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Flying and suffering in silence: Prioritising pilot mental health by proactively regulating the use of Selective Serotonin Reuptake Inhibitors (SSRIs)

Key words: Pilot mental health, Psychoactive substances, Anti-depressants, Selective Serotonin Reuptake Inhibitors (SSRIs), Voluntary or self-disclosure.

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Abstract

Commercial pilots are the primary custodians of safety during scheduled international and domestic air services. The class I medical certificate validates the health of a pilot, ensuring that they meet the necessary requirements to safely carry out their duties and responsibilities. Failure to pass the medical assessment may lead to a pilot being temporarily or permanently grounded dependent on the identified problem. The physical health of pilots, in relation to the issuance of a class I medical certificate, has been studied extensively with a high level of standardisation across jurisdictions. In contrast, the mental health of pilots has only recently, following fatal accidents, been taken into serious consideration. ICAO States have varying approaches towards addressing pilot mental health as derived from their respective interpretations of Chapter 1.2.7 of Annex 1, Chapter 2.5 of Annex 2, and Chapter 3.4 of Annex 6, Part I of the Chicago Convention. This has led to differing attitudes towards the use of psychoactive substances by rostered pilots, particularly selective serotonin reuptake inhibitors (SSRIs), a type of medicine used to treat depression, anxiety, and other mental disorders. By way of a comparative analysis, this study investigates the diverging approaches of the Federal Aviation Authority (FAA) and the Civil Aviation

Safety Authority (CASA) in regulating SSRI usage among their pilot populations. The study examines the stigma associated with pilot mental health and the voluntary or self-disclosure culture amongst pilots. The study seeks to demonstrate that the proactive approach of the CASA, as opposed to the restrictive application by the FAA, on the use of prescribed SSRIs by active pilots, results in the improvement of pilot mental health, leads to increased rates of voluntary or self-disclosure, and facilitates the destigmatisation of mental health in the piloting community.

1. Introduction

The United Nations World Health Organisation (WHO) estimates that 1 in 7 people of the global population live with a mental disorder.¹ Depression and anxiety account for 60% of all cases, they have been described as “the common cold of psychiatry”, alluding to their high rates of diagnoses and the successful treatment of these conditions.² Studies have demonstrated that the pilot population, a subsection of the global population, are as susceptible to mental health disorders, with some scholars arguing that pilots are predisposed to these disorders due to the unique pressures associated with being a commercial line pilot.³

The first Director-General of the WHO, Dr Brock Chisholm, stated that “without mental health there can be no true physical health”.⁴ This statement aptly describes the reality of commercial pilots across the world as mental fitness screening forms part of their class I medical certificate issued in accordance with the biannual or annual medical

¹ World Health Organisation “Mental disorders” (30 September 2025), online: <<https://www.who.int/news-room/fact-sheets/detail/mental-disorders>>. See also Ziwei Zhang et al. “Global, regional and national burden of anxiety and depression disorders from 1990 to 2021, and forecast up to 2040” (2026) *Journal of Affective Disorders* 3.

² Jake Durham & Timm Bliss, “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” (2019) 37 *Collegiate Aviation Review International* 84.

³ Alexander Wu et al, “Airplane Pilot mental health and suicidal thoughts: a cross-sectional descriptive study via anonymous web-based survey” (2016) 15:121 *Environmental Health* 3.

⁴ Kavitha Kolappa, David Hnederson, & Sandeep Kishore, “No Physical health without mental health: lessons unlearned?” Editorial Comment (2013) *Bulletin World Health Organisation* 1.

assessment.⁵ Failure to pass this mandatory medical may result in the grounding of a pilot, either permanently or temporarily, depending on the treatability of the identified issue. In the case of mental health screening, pilots undergo a variety of differing questioners and assessments to determine the state of their mental fitness. Physical assessments, examine a pilot's vision and auditory capabilities, cardiac health, lung functionality, and others.⁶ These tests are well developed with clear guidelines on qualifying and disqualifying physical factors affecting a pilot's ability to safely and properly perform their function.

