initiatives and to leverage existing resources to provide comprehensive support for aviation professionals.

Barriers Addressed: Culture, Trust, Fear, Stigma

REC4 – Disclosure Requirements for Peer Support Programs

The FAA should allow pilots/controllers working with a Peer Support Program to receive mental health professional care with less restrictive reporting and grounding requirements.

INTENT: To destigmatize seeking mental health assistance and use aviation-savvy resources to assist in arriving at a "Fly/No-Fly" determination without requiring the certificate/clearance holder reporting mental health professional (MHP) care to FAA.

RATIONALE: There is anecdotal evidence that a significant portion of individual contacts with mental wellness challenges can be resolved *without* involving a mental health professional. [72] Moreover, when escalation to a mental health professional is required, the trusted opinion of a PSP advocate helps destigmatize the condition and provides better support for the individual as they navigate the FAA processes. Specifically, the individual is encouraged when seeking help by:

- being reassured that many other pilots/controllers have had similar issues resolved successfully;
- having support to develop a plan and a timeline for getting help;
- having assistance with their decision to remain on duty or self-remove for safety reasons; and
- being provided information about resources available for medical, financial, and operational support.[73]

Ultimately, this will improve the safety of the NAS via increased mental healthcare seeking behaviors.

APPROACH: Reporting MHP care to the FAA would only be required if the individual pilot/controller is no longer participating in a PSP. In addition, any consultation with the PSP's mental health professional about seeking mental health treatment would not be reportable.

The ARC further recommends that all aviation stakeholders without an existing PSP work collaboratively and expeditiously to develop and implement such a program. This includes coordinating with mental health organizations, existing PSP managers, and employee bargaining representatives (as needed) to review best practices and create programs to support and assist all pilots/controllers.

Barriers Addressed: Fear, Stigma, Financial

[72] Peer Support Programs such as Allied Pilots Association- Project Wingman and United ALPA-SOAR (Support Outreach Assistance Resources) report that greater than greater than 80% of PSP calls are resolved by peers without escalation to mental health providers or other counselors/clergy.
[73] *See* CASA and CAA NZ – Safe Haven Draft Policy Appendix C.

REC5 – Requirements for Neurocognitive Testing

The FAA should minimize the requirement for neurocognitive testing for pilots/controllers.

INTENT: To reduce fear of loss of medical certification, process delays, and excessive costs by employing neuropsychological screening or full battery testing only when clinically indicated.

RATIONALE: The FAA is the only CAA that requires neurocognitive testing in *every* case involving medical certificate/clearance holders who use approved monotherapy medications. These evaluations must be performed by a HIMS trained neuropsychologist, which requires the pilot/controller to meet with a HIMS trained AME to obtain a referral, and then often wait several months for physician availability. The evaluations can also be costly in some cases.

APPROACH: The ARC notes that the FAA has previously removed the requirement for neurocognitive testing for routine renewals in cases involving antidepressants. The ARC recommends a similar approach for all applicants to reduce the use of neurocognitive/neuropsychological testing as much as possible.

Barriers Addressed –Trust, Fear, Stigma, Financial

REC6 – Requirements for Depression & Anxiety

The FAA should revise the requirements for pilots/controllers on approved monotherapy antidepressants for the treatment of uncomplicated[74] depression or uncomplicated anxiety.

INTENT: To set a new, reduced minimum wait time for reconsideration of medical certification following any initiation or change to an approved monotherapy antidepressant/anxiety medication.

RATIONALE: The ARC wishes to remove barriers that discourage initiating or adjusting pharmacological treatment with approved monotherapy antidepressant medications, thereby allowing pilots/controllers to function in a healthier mental state. Individuals with uncomplicated depression or uncomplicated anxiety, and without a history of psychiatric complications, have a higher likelihood of responding positively to a single antidepressant medication. In fact, studies indicate the most common neurocognitive effects of antidepressant usage in individuals with depression is improved cognitive function over time. Under international standards, individuals who start or change medications to treat depression have minimum observation periods before they can be considered for reinstatement of medical qualification.[75] These observation periods vary from two weeks to six months. Evidence-based practice guidelines state:

> Improvement with pharmacotherapy can be observed as early as the first 1–2 weeks of treatment, and improvement continues up to 12 weeks. Many patients may show partial improvement as early as the end of the first week. Others achieve improvement within the first 2–4 weeks. In short-term efficacy trials, all antidepressant medications appear to require at least 4–6 weeks to achieve maximum therapeutic effects.[76] Caution and monitoring are required. An FDA-mandated "black box" warning[77] on antidepressants notes an increased risk of suicidal ideation and treatment-emergent suicidal ideation" at the onset of treatment, particularly in younger patients.[78]

The ARC reiterates that consideration for issuance of medical certification is not the same as issuance of a medical certificate. This requires ongoing physician-level monitoring to document a period of stability, as opposed to being in a temporary state of stability. Further in-depth assurance is achieved through post-issuance review with AMCD, using an "AME-Issued with Review (AIR)" model. This approach is similar to what is presently done for applicants with Obstructive Sleep Apnea (OSA).

The current six-month observation period may create a financial hardship for pilots/controllers and introduces a safety risk by discouraging initiation of antidepressant medication or if under treatment of changing the dosage. The result is that pilots/controllers are reluctant to seek help for

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[74] For the purposes of this report, uncomplicated means without co-morbid psychiatric illnesses; treated with a single medication; not requiring hospitalization, electroconvulsive therapy, or similar treatments; and not associated with suicidal ideation, actions, or self-injurious actions.
[75] *See* Tables 1 and 2 above in Section VI. Task D discussion.
[76] Pilot specific data found in the EASA MESAFE D-1.2, 3.1 Pilots (Class 1), 3.1.1 Biological Treatments
[77] *See* Food and Drug Administration regulation 21 CFR 201.57(c)(1) requiring certain contraindications or serious warnings, particularly those that may lead to death or serious injury, to be presented as a warning on the box containing the medication.
[78] *See* https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf.

mental health conditions, even if the condition can be successfully treated in a primary care setting with monotherapy antidepressant medication and/or psychotherapy (when available and if affordable). Adopting this protocol would reduce the time without a medical certification/clearance for pilots/controllers.

APPROACH: The ARC recommends the FAA adopt a program modeled on "Decision Path 2 for Depression."[79] Specifically, the FAA should reduce the special issuance consideration minimum wait time from six-months to two-months. The two-month time frame is predicated on the amount of time typically required to respond to a medication, as well as concerns for the appearance of suicidal ideation as noted in the Food and Drug Administration's black-box warning. The FAA should also allow the certificate/clearance to be issued under the AIR process.

This approach would allow pilots/controllers who have major depressive disorder, generalized anxiety disorder, or are using an SSRI for a non-psychiatric condition without any of the "SSRI rule-outs,"[80] to be considered *by the AME* for issuance of a medical certificate/clearance two months after starting or changing the dose of an allowed antidepressant medication. The following conditions would apply:

- an in-person assessment by the AME that the applicant is stable and fit for duty;
- there has been adequate monitoring by the prescribing physician and documentation of stability over time; and
- the AME has reviewed the prescribing physician's evaluations.

The ARC emphasizes that this approach is similar to how OSA is presently handled.[81] When developing the protocol and procedure, consideration should be given to whether a checklist and attestation for the prescribing physician would be beneficial in simplifying the process and reducing the time required to provide clinical information to the AME. A sample checklist is provided at Appendix B.

Barriers Addressed: Financial, Process

[79] *See* SSRI Decision Path II.
[80] *See* FAA Certification Aid for SSRI Initial Certification.
[81] *See* Decision Considerations & Disease Protocols for Obstructive Sleep Apnea.

REC7 – Requirements for Attention Deficit Hyperactivity Disorder (ADHD)

The FAA should evaluate the feasibility of permitting pilots/controllers with an ADHD diagnosis to use appropriate and acceptable medications while on duty.

INTENT: To establish whether circumstances and conditions exist under which pilots/controllers may operate while taking approved medications for the treatment of their properly diagnosed ADHD.

RATIONALE: *Untreated* ADHD raises indisputable safety concerns. Accordingly, under current FAA policy, the diagnosis of ADHD, as well as all FDA approved medication options used to treat ADHD, are disqualifying. However, adults with active ADHD are estimated to be as high as 4.4% of the population,[82] and the diagnosis among children is also increasing, which may have implications for future pilot/controller ranks. While misdiagnosis may partly be a factor in this phenomenon, there is no reason to doubt there are pilots/controllers operating in the NAS with unreported or untreated ADHD. Thus, a renewed look at FAA policies regarding treatment and clearance of controlled ADHD would help normalize safety-enhancing treatment and contribute to the perception of the aeromedical system as fair and just.

As noted above, [83] many current and aspiring pilots/controllers are known to alter their ADHD treatment specifically to meet FAA certification standards due to the mistaken belief that it is the medication only, and not the condition itself, that is disqualifying. However, the ARC notes that certain ADHD medications are demonstrably well tolerated and known to improve some cognitive function and performance in correctly diagnosed ADHD patients.[84]

APPROACH: The ARC recommends that the FAA reexamine its ADHD certification/clearance policies to determine the potential aeromedical effects of ADHD. This reexamination should be consistent with contemporary treatment options and protocols and appropriately prescribed medications to mitigate symptoms of ADHD in various operational environments. This should include a study designed in conjunction with research experts to determine appropriate assessment methodologies and operational performance outcomes.

Barriers Addressed: Fear, Process, Knowledge and Information Gap

[82] *Id*.
[83] *See* ADHD discussion above at Section VII.G. Knowledge and Information Gap.
[84] McKenzie et al. (2022), *The Effects of Psychostimulants On Cognitive Functions In Individuals With Attention-Deficit Hyperactivity Disorder: A Systematic Review*, Journal of Psychiatric Research, Volume 149, Pages 252-259.

REC8 – Requirements for Post Traumatic Stress Disorder (PTSD)

The FAA should reevaluate its decision grid on PTSD to liberalize the criteria for issuing a medical certificate/clearance.

INTENT: To allow an AME-Issued with Review (AIR) protocol to issue certification/clearances for mild or complex PTSD, while also enabling post issuance review at AMCD and referral to AAM-200/300 for severe cases.

RATIONALE: The current FAA policy requiring applicants with PTSD to have "no symptoms or treatment for two years"[85] to be eligible for AME issue, is unrealistic for most PTSD cases and difficult to apply. This results in nearly all applicants with PTSD being deferred to the FAA, which causes significant delays and contributes to the Process barrier. Moreover, the FAA policy encourages pilots/controllers to conceal the condition or avoid treatment in order to reach the two-year milestone. This inevitably results in undertreatment, suboptimal care, and increased healthcare avoidance behaviors.

APPROACH: The ARC recommends the FAA reconsider the PTSD decision grid[86] and adopt a policy for PTSD that is similar to the policy for OSA. This approach would allow the AME to issue medical certificates/clearances to applicants with mild or complex PTSD with appropriate restrictions. Specifically, the AME should be allowed to issue certification when the condition has been in remission for more than two months; and the applicant currently or previously participated in psychotherapy or used a single approved antidepressant. The ARC further recommends a requirement for appropriate supporting information, including reports from:

- the treating clinician,
- a doctorate level mental health clinician,
- the applicant's flight instructor or supervisor,
- the medication transcript, and
- other information deemed clinically necessary.[87]

The information should be forwarded to the FAA for post-issuance review within a specified period (e.g., similar to the Specification Sheet[88] provided to pilots/controllers for OSA).

The FAA should also instruct AMEs to only defer the applicant if the criteria for severe PTSD are met (e.g., recurrence of disabling symptoms with or without loss of work, or original traumatic trigger of such severity as to prevent normal function in the aviation environment). For cases that are not severe, the FAA should reiterate its expectation that medical certification should not be withheld.

Barriers Addressed: Fear, Stigma, Financial, Process

[85] *See* PTSD Decision Tool for the AME (faa.gov).
[86] *Id.*
[87] *See* Appendix B for Sample Mental Health Provider Checklist.
[88] *See* Obstructive Sleep Apnea Specification Sheet A .

REC9 – Aeromedical Screening - Proportionate & Publicized Decisions

The FAA should ensure medical certification/clearance decisions are proportional to the aviation safety risks, and the supporting justification communicated to aviation stakeholders.

INTENT: To enhance use of the assessment of aviation safety risk in the certification/clearance process.

RATIONALE: The current aeromedical approach to mental health is clinically/diagnosis based. Thus, pilots or controllers diagnosed with a mental health condition or using mental health services are assumed to pose an undue safety risk. The wide range and spectrum of mental health symptoms and conditions include those that are mild, mild to moderate, or severe. Pilots/controllers with mild or mild to moderate mental health symptoms, (which also includes a significant portion of the US population), are stigmatized by the regulatory consequences of being grounded/removed from duty and deemed unsafe due to their mental health status. The ARC recognizes that a diagnosis of a mild/mild to moderate mental health condition may still be aeromedically significant and will vary by the individual. As such, there may be cases where individuals with a clinically mild condition may not be aeromedically certified; while in other cases, individuals with clinically moderate conditions can be safely certified because the condition is in remission on treatment or is not otherwise aeromedically significant.[89] The FAA's current policies default to an assumption of a hazardous state of illness, which creates a barrier of Fear around the potential loss of medical certification and the Stigma associated with a mental health condition. As a result, pilots/controllers are hesitant to disclose their symptoms or conditions and will refrain from seeking care for their symptoms in the early stages of recognition.

APPROACH: The nature and severity of a mental health symptom or condition should be the basis by which medical certification decisions are made by the FAA. Ideally, a pilot/controller performing to the current standard of their job as determined by operational assessments, should only be grounded or removed from duty if available evidence indicates a likely safety risk to the NAS.

There is evidence that a relevant proportion of pilots are operating with undisclosed health information, and that reconsidering screening and certification criteria would not increase system risk but would address latent risk in the system. Drawing people into the system and lowering the barriers to reporting and seeking care has the potential to improve mental health outcomes and decrease risk to the NAS.

Furthermore, the FAA should communicate the standards and increase transparency surrounding certification decisions, especially in those instances where similar cases resulted in notably different outcomes. This could be done through Peer Support Programs or by sharing accurate narrative-driven information to educate and communicate with aviation stakeholders.

Barriers Addressed: Trust, Fear, Stigma, Process

[89] *See* discussion above in Section VII. G. Knowledge and Information Gap regarding differences in the clinical definitions found in the DSM-5-TR and FAA definitions used for regulatory determinations under 14 CFR Part 67.

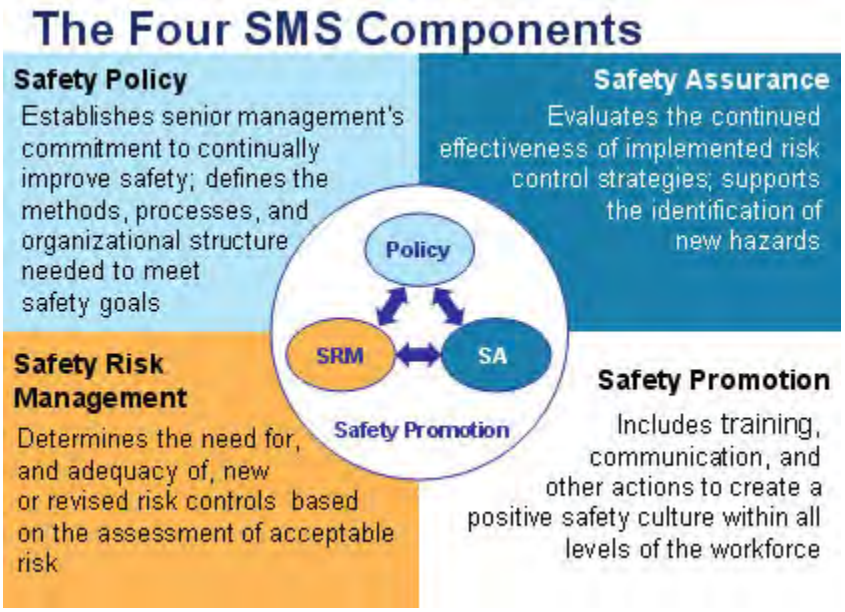
REC10 – Aeromedical Screening - Safety Management Systems (SMS)

Mental health screening functions should be performance based upon and managed within an SMS framework.

INTENT: To employ SMS principles when making medical certification decisions about a mental health condition or treatment and the potential threat of degraded performance. The focus should be on mitigating threats to performance capability relative to occupational standards rather than on the diagnosis *per se*.

RATIONALE: Current FAA policies assume that a mental health diagnosis presents an undue safety risk to the NAS. In many cases, the *mere fact* of a diagnosis (no matter how mild or operationally insignificant) will result in the pilot/controller being removed from duty pending FAA review of extensive documentation on the testing and treatment regarding the person's mental health. This approach discourages mental health care seeking and reporting, and if reported often results in loss of certification/clearance that is disproportional to the purported risk and detrimental to the person.

The ARC considers a better approach to be the use of SMS principles to assess the pilot/controller in a performance operational context in conjunction with their AME. SMS programs rely on non-punitive reporting, hazard identification, threat assessment, and proportional mitigation. By focusing on objective evidence of occupationally significant degraded performance, rather than the diagnosis itself, the FAA can reduce stigma and reframe the relevance of a mental health diagnosis into a safety framework. This would ensure a performance-based approach using safety risk management of mental health concerns instead of a prescriptive approach that does not focus on the individual and skews mitigation efforts toward the most severe disease state.



APPROACH: The FAA should conduct a safety risk assessment of the hazard of pilot/controller mental health conditions focusing on the identification and management of performance-based risks arising from an underlying mental health condition. Rather than a presumptive

disqualification of pilots/controllers reporting a mental health condition, the FAA should consider allowing certification/clearance determinations to be made following relevant operational assessment when appropriate (See Appendix B). These assessments should be made by operational evaluators (e.g., check and training pilots, flight instructors, or air traffic controller managers) following the initial AME evaluation if concerns exist. Upon successful completion of the operational assessment, the AME may issue a medical certificate/clearance. This should reduce the time delay in making determinations and the costs of obtaining additional medical testing.

Barriers Addressed: Culture, Trust, Stigma, Financial, Process

REC11 – Aeromedical Screening - Relevancy & Effectiveness

The FAA should establish a recurrent evaluation process to assess whether its policies, aeromedical screening protocols, and mental health risk controls are evidence-based and consistent with SMS principles.

INTENT: To ensure that aeromedical screening efforts related to mental health are as precise as possible while limiting unnecessary processes. Processes should be reviewed periodically to ensure hazards are controlled to acceptable levels without undue burden on the applicant.

RATIONALE: Aeromedical screening efforts related to mental health aim to optimize safety in the system by identifying hazards to control the risk of an adverse event. These efforts come at a financial, operational, and social cost to pilots/controllers and aviation organizations. All aeromedical screening efforts should be justified with safety/performance data and reviewed on a recurrent basis. This will require dedicated human, financial, and organizational resources to accomplish in a systematic way. The ARC recommends the FAA establish a recurrent process to review policies, screening interventions and actions related to mental health to ensure hazards are controlled to acceptable levels with evidence-based and outcome-focused measures. If a process or procedure is not meaningfully contributing to the objective, it should be removed or modified.

APPROACH: The FAA should use its SMS to:

- establish a comprehensive model that identifies:
    - the hazards related to mental health,
    - the aeromedical and non-aeromedical safeguards that protect against those hazards becoming mishaps,
    - clear performance standards for these safeguards, and
    - the factors that either strengthen or weaken those safeguards.
- establish acceptable levels of safety (i.e., acceptable level of risk) based on the safety continuum as well as the collection of necessary data to measure safety performance through collaboration with operators, and
- conduct recurrent assessments to determine whether safeguards are controlling risk to an acceptable level (i.e. safety assurance), and adjust safeguards to ensure they are neither overly restrictive nor ineffective. These assessments should occur at least every year and be overseen by aeromedical and operational personnel.

Barriers Addressed: Trust, Fear, Financial, Process

REC12 – Aeromedical Screening - Safety Continuum

The degree of regulation and oversight related to pilot and controller mental health should mirror the demand for safety assurance framed within the safety continuum.

INTENT: To ensure that the FAA's approach to managing mental health risk is proportionate to the level of risk and consistent with the public's expectation that the FAA will honor its safety mission.

RATIONALE: Tailoring the level of regulation and oversight will allow the FAA to allocate regulatory resources to the hazards with the highest risk of large-scale mishap. This is consistent with a risk-based regulatory approach and reflects the demand for safety assurance, particularly for commercial operations where the risk tolerance is lower when compared to the risk tolerance for general/recreational aviation. Indeed, the existing safety continuum reflects the lower level of safety assurance that is already accepted in these sectors. Generally, pilot medical fitness oversight (e.g., certification standards) is incrementally reduced, beginning with each class of medical certificate (e.g., Class 1 v. Class 3), type of operation (e.g., air carrier v. recreational), and aircraft type (e.g., turbine powered v. light sport aircraft), then proceeding down the safety continuum. The oversight of pilot/controller mental health hazards should be similarly tailored for aircraft sectors above light sport aircraft.

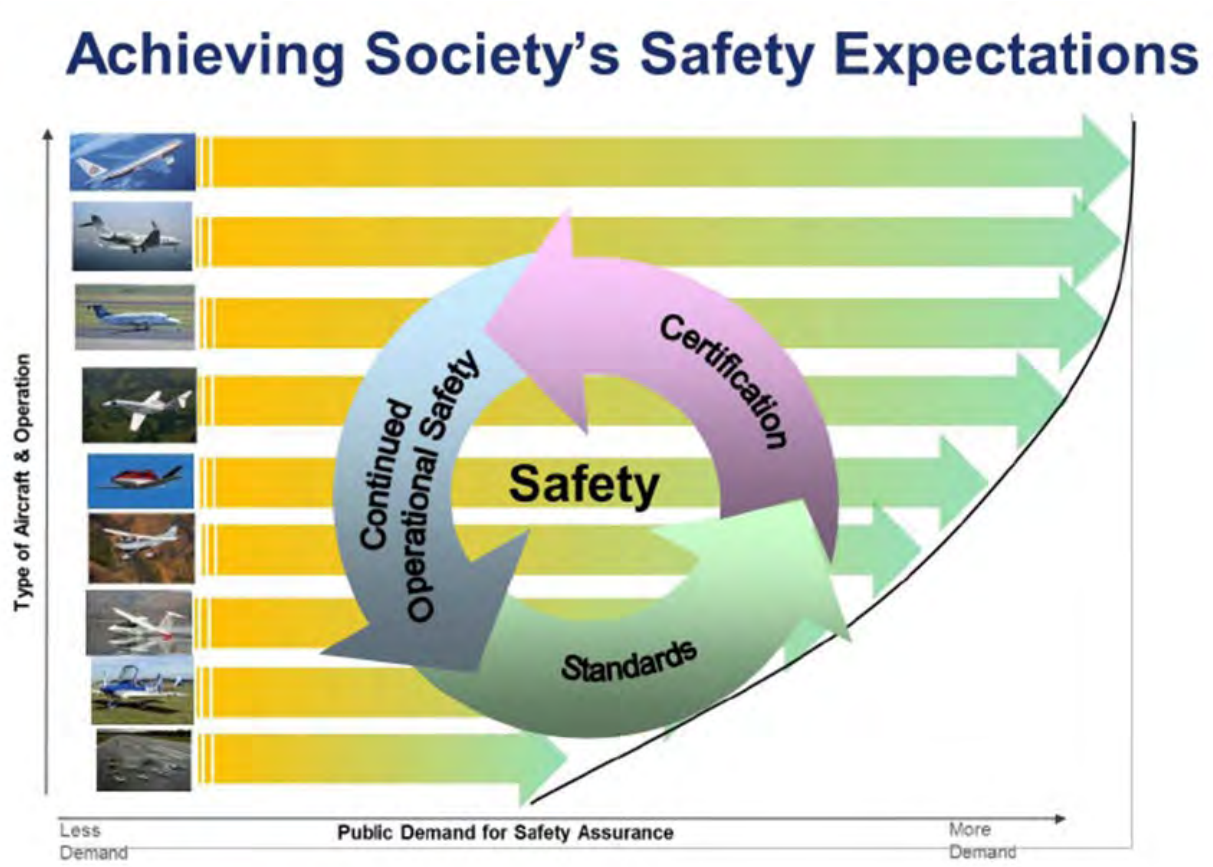
APPROACH: This requires right sizing the acceptable level of safety and establishing medical certification standards and criteria. The standards should be developed within the concept of a safety continuum and based on the hazard presented by the individual's mental health condition and the aviation sector in which the person intends to operate.

The FAA should:

- establish acceptable levels of safety for the hazard of pilot/controller mental health conditions based on the safety continuum;
- conduct safety risk assessments to refine the risk controls and oversight approach for each sector necessary to achieve the acceptable level of safety;
- collect the necessary data to measure safety performance relative to the acceptable level of safety in each sector through safety assurance activities; and
- adjust risk controls (i.e. standards) and oversight based on safety assurance data through SRM.