On the contrary, the mental assessments and requirements are generally opaque and ridged as research into pilot mental health continues to mature. Stricter and ambiguous regulations inadvertently fuel a culture of silence that contributes to stigmas that deter pilots from seeking legitimate professional help.⁷ Silencing the pilot population in this manner leads to unsupervised use of psychoactive substances, whether beneficial or not, to self-treat symptoms of depression and anxiety amongst other disorders. The versatility of psychoactive substances is witnessed through their therapeutic and intoxicating effects determined by the type of substance in question.

Psychoactive substances, broadly speaking, range from caffeine (licit) on one side of the spectrum to heroin or cocaine (illicit) on the other.⁸ Selective serotonin reuptake inhibitors (SSRIs), the psychoactive substances used in the successful treatment of

⁵ Ch 1.2.5.2, Ch 2.6.1.4, Ch 6.2.1(a), and Ch 6.2.2, Annex 1 of the Convention on International Civil Aviation 7 December 1944 (Chicago Convention).

⁶ Chapter 6.3.2, Annex 1, Chicago Convention.

⁷ Cameron Lanier et al, "Mental Health Caught in the Crossfire: Selective Serotonin Reuptake Inhibitors (SSRIs), Stigma, and the Political Debate (2025) 59 *Annals of Pharmacotherapy* 1129.

⁸ Stefania Chiappini & Fabrizio Schifano, "An Update on Psychoactive Substances: Pharmacology and Toxicology Issues" (2023) *Pharmaceuticals* 1.

mental health, are located on the same spectrum. Alcohol,⁹ opioids,¹⁰ psychedelics,¹¹ and SSRIs, with the exclusion of caffeine and tobacco, are some examples of psychoactive substances that fall within the ambit of Chapter 1.2.7 of Annex 1, Chapter 2.5 of Annex 2, and Chapter 3.4 of Annex 6, Part I of the Chicago Convention.¹² The overarching challenge for ICAO states, through their interpretation and application of these SARPs, is to adequately regulate the proactive use of SSRIs while preventing the abuse of intoxicating psychoactive substances that negatively impact on safety.¹³

This paper is divided into four substantive parts. The first discusses the use of SSRIs in the treatment of mental health in general. The second part identifies the Standards and Recommended Practices (SARPs) that address the issuance of a class I medical certificate and regulate the use of psychoactive substances by pilots. Part three delineates how the Federal Aviation Authority (FAA) interprets and applies the SARPs relating to the issuance of a class I medical certificate and use of psychoactive substances within the context of pilot mental health. The fourth section mirrors part three and examines how the Australian Civil Aviation Safety Authority (CASA) interprets and applies the same SARPs. By way of comparative analysis, section five puts into contrast the diverging approaches of the FAA and CASA in their regulation of pilot mental health read through their respective interpretation and application of the same SARPs. The paper ends with a conclusion.

⁹ Magdalena Zaniowska, "Decoding the serotonin-alcohol crosstalk: the role of central serotonergic dysregulation in alcohol use disorder" (2026) *Pharmacological Reports* 7.

¹⁰ Jolanta Zawilska, "An Expanding World of Novel Psychoactive substances: Opioids" (2017) 8 *Frontiers in Psychiatry* 1 – 14.

¹¹ Peter Tanuseputro et al, "Psychedelics for Patients Experiencing Existential Distress, Anxiety or Depression in Palliative Care" (2026) *CNS Drugs* 1 – 4; See also S Schippers et al, "Psychedelic-assisted therapy for treating anxiety, depression, and existential distress in people with life-threatening diseases" (2024) *Cochrane Database of Systemic Reviews* 1 – 71.

¹² Chapter 1, Psychoactive substances definition, Annex 2, Chicago Convention. Ch 1.2.7 of Annex 1, Ch 2.5 of Annex 2, & Ch 3.4 of Annex 6 of the Chicago Convention.