Barriers Addressed: Trust, Fear, Financial, Process

Figure D: Safety Continuum and Societal Expectations[90]



[90] The Safety Continuum – A Doctrine for Application, (2014) (faa.gov).

REC13 – Information Management – Applicant Guide

The FAA should publish practical medical certification/clearance guidance for applicants.

INTENT: To ensure applicants have the information necessary to allow pilots/controllers to successfully navigate the medical certification/clearance and special issuance pathways.

RATIONALE: The AME Guide is a valuable, public resource, but as the name suggests, it is written for medical personnel and not applicants. As such, it does not always contain usable information an applicant needs, especially for cases requiring detailed evaluation. Applicants need explicit information about the certification/clearance process, such as the expected timeline for approval, the types of evaluations that may be required, or how a particular diagnosis or medication has been handled in the past; but in many cases, the AME Guide simply says, "requires FAA decision."

APPROACH: AAM should work with other relevant FAA lines-of-business and aviation stakeholders to develop comprehensive guidance for applicants. The guidance material should outline best practices for certification/clearance, and describe the steps applicants are expected to follow, information they are expected to provide, and helpful resources they can use. The guidance should also contain information about the estimated timeline for the special issuance pathway based on reporting criteria, diagnosis, and medication. This FAA should use the Medical Matters Guide developed by CAA NZ as a model for its applicant guide.[91] This guidance should be a standalone document and its target audience should be applicants, not AMEs. The ARC also recommends that the guidance material undergo a formal assessment to confirm its suitability for end users.

To that end, the ARC recommends the FAA develop layman-friendly guidance material to educate applicants on all aspects of the medical certification process. The guidance material should include information about the aeromedical concern of the diagnosis, conditions of the diagnosis for which an AME can issue a medical certificate/clearance, whether special issuance will be required based on a specific diagnosis, what test(s) might be required, and the expected timelines for medical review and recertification. The guidance material is intended to be an enhancement of the current AME Guide, which is written for medical professionals but not easily interpreted by individuals without medical training.

Barriers Addressed: Trust, Knowledge and Information Gap

[91] *See* CAA NZ –Medical Matters – Good Aviation Practices.

REC14 – Information Management - System Modernization

The FAA should modernize its information management systems.

INTENT: To modernize the FAA's information management system for medical certification/clearance to reduce processing times and improve decision making.

RATIONALE: The FAA's current information management systems and processes are too slow, resulting in avoidable delays and negative financial impact to applicants and their employers. Delayed responses from the FAA about whether information has been received, was adequate, or whether additional information is required fuels uncertainty about the aeromedical process and leads to underreporting of mental health concerns.

In most cases, information submitted to the FAA must be submitted via US Mail then manually scanned into the system. The FAA acknowledges that manual scanning adds many days to the processing time due to FAA mail security protocols and leads to errors, as documents are sometimes scanned into the incorrect section of an applicant's medical file. Moreover, scanned or 'flat' electronic files and hardcopy documents are not searchable. Non-searchable information is of limited value for organizational learning and undermines the FAA's efforts to continuously improve aeromedical assessment practices.

The ARC believes that the ability of applicants, AMEs, HIMS Specialists, and others to easily submit information to an FAA-industry shared portal would promote more efficient processing, effective communication, and enhanced quality control and quality assurance of the information. The ARC acknowledges that the *MedXPress*[92] electronic upload feature is an improvement over scanned documents, but *MedXPress* is still very limited in its capability and does not allow information to be transferred between the AME and the HIMS Specialist. An expedited transition to a modernized electronic information management system would provide greater efficiency, improved speed and accuracy of responses, and easy sharing of clinical information. This would also provide better learning opportunities for the FAA and AMEs/HIMS Specialists, by having easy access to searchable relevant information from previous cases.

APPROACH: The ARC recommends the FAA implement an integrated electronic information management system that is accessible to applicants, AMEs, HIMS Specialists, and the FAA. The system should allow information to be uploaded in a searchable format and be capable of immediately confirming receipt of information submitted. The system should also, when queried, provide information (ideally in less than one week), as to the adequacy of the submission, the status of the application, and whether any additional information is required. This would improve the quality of the application packages prior to FAA review, which would facilitate faster and better-informed decisions regarding pilot/controller fitness for duty. The FAA should also conduct an in-depth systems analysis of its information management systems to identify other shortcomings and areas of improvement.

Barriers Addressed: Fear, Financial, Process

[92] The MedXPress system allows anyone requesting a medical certificate/clearance to electronically complete an application. Information entered into MedXPress is available to the applicant's AME for review at the time of your medical examination. (https://medxpress.faa.gov).

REC15 – Information Management – Accurate Documentation

The FAA should ensure that information and documentation made available to aviation stakeholders is correct and consistent.

INTENT: To encourage the FAA to develop a well-functioning quality assurance program to ensure continuity in its documentation and consistency in aeromedical decision-making practices and outcomes.

RATIONALE: There is currently an inadequate quality assurance function at the FAA to ensure that information sources such as the AME Guide, *MedXPress*, and internal FAA guidance are consistent and correct. (See Appendix D for examples of inconsistencies *in MedXPress* instructions). In addition, there is currently no standard usability testing to assure that the internal and external tools and procedures are fit for purpose and driving efficient, effective, and desirable outcomes that facilitate a robust cycle of continuous improvement. This is evidenced by inconsistencies within the AME Guide.

APPROACH: A robust quality assurance program should be implemented that is capable of not only identifying quality issues but is also capable of implementing systems-based changes that address usability and other technical issues. The program should inform upper FAA management and other oversight entities so shortcomings can be appropriately addressed, and effective practices can be expanded to other lines of business as appropriate.

Barriers Addressed: Trust, Process, Knowledge and Information Gap

REC16 – Information Management - Data Submission

The FAA should develop a templated electronic submission platform to reduce errors and omissions in information submitted to the FAA by AMEs.

INTENT: To improve the quality, content, and management of data submitted to the FAA by AMEs and improve processing times.

RATIONALE: The FAA reports that AMEs often provide incomplete information, requiring repeated rounds of communication to obtain the information necessary to evaluate an applicant. AMEs would benefit from a clear description of what is required and the ability to submit it electronically. Electronic communication (rather than the current process of using the US mail) would greatly reduce the decision-making timeline, create a searchable database, and allow the FAA to provide real-time feedback about the completeness of the certification package. This would also improve quality control of required data prior to FAA review.

APPROACH: The ARC recommends the FAA create electronic templates with input fields for each case type (e.g., depression/anxiety, PTSD, drug/alcohol, cardiac arrythmia, or head injury). The AME would be required to input information into each field or document to minimize errors and omissions. The information would be automatically verified to the level of detail and quality the FAA requires before it could be transmitted to the FAA, with immediate feedback if the required elements are not included in the template. The system should also be capable of providing, as close to real-time as possible, information about the status of the application and the anticipated timeline for review and disposition. The FAA should specify what applicants need to provide (see REC13) and provide training to AMEs to help them better communicate with applicants. AMEs should also be evaluated to assess their ability to provide the desired quality and content of information.

Barriers Addressed: Process

REC17 – Mental Health Awareness – Aviation Stakeholders

The FAA should work collaboratively with aviation stakeholders to raise awareness of mental health.

INTENT: To ensure that medical applicants are informed of the advancements in the mental health regulatory system and encourage applicants who may have a mental health condition to self-report.

RATIONALE: The FAA currently has several methods of disseminating information on mental health, including the Pilot Minute, presentations at industry events/mental health forums, articles in aviation magazines, and updates to the AME Guide. The ARC commends the FAA's frequent and admirable efforts to engage with the aviation community, but notes that these efforts are unlikely to reach younger generations of pilots using social media as a primary information source. There is significant evidence that sharing narrative-driven information is an effective approach to educating and communicating with people.[93] Sustained educational efforts will reach more aviation professionals, especially those who only obtain medical certificates every two to five years. Many of these individuals do not regularly access FAA informational sources or read print media. By utilizing the power of social media and information campaigns, a broader audience will be more educated about the changes to the aeromedical system, as well as about how they can successfully navigate them.

APPROACH: The FAA should work with aviation stakeholders to develop and execute a multi-year, narrative-driven information campaign that utilizes traditional media, social media, live events, and industry partnerships to raise awareness about advancements in the mental health regulatory system and FAA policies. The campaign should include individuals with various common mental health conditions who successfully navigated the certification process (e.g., SSRI special issuance pathway). The FAA should recognize Mental Health Awareness Month and increase activity during that period as part of this campaign.

Conventional and unconventional ambassadors should be engaged to help convey and disseminate relevant, narrative-based information, including peer storytelling, stress-reducing tips and practices, success with PSPs, the Green Bandana Project, [94] and updated fast-track options. The campaign should not be limited to social media but should also include in-person events, advertisements, video productions, print media, and podcasts. The industry-embedded ambassadors must span all aspects of the industry and highlight the diverse experiences of many pilots/controllers. This will help ensure that current and future applicants who do not routinely engage with FAA content, receive updated information about changes to the aeromedical system. It will also increase the knowledge base of current pilots/controllers.

FAA senior leadership should also be involved in the campaign to promote awareness of new approaches in FAA policies so that individuals are encouraged to come forward and feel

[93] Lien et al., (2023)

[94] The Green Bandana Project is a program dedicated to preventing suicide through promoting help-seeking behavior and increasing awareness of vital mental health resources. After a short orientation and basic suicide prevention training, student participants can proudly attach or display a lime-green bandana on their backpack, bag, or person, signifying they have pledged to be a safe individual to approach for mental health and suicide prevention information and resources.

comfortable doing so. Sharing information about how common mental health conditions are, and how the FAA is adapting to better manage them, will increase awareness, and reduce Stigma. The FAA should also partner with other thought leaders to provide education on mental health-related conditions and tools to help pilots/controllers assess symptoms and promote wellness.
The ARC further recommends that the FAA analyze public sentiment, knowledge, and education on mental health to establish a baseline education level and continue to regularly monitor the target population to ensure the information campaign is effective. This campaign should be in effect for at least 3 years.

Barriers Addressed: Trust, Stigma, Knowledge and Information Gap

REC18 – Mental Health Awareness - Annual Summit

The FAA should partner with aviation stakeholders to hold an annual summit on mental health.

INTENT: To be current with best practices on managing, testing, and treating mental health conditions and ensure contemporary and effective regulatory standards are applied.

RATIONALE: The fields of psychology, psychiatry, and psychopharmacology are areas that change over time based on clinical research and resulting data. Recent advances in wearable digital health technologies in managing depression are one example.[95] Providing an annual forum to present and discuss the current medical literature would promote inter-specialty collaboration and greater communication between fields and professions, as well as updated relevant information. An annual summit will facilitate information sharing, mental health awareness, and greater educational opportunities to support the FAA's efforts to reduce barriers to reporting mental health conditions or seeking help.

APPROACH: The FAA should partner with aviation stakeholders to hold an annual mental health awareness summit. The summit should bring together interdisciplinary fields and experts on mental health (e.g., psychiatry, psychology, neuropsychology, and pharmacology) to present the latest research, clinical data, and therapeutic updates on mental health conditions. The summit should have broad FAA and aviation stakeholder representation.

Barriers addressed: Trust, Stigma, Knowledge and Information Gap

[95] Fedor S, Lewis R, Pedrelli P, Mischoulon D, Curtiss J, Picard RW. *Wearable Technology in Clinical Practice for Depressive Disorder*. N Engl J Med. 2023 Dec 28;389(26):2457-2466. doi: 10.1056/NEJMra2215898. PMID: 38157501.

REC19 – Mental Health Training – AME

The FAA should improve mental health training, quality assurance, and oversight of AMEs to improve mental health literacy.

INTENT: To ensure that AMEs have verified knowledge and capability to address mental health issues of pilots/controllers comfortably and competently, particularly during the time of assessment and examination.

RATIONALE: Mental health conditions represent the most common, potentially disqualifying, but nuanced condition an AME may see during an exam.[96] Unlike many other medical conditions that can be measured quantitatively, the qualitative and variable aspects of mental wellness are more difficult to diagnose and are subject to denial and minimization because of stigma and fear. Pilots/controllers are unlikely to openly admit to mental health problems on standardized questionnaires during a medical exam, and AMEs have reported lacking the confidence to perform mental health assessments or to meaningfully inquire about these topics with pilots/controllers.[97] As more fully explained below, this lack of confidence can be attributed to training, notification, and variations in AME capability. This lack of confidence also undermines Trust between the pilot/controller and AMEs.