¹³ Joseph Westermeyer, "Historical and Social Context of Psychoactive Substance Use Disorders" in Richard Frances, Sheldon Miller and Avram Mack, eds, *Clinical Textbook of Addictive Disorders* 3rd edition (Guilford Press, 2005) 16.

2. The use of selective serotonin reuptake inhibitors (SSRIs) to treat mental health

SSRIs are described as the first line drug in the contemporary treatment of depression, anxiety, and other disorders.¹⁴ Fluoxetine, paroxetine, sertraline, fluvoxamine, and citalopram are the primary SSRIs. By targeting the (5-HT) transmitters, SSRIs increase serotonin signally in the brain by concentrating the serotonin and norepinephrine within the synapses.¹⁵ The desired therapeutic effect is achieved once the firing of the synapses gradually improves in tandem with enhanced levels of serotonin in the cortex.¹⁶

The use of SSRI in successfully treating and alleviating symptoms caused by mental disorders has been well documented.¹⁷ SSRIs revolutionised psychopharmacological care therapies as their rational development resulted in relatively stable and measurable outputs.¹⁸ Prior to their introduction, medical practitioners predominantly relied on luck of the draw prescription practices.¹⁹ Patients were treated with an array of medications and doctors would then have to monitor patient symptoms to track the (in)effectiveness of the prescribed treatment to determine the efficacy of the dispensed medicine.²⁰ This trial and error method was far from ideal as treatment of mental health conditions was largely left to chance.²¹ The wide rollout of SSRIs fundamentally improved predictability in the efficacy of treating certain mental

¹⁴ P Andersson and R Delgado, "Side effects and tolerability of Selective Serotonin Reuptake Inhibitors (SSRIs) antidepressants: a review of the literature" (2024) 16 *Journal of Research in Health Science* 47; See also S Murphy et al, "The knowns and unknowns of SSRI treatment in young people with depression and anxiety: efficacy, predictors, and mechanisms of action" (2021) 8 *Lancet Psychiatry* 824.

¹⁵ C Hamer, R Duman, & P Cowmen, "How do antidepressants work? New perspectives for refining future treatment approaches" (2017) 4 *Lancet Psychiatry* 409.

¹⁶ D Nutt et al, "Mechanisms of action of selective serotonin reuptake inhibitors in the treatment of psychiatric disorders" (1999) 9 *European Neuropsychopharmacology* 82.

¹⁷ Ibid.

¹⁸ Meera Vaswani et al, "Role of selective serotonin reuptake inhibitors in psychiatric disorders: a comprehensive review" (2003) 27 *Progress in Neuro-Psychopharmacology & Biological Psychiatry* 86.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid.

disorders, making them the drug of choice today.²² Their proven safety in adults has revolutionised how individuals with mental health conditions conduct their day to day lives.²³

Despite their success, SSRIs do have unwanted and adverse side effects. Sexual dysfunction, particularly in men, extends to erectile dysfunction, reduced libido, delayed ejaculation, diminished orgasm intensity, and reduced sexual pleasure.²⁴ Other concerning side effects of SSRI usage over prolonged periods are increased rates in weight gain, disturbances in sleep patterns, and risk related to gastrointestinal bleeding.²⁵ Studies have shown that side-effects are experienced at similar rates irrespective of the type of SSRI being used.²⁶ The stated benefits of SSRI usage to treat mental health disorders must consistently be weighed up against experienced side effects.

3. ICAO SARPs: the issuance of a class I medical certificate and the use of SSRIs by pilots

This section identifies and examines the SARPs that regulate the issuance of a valid class I medical certificate, specifically those relating to the metal fitness assessments and requirements to attain this certificate, by commercial pilots. The SARPs addressing the use of psychoactive substances by flight crew members are discussed thereafter.

²² Ibid.

²³ J Homberg, D Schubert, & P Gasper, "New perspectives on the neurodevelopment effects of SSRIs" (2010) 32 Trends in Pharmacological Sciences 60.