AME Training

EASA's ME SAFE document states that AME interviewing techniques and social engagement are the most effective methods of evaluating pilot/controller mental health and support systems.[98] Thus, an AME's assessment of an applicant's mental health is enhanced by their ability to engage in conversation with the applicant about social, familial, and occupational status in a supportive manner, rather than just administering questionnaires. Unfortunately, training in interviewing skills and establishing rapport does not lend itself well to the lecture format that is foundational to AME training; and even if it did, once initial training is complete, formal AME training only occurs once every three years.

AME oversight is also less than ideal, with limited opportunities for the FAA to assess the AME ranks in between recurrent training. Currently, oversight is conducted by the Regional Flight Surgeons (RFS), as the Designee Managers for AMEs. It includes a one-year mentoring program (following designation), ongoing performance monitoring (with routine review of a percentage of issued certificates), and recurrent site visits every five years unless more frequent visits are warranted.

AME Notifications

The FAA currently uses several methods to notify AME's of the latest changes to policy and guidance. Notifications about routine interim policy updates are transmitted monthly via the Aerospace Medical Certification Subsystem (AMCS). Urgent notifications are also transmitted via

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[96] Fitness to Fly – A Medical Guide for Pilots, p.13, noting that mental and nervous disorders are the leading cause of disability payouts for North American pilots.

[97] This lack of confidence has been expressed by AMEs in both the US and Europe. *See* Mental Health Assessment: A survey to Collect Aeromedical Examiners and Assessors Point of View - A Booklet of Results. *See also* EASA ME SAFE project highlighting the desire of European AMEs to have improved mental health training and fluency at EASA MESAFE (Mental health).

[98] *See* EASA MESAFE - D-1.1 - Report on the Review of Diagnostic Measures.

AMCS but are done in real time and supplemented with emails. Both routine and urgent AMCS notifications require acknowledgement of receipt and confirmation that the material has been read. Further education occurs via the Federal Air Surgeon's Medical Bulletin, AME Minutes, and during surveillance visits.

Variations in AME Capability

The AME program has evolved to account for AME differences. Each AME brings a different background and experience to the position by design, but this may result in an AME being less familiar with the current diagnoses and treatments for mental health conditions. Applicants may also not fully understand the various capabilities and regulatory privileges that AMEs hold, resulting in them engaging with an AME that may be ill-suited or unwilling to effectively manage their case. For example, AME categorizations include HIMS AMEs, Senior AMEs, FAA employee examiners, and regular AMEs; all of whom have different certification privileges and limitations.

APPROACH: The FAA should increase mental health instruction in AME training to ensure that AMEs have the requisite knowledge and ability to evaluate pilots/controllers in accordance with the relevant criteria and guidelines. AME initial and recurrent training courses should be designed to raise mental health awareness and improve interviewing techniques and related rapport building skills. The FAA should also offer online training to provide contemporary courses and refresh skills between recurrent training due dates that AMEs can complete at their convenience. The EASA ME SAFE documents can be used as a guide for course development. With improved training, the FAA can expand conditions eligible for CACI and increase AME assisted special issuances in the realm of mental health. This will lead to greater AME comfort in issuing, rather than deferring, applications involving mild/moderate mental health conditions. This will also reduce processing time, lower costs, and increase trust between pilot/controllers, AMEs, and the FAA.

The ARC further recommends the FAA improve training for its own staff to better assess AMEs' mental health literacy and ability to provide appropriate mental health screenings. The training should emphasize proven mental health assessment techniques and qualification determinations during medical examinations.

Barriers Addressed: Culture, Trust, Stigma, Knowledge, and Information Gap

REC20 – Mental Health Training - Aviation Stakeholders

The FAA should collaborate with aviation stakeholders and medical professionals to develop training courses on Aviation Mental Health.

INTENT: To increase knowledge and mutual understanding of all aviation stakeholders regarding mental health issues, policies, procedures, and their critical role in aviation safety.

RATIONALE: The well-documented success of the HIMS education process derives from the FAA's endorsement and collaboration with aviation stakeholders at HIMS seminars. However, HIMS only focuses on substance use disorders, and does not address mental health conditions. This creates a knowledge gap for individuals who attend HIMS seminars seeking greater insight into mental health. A separate course with focused mental health training and industry-wide collaboration will increase knowledge of the spectrum of mental health disorders and aid in destigmatizing periods of mental unwellness. Industry knowledge of the FAA criteria and decision making for mental health conditions will also increase transparency in trust and define certification pathways for those seeking help for mental health conditions.

APPROACH: The FAA should partner with aviation stakeholders to create a training course to develop qualified aviation-savvy mental health providers and advance training for AMEs. This will increase the ranks of aviation savvy MHP and AME's fluent in mental health concerns. The training course should include the differences between 14 CFR Part 67 and DSM-5-TR, all FAA protocols relating to mental health, and common mistakes in application submissions.

This approach would assist applicants who require mental health assessments, but do not live near mental health trained AMEs. This would also increase the number and diversity of locations of aviation savvy mental health providers available to competently assist pilots/controllers who seek care for mental health issues.

AMEs that complete the training course (and all other required training) could be recognized by the FAA as having *enhanced* mental health awareness in the aviation context. These AMEs should be authorized to issue medical certificates, under yet to be developed CACI's, for applicants with mental health conditions. AMEs that are *in the process* of completing the mental health training course would be allowed to perform mental health exams and issue certificates/clearances under CACI **if:**

- there are no AMEs available that have completed the course; **and**
- the CACI-like checklist has no unfavorable responses from the applicant.

The FAA should secure adequate Congressional funding to host a 1-2 day "Mental Wellness in Aviation" course at least three times per year, with a syllabus developed by AAM, Office of Safety Standards (AFS), and other aviation stakeholders. The FAA should also consider the feasibility of virtual and in-person course offerings and create an Advisory Board to ensure continuous improvement of the program.

Barriers Addressed: Trust, Stigma, Process, Knowledge, and Information Gap

REC21 – Mental Health Training – Initial & Recurrent

The FAA should partner with aviation stakeholders to incorporate mental health literacy and awareness training in initial/recurrent training and/or checking/testing events.

INTENT: To disseminate mental health literacy and awareness training to all certificate/clearance holders.

RATIONALE: Certificate holders, training providers and instructors teach students to meet the Airman Certification Standards (ACS) & Practical Test Standards (PTS) for all licenses and aircraft ratings. There are also training elements required as part of the Flight Review and Flight Instructor refresher courses. Including mental wellness information in FAA publications, testing standards, and approved course syllabi for required aviation knowledge will ensure that mental health awareness is taught in all phases of pilot/controller training. It will also ensure that pilots/controllers are assessed on mental wellness during practical tests.

Increased mental health knowledge and awareness will support standardized self-evaluations and fellow crewmember evaluations as a key component of pre-flight/operational assessments. It will also provide individuals with information about available pathways to pursue if they need mental health treatment or counseling, including how to contact an AME and comply with existing regulations.

APPROACH: The ARC recommends that the FAA include mental health training in the Aeronautical Knowledge requirements in FAR parts 61, 121, 125, 135, and 141. The requirements should be applicable to all pilots, instructors, and controllers. The training should emphasize mental health and physical wellness as a critical component of aviation safety. All relevant FAA publications should be amended in support of this recommendation, and mental wellness should also be added as an element in the ACS/PTS for all airmen ratings in either the Pre-Flight Preparation or Aeronautical Decision-Making Tasks.

The training should be comprehensive and recurrent, with standardized module content regularly reviewed to ensure continuity across all platforms of training and exposure. Online training and/or testing should be available to all pilots/controllers, and the training should be incorporated at regular intervals.

The ARC further recommends that the FAA increase visibility and utilization of the FAA Safety Wings program,[99] and allow documentation of course completion for pilots/controllers pursuing special issuance or special consideration for medical certification/clearance. The Wings program is a widely accepted AFS program available to any airman free of charge. It is a safety educational tool with hundreds of knowledge courses that can be used to update currency of a flight review available and completed at the pilot/controller's convenience. The FAA should design three courses and corresponding tests for inclusion in the Basic, Advanced, and Master phases of the Wings program. Suggested topics include mental health as a safety factor, effects of medications and dangers of self-medication, and resiliency techniques to optimize performance.

The FAA should also consider incorporating mental health awareness into pre-medical certification/clearance training for pilots/controllers. This could include informational videos, such

[99] The WINGS Program consists of learning activities and tasks selected to address the documented causal factors of aircraft accidents. *See* FAA Advisory Circular AC 61-91J.

as those provided through the Wings Program, to disseminate mental health knowledge that applicants would need to know prior to completing a *MedXPress* application.

Barriers Addressed: Trust, Fear, Stigma, Knowledge, and Information Gap.

REC22 – Regulatory Pathway - Operational Limitations on Certificates & Clearances

The FAA should clarify whether it is empowered to issue medical certificates/clearances with operational limitations.

INTENT: To determine when it would be appropriate for an applicant's medical condition to be mitigated by having another equally qualified person available in the immediate vicinity, and whether the FAA has the authority to issue the medical certificate/clearance with that limitation rather than denying the special issuance.

RATIONALE: The ARC's review of the 1980 memorandum opinion in the matter of Delta Airlines v. United States[100], calls into question the current FAA position that it is prohibited from issuing medical certificates restricted to two pilot operations. The FAA's position is based on the text of the memorandum opinion, which distinguishes between functional limitations and operational limitations:

> *[C]onditions on medical certificates of the type referred to herein as "functional limitations," which specify the job an airman may hold in a cockpit, such as "not valid for pilot-in-command duties," "valid for first officer duties only," or "valid for flight engineer duties only." These "functional limitations" are readily distinguishable from the "operational limitations" which are expressly authorized by 14 C.F.R. § 67.19(c). (The latter, instead of specifying job functions, specifies conditions which would operate to compensate for a medical deficiency, e. g., requiring corrective lenses or requiring that a pilot with night blindness fly only in the daytime.) The operational limitations are specifically provided for in the Regulations and by the explicit language of 14 C.F.R. § 67.19(d) do not apply to airmen with any of the absolutely disqualifying conditions.*

The specific order reads "*The Federal Air Surgeon is further enjoined from placing any limitation on the medical certificate of an airman that describes the flight functions that such airman may perform.*"

The ARC submits that it is unclear whether this order prohibits the FAA from setting the operational limitation of only being valid when another equally capable individual is in the immediate vicinity. Allowing such an operational limitation opens the door to the FAA being able to grant special issuances to pilots/controllers who otherwise might not be able to obtain medical certification. Title 14 CFR § 67.401(d)(3) specifically states:

> State on the Authorization or SODA, and any medical certificate based upon it, **any operational limitation needed for safety**; or (emphasis added).

This is of particular importance to pilots operating in two-pilot operations (e.g., many Part 135 operations and all Part 121 operations), who may be allowed to return to work sooner, as these pilots are already functioning in a situation consistent with this limitation and no

[100] https://law.justia.com/cases/federal/district-courts/FSupp/490/907/1905311/ *Delta Air Lines, Inc. v. United States*, 490 F. Supp. 907 (N.D. Ga. 1980).

further action would be required to comply with the limitation. ICAO SARP's (Standards and Recommended Practices) allow this practice and nearly all international CAA's make use of this option to increase safety mitigation barriers for pilots with physical and mental health conditions.

APPROACH: The ARC recommends the FAA undertake a legal analysis to determine whether it has the authority to issue operational limitations on medical certificates/clearances in all operating environments, and to specifically limit the validity of the medical certificate when there is at least another equally qualified[101] person in the immediate vicinity of the 'limited' certificate holder.

Barrier Addressed: Financial, Process

[101] With respect to both adequate pilot/controller certificate and appropriate medical certificate.

REC23 – Mental Health Parity – Legislative Amendments

***Non-governmental* aviation stakeholders and mental health advocacy organizations should petition Congress to expand the Mental Health Parity Act to include affordable access to disability insurance benefits for mental health diagnoses.**

INTENT: To encourage Congress to expand mental health parity beyond medical insurance to include disability insurance. This will help address the financial barrier to mental health reporting.

RATIONALE: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[102] requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. [103]The MHPAEA does not apply to disability insurance, leaving a gap in benefit coverage for pilots/controllers diagnosed with a mental health condition once they transition to long-term disability. As this is an issue of national importance, mental health advocacy organizations, such as the National Alliance on Mental Illness, the National Association for Behavioral Healthcare, the American Psychiatric Association and the Depression and Bipolar Support Alliance are natural partners.