²⁴ J Noakes et al, "Selective serotonin reuptake inhibitors, erectile dysfunction, and the changing landscape of male sexual health" (2026) Your Sexual Medicine Journal 1.

²⁵ J Ferguson, "SSRI Antidepressant Medications: Adverse Effects and Tolerability" (2001) Primary care Companion to the Journal of Clinical Psychiatry 22. See also Ainhoa Gomez-Lumbreras et al, "Risk of gastrointestinal bleeding by specific SSRIs and SNRIs: A systematic Review and meta-analysis" (2026) 99 British Journal of Clinical Pharmacology 777 – 1007.

²⁶ P Brambilla, "Side-effects of Fluoxetine in Comparison with other SSRIs, Tricyclic and Newer Antidepressants: A Meta-Analysis of Clinical Trial Data" (2005) 38 Pharmacopsychiatry 80.

3.1 Class I medical certificate

Annex 1 of the Chicago Convention contains the SARPs pertaining to personal licensing.²⁷ Flight crew members by definition, according to the Annex, are licensed individuals charged with duties essential to the operation of an aircraft during the flight duty period.²⁸ This definition includes airline transport pilots operating commercially operated aeroplanes on scheduled routes.²⁹ Authorised flight crew members are required to possess a valid license that is in compliance with the specifications of Annex 1.³⁰ The authorisation of a valid license may be revoked or suspended for non-compliance with the licensing SARPs.³¹

Medical fitness is a key element that is taken into consideration to satisfy the licensing requirements for flight crew members.³² Pilots may not exercise the privileges under their valid license if there is any deterioration to their medical fitness that may prevent them from carrying out their functions in a safe and proper manner.³³ Despite their extensive coverage of aeromedical eventualities, these SARPs are not capable of covering every medical situation.³⁴ Under certain conditions discretion may be given by a aviation medical examiner (AME) to issue a valid medical certificate despite a medical standard for a particular license not being met.³⁵

Under Ch 6.3.2.1 of Annex 1, the applicant for a class I medical certificate shall not have an established history or clinical diagnosis of any of the listed condition.³⁶ The list includes but is not limited to organic mental disorders,³⁷ a mental or behavioural

²⁷ Annex 1, Chicago Convention.

²⁸ Ch 1, Flight Crew Definition, Annex 1, Chicago Convention.

²⁹ Ch 1.2 General rules concerning licenses, Annex 1, Chicago Convention.

³⁰ Ch 1.2.1.1 Authority to act as a flight crew member or a remote flight crew member & 1.2.1 Method of rendering a license valid, Annex 1, Chicago Convention.

³¹ Ch 1.2.1 Method of rendering a license valid, Annex 1, Chicago Convention.

³² Ch 1.2.4 Medical Fitness, Annex 1, Chicago Convention.

³³ Ch 1.2.6 Decrease in medical Fitness, Annex 1, Chicago Convention.

³⁴ Stuart Mitchell & Anthony Evans, "Safety and Medical Incapacitation Risk of Airline Pilots" (2004) 75 Aviation, Space, and Environmental Medicine 260.

³⁵ Ch 1.2.4.10, Annex 1, Chicago Convention.

³⁶ Ch 6.3.2.2 (a-k), Annex 1, Chicago Convention.

³⁷ Ch 6.3.2.2 (a), Annex 1, Chicago Convention.

disorder due to use of psychoactive substances,³⁸ and a mental disorder not otherwise specified that might affect the applicant's ability to safely exercise the privileges of the license.³⁹ A diagnosis of a listed condition therefore does not immediately preclude an applicant from applying for or holding a licence, the validity is assessed on the impact that the condition has on the pilots ability to safely carry out their duties.