APPROACH: Non-governmental aviation stakeholders and mental health advocacy organizations should petition the government to require mental health parity with physical health diagnoses. This should specifically include coverage for any FAA required test deemed medically necessary, for medical certification/recertification decisions, as well as disability insurance coverage like the MHPAEA. The tests should be covered by any employer-provided or privately purchased healthcare plan.

Barriers Addressed: Financial

[102] 29 USC Ch. 18: Employee Retirement Income Security Program, (Subchapter I, Subtitle B, Part 7). The MHPAEA ensures that group health plans (or health insurance coverage associated with such plans) provide equal coverage for mental health and substance use disorder benefits as they do for medical and surgical benefits.

[103] Centers For Medicare & Medicaid Services, Fact Sheet - Mental Health Parity and Addiction Equity Act of 2008.

REC24 – Mental Health Parity – Disability Insurance

Aviation stakeholders should consider providing mental health disability insurance programs for their employees.

INTENT: To encourage aviation stakeholders to provide job-specific disability insurance programs that include coverage for mental health conditions, preferably to retirement age.

RATIONALE: The ARC recognizes that the lack of a disability insurance program that includes coverage for mental health conditions is a significant barrier to the reporting of mental health concerns. The potential loss of income for a pilot is associated with being unable to perform their job and could extend from the time of disclosure of a mental health condition requiring grounding through the process of medical recertification. For controllers, the potential loss of income could extend from the time of disclosure of a mental health condition resulting in a loss of medical clearance through the process of achieving a renewed medical clearance. This timeline can be negatively affected by the length of treatment, the delay in scheduling any specific test that may be required by the FAA and prior to submission of required documentation. Most disability carriers do not recognize the medical certification clearance requirement for pilots/controllers and may not pay benefits if the individual is clinically stable, but still not able to maintain FAA medical qualification. See Section VII.E. 'Financial' above for a detailed discussion of the Financial barrier.

APPROACH: The ARC understands that many of the mechanisms to fulfill the goals of this recommendation would be established during the collective bargaining process between working groups and their bargaining agents or through the pooling of resources within member organizations and/or trade associations. The ARC highlights the importance of such disability benefits in lowering the barrier to self-reporting. During the collective bargaining process, both aviation industry entities and the representative bargaining agents should recognize the importance of needed financial stability in a pilot/controller's decision to self-report a possibly mental health issue that may cause a loss of certification/clearance.

Barriers Addressed: Stigma, Financial

IX. Definitions and Glossary of Terms

A. Definitions

Term	Definition
Aeromedical advisor	An aeromedical professional who assists pilots/controllers with health concerns by providing specialized aeromedical advice and works as a liaison with the Federal Aviation Administration (FAA) to help pilots maintain or regain their medical certification.
Air carrier	A business that undertakes directly by lease, or other arrangement, to engage in air transportation.
Aviation Medical Examiner	An FAA-designated physician authorized to receive airman medical certificate applications, perform airman physical examinations, and to issue airman medical certificates.
Aviation Stakeholders	Airlines, the FAA, Air Navigation Service Providers (ANSP), labor unions, regulatory bodies, pilot advocacy groups, business aviation, general aviation, the Aerospace Medical Association, academia, and many other organizations
Employee Assistance Program (EAP)	A workplace benefit program designed to provide confidential and professional assistance to employees who are dealing with personal or work-related problems that could affect their well-being and job performance. EAPs are offered by employers to support their employees' mental health, emotional well-being, and overall productivity.
Medical professional	Physicians, physician assistants, nurse practitioners, psychologists, and clinical social workers or substance abuse specialists (all "health professionals" as defined on FAA Form 8500, the medical application form).
Mental health literacy	Knowledge and beliefs about mental disorders which aid their recognition, management, or prevention.
Mental Health Provider	A mental health professional is a health care practitioner or social and human services provider who offers services for the purpose of improving an individual's mental health or to treat mental disorders.
Mental illness	Disorders are generally characterized by dysregulation of mood, thought, and/or behavior.
Peer	A person who shares professional qualifications and experience.
Peer Support Program (PSP)	A confidential peer-led program designed to support mental health and wellness. The Program aims to provide pilots/controllers with the tools needed to support and restore their mental wellbeing and direct them to appropriate resources if needed. At the heart of the program are trained peers ready to help in a confidential and non-punitive way.
Pilot mental fitness	Issues affecting a pilot's emotional state, mental health, or cognitive ability to safely conduct their duties.
Pilot Representative Organizations	An official or ad hoc organization representing pilot interests at an air carrier such as labor unions, nonunion organized pilot groups, or professional associations.
Psychological Avoidance:	Admitting a mental health concern and the personal realization that one must address it, which leads to the natural defense mechanism of denial of the issue.

Public safety	The welfare and protection of the general public.
Safety Management System (SMS)	A set of policies and procedures that an organization uses to reduce workplace accidents and illnesses. An SMS is a formal, top-down approach that includes systematic procedures, practices, and policies for managing safety risk. It can be tailored to the size and complexity of an organization and can fit any business type and/or industry sector.
SODA	At the discretion of the Federal Air Surgeon, a Statement of Demonstrated Ability (SODA) may be granted, instead of an Authorization, to a person whose disqualifying condition is static or nonprogressive and who has been found capable of performing airman duties without endangering public safety.
WINGS Criteria	FAA Pilot Proficiency course as per AC 61.91J

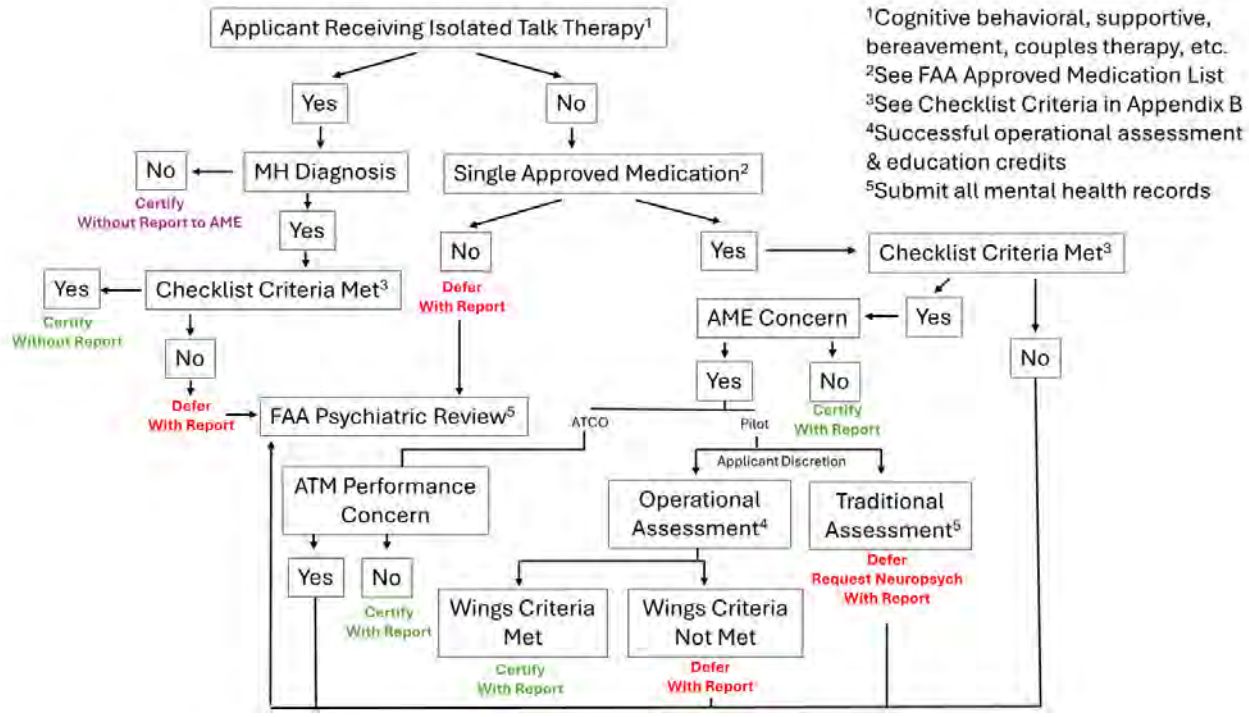
B. Acronyms

Acronyms	
AAM	Office of Aerospace Medicine
ACS	Airman Certification Standards
AIR	AME-Issued with Review
AMCD	Aerospace Medical Certification Division (AAM-300)
AME	Aviation Medical Examiners
ANSP	Air Navigation Service Provider
ARC	Aviation Rulemaking Committee
ASAP	Aviation Safety Action Programs
AsMA	Aerospace Medical Association
ATO	Air Traffic Organization
CAA	Civil Aviation Authority
CACI	Certificates AMEs Can Issue
CBA	Collective Bargaining Agreement
CIRP	Critical Incident Response Programs
CISM	Critical Incident Stress Management
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
EAP	Employee Assistance Programs
FAA	Federal Aviation Administration
HIMS	Human Intervention Motivation Study
HIMS AME	FAA Senior AME completed HIMS Training and Testing
MHP	Mental Health Professional
NAS	National Airspace System
NTSB	National Transportation Safety Board
OSA	Obstructive Sleep Apnea
PTS	Practical Test Standards
RFS	Regional Flight Surgeon
SARP	Standards and Recommended Practices
SMS	Safety Management System
SODA	Statement of Demonstrated Ability
SSRI	Selective Serotonin Reuptake Inhibitor

X. Appendices

Appendix A – Talk Therapy Process Flowchart

This diagram pertains to Recommendations REC1, REC5, REC6, REC10, & REC19.



Wings Criteria – Completing one Phase of the FAA Wings Program with Knowledge and Flight credits documented in the FAA AFS Pilot Proficiency Wings Program and providing Completion certificate.

Appendix B – Sample Mental Health Provider Report Checklist

Potential Items to include on the mental health provider checklist that the pilot/controller would give to the AME:

- Name of individual
- Name and credentials of therapist
- Type of therapy
- Date of initial therapy
- Frequency of therapy
- Date of termination of therapy if not ongoing
- Results of therapy
- Medication used currently if any (date of initiation)
- Medications previously used, (list date range of use, if known)

Does this individual have any of the following?

1. A personality disorder repeatedly manifests by overt acts
2. A history of psychosis manifested delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition
3. Bipolar disorder
4. A Substance Use Disorder
5. Personality disorder, neurosis, or other mental condition that makes the person unable to safely perform the duties.
6. History of suicidal plans or attempts
7. Have you been prescribed or recommended to take multiple simultaneous psychoactive medication related to the therapy? If so, list name(s) of medication(s)
8. Has there been a recommendation or referral to a psychiatrist or psychologist because of the severity of the mental health condition?
9. History of non-compliance with treatment recommendations
10. History of psychiatric hospitalization
11. History of non-trivial criminal behaviors
12. Do you have any other concerns about the individual ability to function in a safety sensitive role?

Signed
Dated
License # and State

Appendix C – CASA and CAA NZ Safe Haven Pathway Draft Policy

Overview

CASA and CAA NZ are developing a pathway by which certificate-holders with mental health problems are encouraged to self-disclose and supported when they do so. The intent is to develop a safety culture that enhances help-seeking for and self-disclosure of mental health and other problems.

Policy principles

Certificate holders who meet clearly defined criteria are allowed to maintain medical qualification status under supervision by an aviation medical examiner (as defined by ICAO). Certificate holders have the options of disclosure directly to the regulator (CAA and CASA) or through the alternative Safe Haven pathway. Through the conventional direct-disclosure pathway the medical certificate is suspended pending final determination from the Aviation Medicine Section at CASA or the CAA NZ Medical Unit. For those medical certificate holders who use the Safe Haven pathway such determinations are made by Safe Haven medical examiners, and only referred to the CAA Medical Unit or CASA Aviation Medicine Section using a designated escalation pathway.

Safe Haven eligibility for maintaining qualification pending determination and for the ongoing certification pathway is contingent on the pilot or controller:

- providing all available medical treatment records to the supervising AME
- meeting the CASA and CAA NZ-defined diagnostic and medication criteria (confirmed by the AME)
- continuing compliance with the requirements of the Safe Haven pathway throughout the period of their certification.

Certificate-holders who meet the criteria and are subsequently managed under this pathway will not be subject to referral for administrative or enforcement action due to any prior non-disclosure of illness or medication use. Certificate-holders who do not meet the criteria or are not eligible for or compliant with the pathway remain subject to the normal processes for administrative and enforcement action.

Eligibility for the pathway does not depend on the way in which the certificate-holder's mental health problem or its treatment is disclosed to CASA or CAA NZ. However, where the CASA and CAA NZ become aware of the diagnosis and/or treatment, continued certification is contingent upon the certificate-holder's ongoing engagement in the CASA's or CAA NZ's certification processes.

Supporting documents and processes

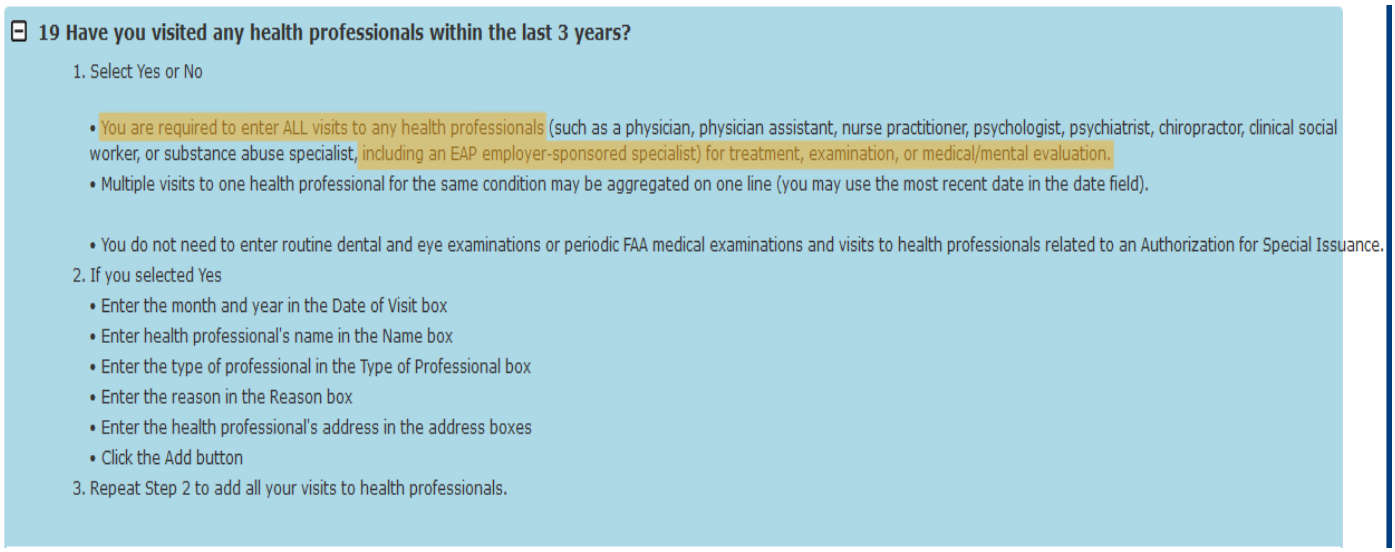
CASA and CAA NZ will develop a suite of documents to guide certificate-holders and AMEs on the implementation of the program. These include:

- Eligibility criteria and evidence requirements for demonstration of eligibility
- AME checklist for confirming eligibility for the certificate-holder
- AME forms for documenting and reporting compliance

- Escalation pathways for non-compliance or change in risk assessment
- Guidance for the certificate-holder
- Guidance for development of a Safe Haven Plan with which the certificate-holder must comply, covering:
    - Therapeutic compliance
    - Healthcare provider contact requirements
    - PSP role and contact requirements
    - AME contact and reporting requirements
- Guidance for qualifications and competencies for AMEs, healthcare providers and PSPs participating in Safe Haven programs

Appendix D- Examples of Conflicting FAA Information for MedXpress Instructions

MedXPress Question 19 Further Information Box



19 Have you visited any health professionals within the last 3 years?

1. Select Yes or No

- You are required to enter ALL visits to any health professionals (such as a physician, physician assistant, nurse practitioner, psychologist, psychiatrist, chiropractor, clinical social worker, or substance abuse specialist, including an EAP employer-sponsored specialist) for treatment, examination, or medical/mental evaluation.
- Multiple visits to one health professional for the same condition may be aggregated on one line (you may use the most recent date in the date field).
- You do not need to enter routine dental and eye examinations or periodic FAA medical examinations and visits to health professionals related to an Authorization for Special Issuance.

2. If you selected Yes
   - Enter the month and year in the Date of Visit box
   - Enter health professional's name in the Name box
   - Enter the type of professional in the Type of Professional box
   - Enter the reason in the Reason box
   - Enter the health professional's address in the address boxes
   - Click the Add button
3. Repeat Step 2 to add all your visits to health professionals.

FAA 8500-8 Instructions for Question 19[104]

19. VISITS TO HEALTH PROFESSIONAL WITHIN LAST 3 YEARS -- List all visits in the last 3 years to a physician, physician assistant, nurse practitioner, psychologist, clinical social worker, or substance abuse specialist for treatment, examination, or medical/mental evaluation. List visits for counseling only if related to a personal substance abuse or psychiatric condition. Give date, name, address, and type of health professional consulted and briefly state reason for consultation. Multiple visits to one health professional for the same condition may be aggregated on one line. Routine dental, eye, and FAA periodic medical examinations and consultations with your employer-sponsored employee assistance program (EAP) may be excluded unless the consultations were for your substance abuse or unless the consultations resulted in referral for psychiatric evaluation or treatment. See **NOTE** below.

No NOTE provided in the 8500-8 Instructions document.

[104] MedXpress Help Instructions

Guide for Aviation Medical Examiners[105]

ITEM 19. Visits to Health Professional within Last 3 Years

The applicant should list all visits in the last 3 years to a physician, physician assistant, nurse practitioner, psychologist, clinical social worker, or substance abuse specialist for treatment, examination, or medical/mental evaluation. The applicant should list visits for counseling only if related to a personal substance abuse or psychiatric condition. The applicant should give the name, date, address, and type of health professional consulted and briefly state the reason for the consultation. Multiple visits to one health professional for the same condition may be aggregated on one line.

Routine dental, eye, and FAA periodic medical examinations and consultations with an employer-sponsored employee assistance program (EAP) may be excluded unless the consultations were for the applicant's substance abuse or unless the consultations resulted in referral for psychiatric evaluation or treatment.

[105] 2024 Guide for Aviation Medical Examiners

APPENDIX E

Aeromedical Update

Presented to: GAJSC

By: Brett A. Wyrick, D.O.,MPH,FACOS

Date: August 30, 2023

Aviation Safety AVS

Job # 1:
Safety of the National Air Space

- **San Diego, California PSA Flight 182**
- **Sept. 25, 1978**
- **B-727 / Cessna 172**
- **Fatalities = 144**

Job # 1:
Safety of the National Air Space

- **San Diego, California PSA Flight 182**
- **Sept. 25, 1978**
- **B-727 / Cessna 172**
- **Fatalities = 144**

Risk Assessment

- **How likely is the condition to occur again?**
- **If it occurs again, how serious is it likely to be?**

•Aeromedical Risks

- Sudden incapacitation e.g. seizure, sudden cardiac death
- Rapid incapacitation e.g. hypoglycemia, MI, stroke
- Impairment (subtle incapacitation) e.g. fatigue, cognitive deficits, depression, pain, medication effects, disturbances of sensory input

What Is Acceptable Risk?

- **No risk = No flying**
- **Flying public – zero on my flight**
- **1% Rule – complex assumptions**
- **Tilton Rule: The risk of adverse medical event approximates that of unscreened population.**

The Next Evolution

- **Tap into Big Data**
- **Adapt artificial intelligence**
- **Evaluate system risk**
- **Predictive analytics**

Challenging Realities

- **“The runway is not age adjusted” -- Gary Kay, PhD**
- **The weather does not provide reasonable accommodation**
- **You can’t just pull over and stop**
- **“Aviation… is terribly unforgiving” – Capt. A.G. Lamplugh**

Myth: Flying Same as Driving

- **Acceleration**
- **3 Axes of motion – spatial disorientation**
- **Altitude**
  - Hypoxia
  - Barometric pressure changes
- **Can’t just pull over and stop**

Where Do I Start?

AME Guide

Medical Certification Process

- **Med Express – medical history**
- **AME exam**
- **Transmission to FAA**
- **New tracking tool**
- **Certification decision**
  - Unrestricted
  - Special Issuance
  - Denial

Decision Levels in Civil Aviation

Level 1: Individual Pilot

14 CFR 61:53

"…shall not act as pilot in command…while that person knows or has reason to know of any medical condition that would make the person unable to operate the aircraft in a safe manner."

Decision Levels in Civil Aviation

Level 2: Aviation Medical Examiner

- **Issue Medical Certificate ~95%**

  - No significant findings on history/exam

  - Common medical conditions specified in the AME Guide if stable

  - Medical conditions cleared with completion of CACI worksheet (May require review of additional information)

- **Defer**

Decision Levels in Civil Aviation

Decision Level 3: AMCD or Regional FS

- **Issue Unrestricted Medical Certificate**
- **Authorization for Special Issuance Medical Certificate**
- **Deny**
- **Defer to Headquarters**

Decision Levels in Civil Aviation

Decision level 4: Federal Air Surgeon

- **Any complex case deferred by AMCD or RFS**
- **All special issuances for SSRI program**
- **All FAS Appeals**
- **All Class 1 & 2 ITDM**
- **All formal HIMS cases**

Decision Levels in Civil Aviation

- **Decision level 5:**

  National Transportation Safety Board

  - Only unrestricted medical certificates

“I didn’t know where I was in the air.”

A Tale of Two Olympians

The Message

- **Mental status is a performance issue and a safety issue.**
- **Communication promotes recognition**
- **Recognition prerequisite to action**

Mental Health Continuum

Federal Aviation Administration

In a pilot, with a mental health diagnosis… return him/her to flying…as soon as it is safe to do so.

Mental Health Issues Are Common

- **21% prevalence in U.S. population**
- **Rates of anxiety & depression 4 times higher than prepandemic**
- **5.9% of Class 3 certificate holders in 2020 had at least one mental health code**
- **Currently AMCD estimates 30-40% of general review cases have mental health component**

History

- 1970 First FAA Chief Psychiatrist
- 1974 HIMS Program
- 2010 SSRI Program
- 2016 ARC on Pilot Mental Health
- 2018 First FAA Neuropsychologist
- 2019 Second FAA psychiatrist
- 2021 Third FAA psychiatrist
- 2022 Recruiting fourth psychiatrist

“No established medical history or clinical diagnosis of …”

(1) Personality Disorder severe enough to have repeatedly manifested itself by overt acts

(2) Psychosis

(3) Bipolar Disorder

(4) Substance dependence

- **Depression**
- **ADD/ADHD**
- **OCD**
- **Anxiety**
- **Other Personality Disorders**

Rarely Waivered Conditions

- **Psychosis**
- **Bipolar disorder**
- **Untreated recurrent major depression**
- **ADHD either on medication or with persistent signs/symptoms**

ADHD

- **Contributing factor in fatal mishaps in 2017 and 2020**
- **Medication controls but does not eliminate underlying condition**
- **Overdiagnosis common**
- **Medications prescribed for performance enhancement without a diagnosis**
- **Medscape survey – 29% of physicians would prescribe psychostimulant solely for performance enhancement**

Special Mental Health Programs

- **Human Intervention Motivation Study (HIMS)**
- **Selective Serotonin Reuptake Inhibitors (SSRI)**

Impact in 2023

- **522 pilots flying while taking SSRI antidepressants**
- **2,996 pilots flying with history of substance dependence**

HIMS Program

- **Success story**
- **Prior to 1974 - permanent grounding for substance dependence – no exceptions**
- **Coordinated effort between management, unions, volunteers, medical professionals and FAA**
- **~85% relapse free**