It is recommended that an applicant with depression who is being treated with antidepressants should be assessed as unfit unless the medical assessor considers that the applicant's condition does not impact the safe exercise of the license.⁴⁰ The AME has the discretion to evaluate whether a pilot with depression is medically fit to possess a valid class I medical certificate despite the diagnosis. The Manual of Civil Aviation Medicine (Doc 8984), although only guidance material for states, has a dedicated appendix addressing the use of antidepressant medication.⁴¹ It highlights that several factors should be taken into consideration with regards to the use of SSRIs.⁴² The appendix expressly notes that mental health diagnoses often carry with it a significant social stigma, usually exacerbated under restrictive aeromedical regulations, fostering a culture of silence amongst the piloting population.⁴³ This rigidity leads to pilot avoidance and suppresses the opportunity for pilots to potentially self or voluntarily disclose their conditions. A paradox exists under these circumstances where pilots experiencing symptoms of mental distress would rather remain silent and do nothing, or worse, turn to self-medicating or substance abuse, all having far worse implications compared to seeking professional help. The enforcement of stringent aeromedical regulations is the main fuel source stoking pilot fears that voluntary disclosure may call the validity of their class I medical certificates into question.

³⁸ Ch 6.3.2.2 (b), Annex 1, Chicago Convention.

³⁹ Ch 6.3.2.2 (k), Annex 1, Chicago Convention.

⁴⁰ Ch 6.3.2.2.2.1, Annex 1, Chicago Convention.

⁴¹ ICAO, Manual of Civil Aviation medicine (Doc 8984), Appendix 2.

⁴² Ibid.

⁴³ Ibid.

Signatory states to the Chicago Convention are required to implement standards at a minimum while retaining the discretion to supersede the set standard. In practice, this defers to states to implement national aviation regulations and policies that ensure the minimum standards are achieved in their jurisdiction. This means that states, in the context of the use of SSRIs and in relation to the issuance of a valid class I medical certificate, may apply their own formulated interpretation with regards to what AME should take into consideration when making a determination on a pilot's ability to safely carry out their duties while taking antidepressants.

3.2 The use of psychoactive substances

It has been established that SSRIs are the preferred type of antidepressant used in the treatment of depression and anxiety. Their success stems from their ability to target certain receptors in the brain without compromising other key receptors.⁴⁴ Despite being a prescribed pharmaceutical drug, SSRIs still fall under the broader psychoactive substance umbrella as regulated by the ICAO SARPs. In addition to the SARPs pertaining to the class I medical certificate, airline pilots may not exercise the privileges of their license and related ratings while under the influence of any psychoactive substance, if such use affects their ability to safely and properly exercise their duties.⁴⁵ In accordance with this standard, pilots are only precluded from exercising the rights under their license if the use of psychoactive substances impedes their ability to perform their functions safely and properly. An express prohibition exists that interdicts licensed pilots from engaging in any problematic use of psychoactive substances.⁴⁶ The problematic use prohibition does not extend to SSRIs when they are taken as prescribed by a licensed medical practitioner. A breach of the problematic use standard may exist where SSRIs are abused or not taken as prescribed.

⁴⁴ Judith Homberg, Dirk Schubert, & Patricia Gasper, "New perspective on the neurodevelopment effects of SSRIs" (2010) 32 Trends in Pharmacological Sciences 61.

⁴⁵ Ch 1.2.7.1, Annex 1, Chicago Convention.

⁴⁶ Ch 1.2.7.2, Annex 1, Chicago Convention.

Annex 2 of the Chicago Convention contains the SARPs overseeing the rules of the air.⁴⁷ It covers general,⁴⁸ visual flight,⁴⁹ and instrument flight rules.⁵⁰ Under these rules, no person whose function is critical to the safety of aviation may perform such function under the influence of any psychoactive substance, if human performance is impaired.⁵¹ The rules further state that no person whose function is critical to safety may engage in any kind of problematic use of substances.⁵² This standard applies to licensed flight crew members under the interpretation that they perform critical functions that are essential to the operation of an aircraft.⁵³ The rules of the air do not outright ban the use of psychoactive substances under the condition that their use does not impair human performance or constitute problematic use.