HIMS Team

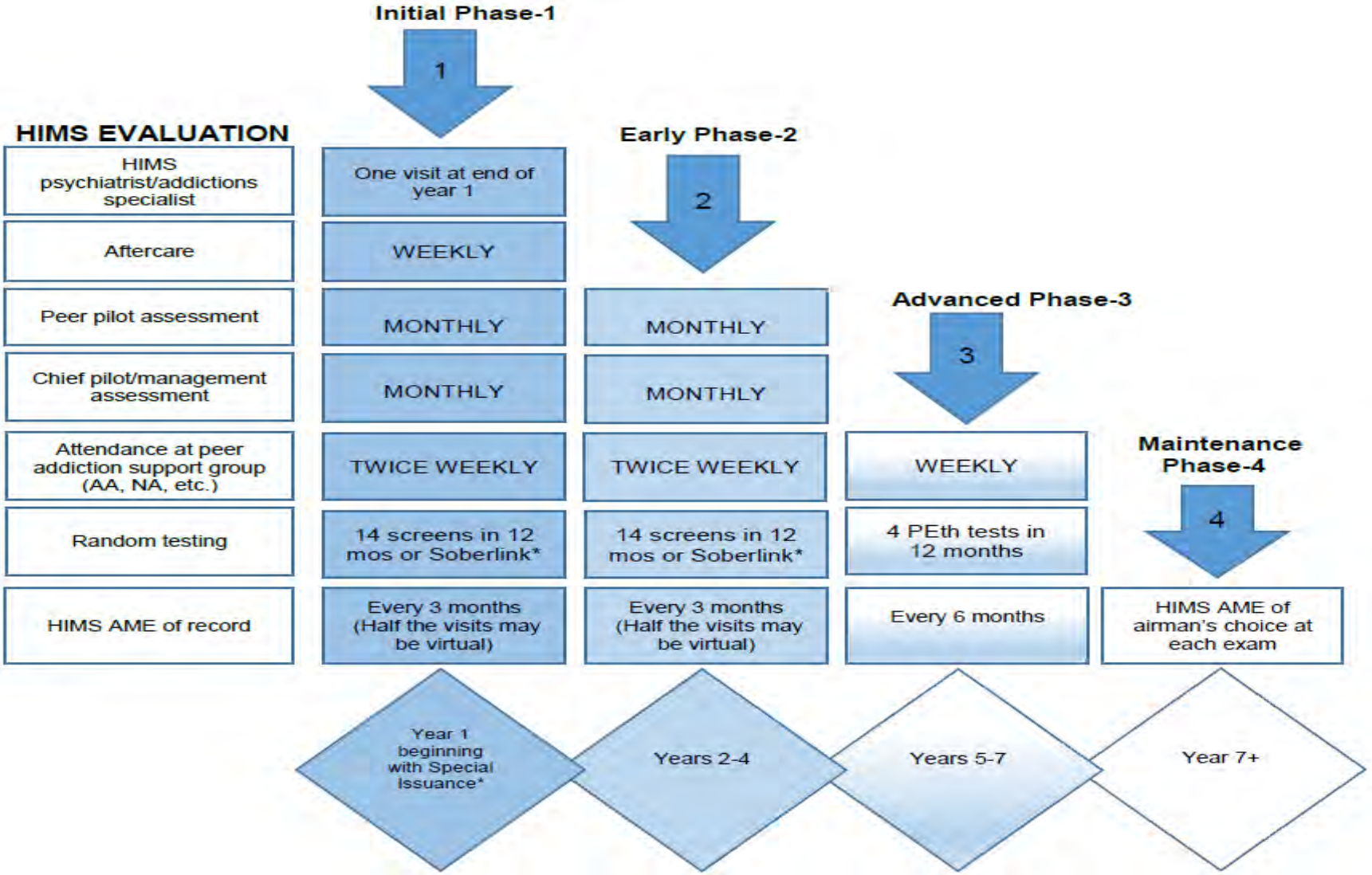
- Employers
- Pilot Unions
- FAA
- HIMS AMEs
- Treatment Facilities
- Psychiatrists
- Peer Support Groups
- Peer Pilots
- Aftercare Providers

Role of the HIMS AME

- **Coordinate care**
- **Administratively manage case**
- **Regular meetings with pilot**
- **Evaluate the quality of the recovery**
- **Make a recommendation regarding safety for special issuance and step down**

FAA Program

- Dependence vs. abuse vs. one-time stupid
- Formal treatment program – 28 day inpatient or intensive outpatient
- Group aftercare
- Peer support group e.g. AA
- Compliance testing
- Evaluation by HIMS psychiatrist
- Initial neurocognitive assessment
- Maintain abstinence
- Step-down plan



*Soberlink or similar portable, alcohol breath-monitoring system that has facial recognition and cellular transmission technology.

Goals of Step Down Plan

- **Support strong recovery program**
- **Extended follow up of life-long disease**
- **Responsible fact-based use of resources**
- **Satisfy as many stakeholders as possible**

DSM 5

Alcohol Use Disorder

- **A problematic pattern of alcohol use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12 month period.**

(3) Misuse of a substance that the Federal Air Surgeon, based on case history and appropriate, qualified medical judgment relating to the substance involved,

finds ….

Makes the person unable to safely perform…

HIMS AME Checklist

1. **HIMS AME FACE-TO-FACE, IN OFFICE EVALUATION: Required <u>EVERY 6 months for ALL CLASSES</u>**
   Any concerns that the airman is not successfully engaged in a continued abstinence-based recovery program or is not working a good program based on your clinical interview/evaluation and review of reports? .....
   - Interval evaluations (every 3 months or as required by Authorization Letter) were unfavorable?.....
   - Any evidence or concern the airman has not remained abstinent? .....
   - Any positive drug or alcohol tests since last HIMS evaluation? .....
   - Any evidence of noncompliance or concern the airman is not working a good recovery program.....
   - Any NEW condition(s) that would require Special Issuance? (Do not include any new CACI qualified condition.).....

No	Yes

2. **TREATING PSYCHIATRIST REPORT** or **HIMS PSYCHIATRIST REPORT: Required <u>EVERY 12 months for ALL CLASSES</u>** unless a different time interval is specifically stated in the Authorization Letter.
   - Report(s) is/are favorable (no anticipated or interim treatment changes) .....
   - The psychiatrist recommends no additional treatment or monitoring.....

Not Due	Yes	No

Items 3 - 5: The AME should review. Do not submit these items (3-5) to the FAA <u>unless concerns are noted.</u>

3. **AFTERCARE COUNSELOR REPORTS**: For 1st and 2nd class: Required every 3 months; 3rd class: Per Authorization Letter.
   - Show continued participation and abstinence-based sobriety? .....

N/A	Yes	No

4. **CHIEF PILOT REPORT(S):** Required monthly for commercial pilots holding first- or second-class certificates (N/A for third-class):
   - Report(s) is/are favorable? .....

N/A	Yes	No

5. **PEER PILOT REPORTS:** Required monthly for commercial pilots holding first- or second-class certificates (N/A for third-class):
   - Report(s) is/are favorable with continued total abstinence? .....

N/A	Yes	No

6. **ADDITIONAL REPORTS:** Required **<u>ONLY</u> when specified by the Authorization letter**
   - HIMS related (AA attendance, therapy reports, etc.) are favorable and meet authorization requirements.....
   - Reports required for other **non-HIMS** conditions all meet Authorization requirements.....

N/A	Yes	No

7. I have no other concerns about this airman and recommend re-certification for Special Issuance. .....

Yes	No

#5 NEUROPSYCHOLOGIST EVALUATION AND RAW TEST DATA

The neuropsychologist report MUST address:

1. **Qualifications:** State your certifications and pertinent qualifications.
2. **Records review:** What documents were reviewed, if any?
   - **a.** Specify clinic notes and/or notes from other providers or hospitals; and
   - **b.** Verify if you were provided with and reviewed a **complete copy** of the airman's FAA medical file.
3. **Results of clinical interview**: Detailed history regarding psychosocial or developmental problems; academic and employment performance; family or legal issues; substance use/abuse (including treatment and quality of recovery); aviation background and experience; medical conditions and all medication use; and behavioral observations during the interview and testing. Include any other history pertinent to the context of the neuropsychological testing and interpretation.
4. **Mental status examination**
5. **Testing results:**
   - **a**. CogScreen-Aeromedical Edition (CogScreen-AE); and
   - **b**. Remainder of the core test battery.
6. **Interpretation:**
   - **a.** The overall neurocognitive status of the airman;
   - **b. Clinical** diagnosis (es) suggested or established based on testing, if any;
   - **c.** Discuss any weaknesses or concerning deficiencies that may potentially affect safe performance of pilot or aviation-related duties, if any;
   - **d.** Discuss rationale and interpretation of any additional testing that was performed; and include
   - **e.** Any other concerns.
7. **Recommendations:** Additional testing, follow-up testing, referral for medical evaluation (e.g., neurology evaluation and/or imaging), rehabilitation, etc.

HIMS Document Links

HIMS-TRAINED AME CHECKLIST

Drug and Alcohol Monitoring – INITIAL Certification

https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/media/HIMS_DA_Monitoring_Initial_Certification.pdf

FAA CERTIFICATION AID

HIMS Drug and Alcohol Monitoring – INITIAL Certification

https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/media/FAACertificationAid-HIMSDrugandAlcohol-Initial.pdf

HIMS-Trained AME CHECKLIST

Drug and Alcohol Monitoring - RECERTIFICATION

https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/media/HIMS_Drug_Alcohol_Monitoring_Checklist.pdf

FAA CERTIFICATION AID

HIMS Drug and Alcohol Monitoring – RECERTIFICATION

https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/media/Drug_Alcohol_Monitoring_Recertification_Aid.pdf

HIMS Program Issues

- **Incorrect regulatory determination**
- **Drug/alcohol monitoring test results**
- **Drug assisted recovery e.g. antabuse, suboxone, ibogaine**
- **FAA delays for initial Special Issuance**

- **General observation that pilots on antidepressants were doing well**
- **General awareness that mild/moderate depression is very common**
- **Publication in Federal Register April 5, 2010**
- **4 approved medications chosen for most favorable side effect profile (fluoxetine, sertraline, citalopram or escitalopram)**

SSRI Program

- **Mild/moderate depression or other diagnosis**
- **Stable 6 months**
- **No history psychosis, suicidal ideation, multiple meds, electroconvulsive therapy**
- **Follow up by psychiatry, treating physician, HIMS AME, neuropsychology**
- **Recurrent major depressive disorder must be treated**

Diagnoses Treated with SSRI's

• Depression	61%
• Anxiety	39%
• Major depression	12%
• Obsessive/compulsive	0.05%
• PTSD	0.02%
• Dysthymia	0.02%

SSRI Program

- **Ongoing monitoring by psychiatry, treating physician, HIMS AME**
- **Bupropion now acceptable medication**
- **Dosage changes will invalidate special issuance authorization**
- **Changes of medical monitor require prior coordination with FAA**
- **Changes in condition must be reported to HIMS AME and FAA immediately**

Yellow Flags

- **Psychosis**
- **Suicidal ideation**
- **History of electroconvulsive therapy (ECT)**
- **Concurrent use of multiple antidepressants**
- **History of use of antidepressant plus other psychiatric drugs**
- **Psychiatric hospitalizations**
- **Bipolar spectrum disorders**
- **Affective instability**

Airliner Assisted Suicide

- **Germanwings flight 9525**
- **March 24, 2015**
- **French Alps**
- **150 fatalities**

Airliner Assisted Suicide

- **LAM Airlines ERJ 190; Namibia 11/29/2013**
- **EgyptAir B767; Atlantic Ocean 10/31/1999**
- **Silk Air B737; Indonesia 12/19/1997**
- **Royal Air Maroc ATR42; Morocco 8/21/1994**
- **Japan Airlines DC-8; Japan 2/9/1982**

Germanwings

- **Very small percentage of mental illness is dangerous**
- **Mishap pilot had track record of depression**
- **Treating physician recommended not flying**
- **No indication of crew concern on outgoing leg**
- **Failure to disclose/failure to report**

Failure to Disclose

- **Airman does not recognize problem**
  - **Diagnosis associated with poor insight**
  - **Symptoms minimized/mischaracterized**
- **Airman chooses to conceal**
  - **Financial hardship**
  - **Career impact**
  - **Stigma**

The Challenge

- **Dispel the Myths**

- **Destroy the Barriers**

Myth: Denial Is a Common Event

- **Initial DQ rate for all mental health diagnoses is ~20%**
- **In an aviator with substance dependence, we return them to the cockpit once they are in satisfactory recovery**
- **In an aviator with uncomplicated anxiety, we return them to the cockpit once they are in remission**

Dispelling Myths

- **Increase Outreach -- presentations, articles, Pilot Minute videos, UND Summit, AOPA webinar**
- **Increased mental health content in AME training**
- **Champion Pilot Peer Support Programs**

- **Published decision grids on PTSD and Adjustment disorders**
- **Hired additional psychiatrist to decrease case review backlog**
- **Decreased cognitive testing in SSRI program**
- **Added acceptable medication**

Regulatory Challenges

- **Scarcity of relevant clinical research**
- **Incomplete/poor quality records**
- **Excessive advocacy**
- **Inconsistent history**
- **Minimization**
- **Poor recollection of past symptoms**

Cognitive Concerns

- SSRI
- HIV
- ADHD
- Substance dependence
- Brain injury
- Aging aviator
- Neurodegenerative disease

Insulin-Treated Diabetes

- **Based on continuous glucose monitoring technology**
- **75+ Class 1 & 2 pilots currently flying**
- **Coefficient of variance ≤ 33**
- **Time in range ≥ 70%**
- **No end organ disease**
- **Followed by endocrinologist**

Elusive Solutions

- **Color Vision – NTSB Rec A-04-47**

- "…develop a standard battery of tests to be performed at least once on each applicant for a Class 1 or 2 medical certificate that would prevent applicants with color vision deficiencies that could impair their ability to perform color-related critical aviation tasks from being certificated without limitations."