ICAO monitors SARP implementation by states through the Universal Safety Oversight Audit Programme (USOAP) Continuous Monitoring Approach (CMA).⁵⁴ The USOAP CMA audits a state's ability to provide safety oversight in line with their safety oversight obligations.⁵⁵ ICAO states domesticate the various SARPs into their national aviation legislation and policies to bring their safety standards in line with ICAO SARPs. The Federal Aviation Authority (FAA) is widely regarded as the leading regulator in the world.⁵⁶ The FAA is responsible for the oversight and implementation of aviation safety standards in the United States of America (USA). As one of the leading aviation authorities, other civil aviation authorities tend to follow the FAAs lead in terms of their interpretation and application of ICAO SARPs. There are benefits to this practice as

⁴⁷ Annex 2, Chicago Convention.

⁴⁸ Chapter 3, Annex 2, Chicago Convention.

⁴⁹ Chapter 4, Annex 2, Chicago Convention.

⁵⁰ Chapter 5, Annex 2, Chicago Convention.

⁵¹ Ch 2.5, Annex 2, Chicago Convention.

⁵² Ch 2.5, Annex 2, Chicago Convention.

⁵³ Ch 1, Flight Crew member definition, Annex 2, Chicago Convention.

⁵⁴ ICAO, "Universal Safety Oversight Audit Programme (USOAP)" online: <
<https://www.icao.int/usoapcma>>.

⁵⁵ Ibid.

⁵⁶ Ibid.

ICAO states with limited aviation knowledge and resources can mirror decisions of the FAA to enhance their own safety standards without expending their limited resources.

The practice of regulation and policy mirroring is beneficial for the most part, however, it does have its shortcomings. In the context of pilot mental health and SSRI use, if the FAA's regulations are stringent and restrictive, hampering pilot mental health and wellness, this could lead other ICAO states to do the same. The next section investigates the FAA's approach to pilot mental health and SSRI use.

4. The Federal Aviation Authority

Historically, the mere use of antidepressants was cause enough to disqualify a pilot from holding any medical certificate issued by the FAA.⁵⁷ It was believed that the use of SSRIs compromised aviation safety. It was extremely rare for pilots to self – disclose a mental health condition or the use of SSRIs under this aeromedical regulatory regime.⁵⁸ Pilots were aware that disclosure would put their livelihood at risk. This fear stemmed from the fact that it was highly likely that their medical certificate would be revoked or suspended causing them to lose their privilege to fly commercially as a licensed flight crew member.

After 2010, the Authorisation for Special Issuance of a Medical Certificate (ASIMC) was introduced by the FAA for flight crew members who were using SSRIs.⁵⁹ The ASIMC validates a pilot's license by way of a waiver issued under certain set requirements. This includes periodic follow ups, drug testing, and monitoring by a licensed psychologist.⁶⁰ Additionally, the discretion to issue a ASIMC is given to an aviation Human Intervention

⁵⁷ Paul Rogers et al, "Pilots using selective serotonin reuptake inhibitors compared to other fatally injured pilots" (2017) 107 Accident Analysis and Prevention 86.

⁵⁸ Ahmey Khan & Arvind Chaturvedi, "Selective Serotonin Reuptake Inhibitors in Pilot Fatalities of Civil Aviation Accidents, 1990 – 2001" (2003) 14 Aviation, Space, and Environmental Medicine 1169. See also Alpo Vuorio, Tanja Laukkala, & Pooshan Navathe, "Major Depression and Fitness to Fly by Different Aviation Authorities" (2012) 83 Aviation, Space, and Environmental Medicine 909. Alpo Vuorio et al, "Assessing Suicide Risk in Airline Pilots with Major Depression" (2026) 16 Aviation Psychology and Applied Human Factors 56.

⁵⁹ Ibid.

⁶⁰ Clare Kelley, "The Call for FAA Regulation Change: Why Individuals with ADHD and ADHD Medication Prescriptions Should Be Permitted to Become Pilots" (2024) 34 Health Matrix 380.