Color vision

Color Vision

New Color Vision Tests

- **Colour Assessment and Diagnosis (CAD)**
- **Rabin Cone Contrast Test (RCCT)**
- **Waggoner Computerized Color Vision Test (CCVT)**
- **All computer based**
- **All evaluated at CAMI**

Takeaways

- **Mental status is a performance and safety issue**
- **Mental health issues are common**
- **Permanent grounding is rare**
- **Issues are best addressed early**
- **Failure to disclose and failure to seek appropriate care is a growing concern**
- **Aeromedical risk analysis is evolving**

Questions?

There are many challenges ahead.

Appendix F – ARC Participants[106]

FAA Co-Chair	Organization
Mark Steinbicker	FAA
Industry Co-Chairs	**Organization**
Charles Curreri	International Pilot Peer Assist Coalition (IPPAC) & Center for Aviation Mental Health
Capt. Travis Ludwig	Air Line Pilots Association
William McDonald	Airlines for America
Members	**Organization**
Dr. Steven Altchuler	Emeritus, Mayo Clinic
Dr. Jim Bagian	University of Michigan
Dr. Beth Bjerke	University of North Dakota
Mr. Tom Charpentier	Experimental Aircraft Association
Mr. Lee Collins	National Flight Training Alliance
Mr. Jim Coon	Aircraft Owners and Pilots Association
Ms. Jana Denning	Professional Aviation Safety Specialists
Capt. Rondeau Flynn	Coalition of Airline Pilots Association
Ms. Jennifer Iversen	Regional Airline Association
Mr. Mark Larsen	National Business Aviation Association
Mr. Andrew LeBovidge	National Air Traffic Controllers Association
Capt. Mary Ann Schaffer	United Aviate Academy
Capt. Keith Sikes	International Brotherhood of Teamsters
Dr. Quay Snyder	Aviation Medicine Advisory Service
Dr. Alan Stolzer	Embry-Riddle Aeronautical University
Capt. Matt Sturgis	National Air Carrier Association
Ms. Suz Viljoen	National Air Transportation Association
Observers	**Organization**
Mr. William Bramble	National Transportation Safety Board
Dr. Tyler Brooks	Transport Canada
Dr. William Hoffman	US Air Force
Dr. Cristian Iount Panait	EASA
Dr. Anne Suh	John A. Hauser Mental Health in Aviation Initiative Endowment/Northwestern Medicine
Contributors	**Organization**
Dr. Kate Manderson	Principal Medical Officer – CASA
Dr. David Rogers	Senior HIMS AME
Dr. Timothy Sprott	Chief Medical Officer – CAA NZ
Ms. Laila Stein	Certified Flight Instructor

[106] In alphabetical order by participant name.

Appendix G– ARC Member Voting Responses and Ballots[107]

The ARC believes this report fulfills the tasks in the mission of the Charter. The recommendations contained in this report were robustly debated and the report was accepted by the full ARC prior to submission to the FAA.

In support of a transparent ARC process, members were offered the opportunity to include a (2 page) concurrence or non-concurrence on the final document. All submissions are included in this report.

The ARC completed its deliberations and report drafting on March 28, 2024. Ballots were distributed to the 20 voting ARC members. The tally is as follows:

17 – Concur as Written

3 – Concur with Comment

0 – Concur with Exception

0 – Non-Concur

Organization	Primary Representative	Voting Response
Aircraft Owners and Pilots Association	Mr. Jim Coon	Concur
Air Line Pilots Association	Capt. Travis Ludwig	Concur with Comment
Airlines for America	William McDonald	Concur
Aviation Medicine Advisory Service	Dr. Quay Snyder	Concur
Coalition of Airline Pilots Association	Capt. Rondeau Flynn	Concur
Embry-Riddle Aeronautical University	Dr. Alan Stolzer	Concur
Emeritus, Mayo Clinic	Dr. Steven Altchuler	Concur with Comment
Experimental Aircraft Association	Mr. Tom Charpentier	Concur

[107] In alphabetical order by organization name.

International Brotherhood of Teamsters	Capt. Keith Sikes	Concur
International Pilot Peer Assist Coalition (IPPAC) & Center for Aviation Mental Health	Charles Curreri	Concur
National Air Carrier Association	Capt. Matt Sturgis	Concur
National Air Traffic Controllers Association	Mr. Andrew LeBovidge	Concur
National Air Transportation Association	Ms. Suz Viljoen	Concur
National Business Aviation Association	Mr. Mark Larsen	Concur with Comment
National Flight Training Alliance	Mr. Lee Collins	Concur
Professional Aviation Safety Specialists	Ms. Jana Denning	Concur
Regional Airline Association	Ms. Jennifer Iversen	Concur
United Aviate Academy	Capt. Mary Ann Schaffer	Concur
University of Michigan	Dr. Jim Bagian	Concur
University of North Dakota	Dr. Beth Bjerke	Concur

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Travis Ludwig
Voting Member Organization	ALPA-International

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature:  **Date:** 28 March 2024

My personal belief is that the goal of this Mental Health ARC is to better the life of all pilots and controllers both current and aspiring. I know this towering aspiration was shared by all those that participated in the ARC. This ARC strived to save a life, a job, a family. If we accomplish this lofty goal even once, the amount of work thrown into this project with be worth it.

The current document you hold in front of you was produced between Jan 9th, our first plenary session, and our final vote on March 28th. In just 57 working days, this mammoth text with the possibility to generate generational aviation cultural change was produced. This could not have been done without the dedicated, passionate, focused efforts of all the ARC Members and Observers and the excellent support from The Regulatory Group. I have been humbled by the sheer dedication of all parties involved. During the ARC, weekly videoconferencing routinely extended to more than 8 hours. Between which, various versions of this document and graphics where produced, vetted, and debated. The volume of ideas and conversations that were distilled down into the current document could fill volumes.

It has been an honor and a privilege to work alongside all these brilliant individuals. My solemn wish is that this document be the start of a much-needed change within the aviation community with regards to mental wellness. While this change will not happen quick, this document clearly shows a path forward, and that dedicated individuals stand ready to help the aviation community welcome in a new era.

In Unity,

Travis Ludwig
ALPA-International Pilot Assistance Chair

2. Concur with Comment or Exception(s):

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Jim Coon
Voting Member Organization	Aircraft Owners and Pilots Association (AOPA)

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature: James Coon **Date: March 28, 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: **Date:**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	William McDonald
Voting Member Organization	Airlines for America

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature: *William McDonald* **Date:** March 27, 2024

2. Concur with Comment or Exception(s):

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Matthew Sturgis
Voting Member Organization	National Air Carrier Association

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature:  **Date: March 28; 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date: March 28, 2024**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date: March 28, 2024**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Quay Snyder, MD MSPH
Voting Member Organization	Aviation Medicine Advisory Service

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature:  **Date: March 28; 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date: March 28, 2024**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date: March 28, 2024**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Rondeau Flynn
Voting Member Organization	Coalition of Airline Pilots Association

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written Conur

Voting Member Signature: R. Flynn **Date: March 27th, 2024**

2. Concur with Comment or Exception(s):

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: **Date: _____**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Alan J. Stolzer
Voting Member Organization	Embry-Riddle Aeronautical University

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature:  **Date:** March 26, 2024

2. Concur with Comment or Exception(s):

Concur!

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Tom Charpentier
Voting Member Organization	Experimental Aircraft Association

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature:  **Date: March 28, 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date:**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Keith Sikes
Voting Member Organization	International Brotherhood of Teamsters

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature: **Keith Sikes** **Date:** March 26, 2024

2. Concur with Comment or Exception(s):

Concur!

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Charlie Curreri
Voting Member Organization	International Pilot Peer Assist Coalition (IPPAC) and Center for Aviation Mental Health

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature: Charlie Curreri Date: 15 March 2024

2. Concur with Comment or Exception(s):

Concur.

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: Charlie Curreri Date: 15 March 2024

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Steven I. Altchuler, Ph.D., M.D.
Voting Member Organization	Emeritus, Mayo Clinic

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

2. Concur with Comment or Exception(s):

The members of the ARC have an excellent understanding of the barriers that prevent their constituencies from reporting and seeking care for mental health issues. They have been creative and strong advocates for ways to address these challenges. I am the only psychiatrist who is an official member of the ARC and the sole voting member of the ARC with a psychiatrist's in-depth knowledge of the nature and course of psychiatric illnesses and the symptoms associated with them.

An underlying theme is the stigma associated with mental illness and occupational difficulties for individuals with mental illnesses. This is a broad international issue, not unique to the aviation community or to the United States. While there are some unique features for pilots and air traffic controllers, the broader problem is the foundation upon which the stigma and many of the barriers rest. It is worthy for the FAA as well as the entire aviation community to try and reduce these barriers. We must recognize there is a reason so many mental health advocacy organizations have efforts to fight stigma. The issue is bigger than what any one organization by itself can solve. To be ultimately successful, all aviation stakeholders will need to work along side and in an ongoing fashion with other advocacy groups.

The views expressed are solely those of the author and do not reflect the position or policy of Mayo Clinic.

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Steven Altchuler

Voting Member Signature: **Steven I. Altchuler, Ph.D., M.D.** **Date:** 28 March 2024

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Andrew LeBovidge
Voting Member Organization	National Air Traffic Controllers Association

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature: **Date:** March 26, 2024

2. Concur with Comment or Exception(s):

Concur!

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Suz Viljoen
Voting Member Organization	NATA

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature: *Suz Viljoen* **Date:** March 28, 2024

2. Concur with Comment or Exception(s):

Concur

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: *Suz Viljoen* **Date:** March 28, 2024

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Mark Larsen
Voting Member Organization	National Business Aviation Association

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature: **Date:**

2. Concur with Comment or Exception(s):

I concur with this ARC final report which reflects the broad sentiment that pilot/controller mental health is of great importance to the aviation industry. I am grateful to my fellow ARC members and contributors for sharing their knowledge, practical insights, and passion for mental health as well as their dedication in a relatively short timeframe to create this significant report. I believe our substantial contributions indicate the extent to which pilot/controller mental health is an industry-wide challenge and the need for aviation stakeholders to continue working together to enact these recommendations. By doing so, we can reduce the barriers that keep pilots/controllers from getting mental healthcare and bring about positive changes for the mental health and lives of current and future generations of pilots and controllers.

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: Mark E. Larsen **Date: March 28, 2024**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date:**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	**Lee Collins**
Voting Member Organization	**National Flight Training Alliance**

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature: **Date: March 28; 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date: March 28, 2024**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date: March 28, 2024**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Jana Denning
Voting Member Organization	Professional Aviation Safety Specialists, AFL-CIO

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature: Jana Denning **Date: March 28, 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date:**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Jennifer Iversen
Voting Member Organization	Regional Airline Association

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written

Voting Member Signature: **Date:** March 26, 2024

2. Concur with Comment or Exception(s):

Provide comment or exception in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-Concur. Letter of Dissent must be provided.

Voting Member Signature: _____ Date: _____

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Mary Ann Schaffer
Voting Member Organization	United Aviate Academy

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature:  **Date: March 28; 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date: March 28, 2024**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date: March 28, 2024**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	James P. Bagian, MD
Voting Member Organization	University of Michigan

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature: James P. Bagian, MD Date: March 28, 2024

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date:**

3. Non-concur. Letter of Dissent must be provided.

Date:

Voting Member Signature:

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.

Mental Health and Aviation Medical Clearances
Aviation Rulemaking Committee (ARC)
Statement of Concurrence / Non-Concurrence

Voting Member Name	Elizabeth Bjerke
Voting Member Organization	University of North Dakota

As a voting member and full participant of the Mental Health and Aviation Medical Clearances ARC, I hereby acknowledge that I have reviewed the Final Report and recommendations and make the following statement:

1. Concur with the Final Report as written:

Voting Member Signature: **Date: March 28; 2024**

2. Concur with Comment or Exception(s):

Provide comments or exceptions in the text box above or submit a separate paper on company letterhead if additional space is required. Separate papers may not exceed 2 pages in length.

Voting Member Signature: **Date: March 28, 2024**

3. Non-concur. Letter of Dissent must be provided.

Voting Member Signature: **Date: March 28, 2024**

Letter of Dissent must be on company letterhead and may not exceed 2 pages in length.