Motivation Study (HIMS) AME, who makes a determination on a case-by-case basis.⁶¹ The process has additional requirements that allows the Federal Air Surgeon and the FAA to request more information from the pilot above what they initially disclosed to the AME.⁶²

In 2022, the FAA determined that the neuropsychologist evaluation was no longer necessary for renewal of a licence issued in accordance with the ASIMC for the use of SSRIs.⁶³ In 2024, the decision was taken to amend and rename the FAA SSRI Protocol to the Antidepressant Protocol following the addition of Wellbutrin (a Dopamine/Norepinephrine-Reuptake Inhibitor).⁶⁴ Despite these developments, the FAA requires that for a ASIMC to be considered, the applicant must meet certain set requirements.⁶⁵ If these requirements are met, the pilots application may proceed to SSRI decision Path – I.⁶⁶ At this stage the pilot may elect to discontinue SSRI usage, by doing so, the pilot is entitled to reapply for the regular issuance of their license after 60 days, which must be accompanied by a favourable report from a treating physician demonstrating a stable mood.⁶⁷ The application proceeds to SSRI Decision Path – II if the pilot elects to continue SSRI use.⁶⁸

According to SSRI Decision Path – II, a pilot must be on an antidepressant for more than three months for their application to progress to the next stage.⁶⁹ At the next stage the pilot must demonstrate that they are not taking multiple antidepressants

⁶¹ Harold Pinsky et al, "Psychiatry and Fitness to Fly After Germanwings" (2020) 48 J Am Acad Psychiatry Law 70. See also Federal Aviation Authority, "Guide for Aviation Examiners" (3 December 2025) online: https://www.faa.gov/ame_guide/app_process/exam_tech/item47/amd/antidepressants.

⁶² Katie Manworren, "The FAA's Mental Health Standards: Are They Reasonable" (2018) 83:2 J Air L & Com 396.

⁶³ Federal Aviation Authority, SSRI Recertification/follow-up clearance, 2022.

⁶⁴ Federal Aviation Authority, "Guide for Aviation Examiners" (3 December 2025) online: https://www.faa.gov/ame_guide/app_process/exam_tech/item47/amd/antidepressants.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Federal Aviation Authority, "SSRI Decision Path – I" (27 August 2025) online: <https://www.faa.gov/ame_guide/media/SSRI_Decision_Path-I.pdf>.

⁶⁸ Federal Aviation Authority, "SSRI Decision Path – II" (03 December 2025) online: <https://www.faa.gov/ame_guide/media/SSRI_Decision_Path-II.pdf>.

⁶⁹ Ibid.

and/or have a history of unacceptable diagnosis or symptoms, to proceed to the next stage.⁷⁰ If the pilot has not been disqualified at the previous stages, they must then provide statement, evaluation reports, records, tests, and letters as outlined in the specification sheet.⁷¹ After furnishing all these documents, a HIMS AME may review the application and make a determination of whether to grant an ASIMC.⁷² If the application is denied, and depending on the reasons, the applicant may resubmit and go through the SSRI Decision Path – II process again.

The path way to validate a class I medical certificate through the ASIMC for pilots using SSRIs demonstrates that the FAA is, to a certain extent, taking the mental health of pilots into consideration. The question remains as to whether the FAAs approach towards SSRI use by pilots is proactive enough. A determination in this regard is warranted as it influences a variety of factors; rates of self and voluntary disclosure of mental health conditions by pilots, overall mental wellbeing of the piloting population, eradicating problematic uses of psychoactive substances arising from self-medicating and internalisation, and the impact on the de-stigmatisation of pilot mental health. Recently, the USA government has called into question the efficacy of SSRIs in the treatment of depression and other conditions, whether this will adversely influence the FAAs position on SSRIs use, and reverse the marginal improvements made this far, remains to be seen.⁷³

5. The Civil Aviation Safety Authority of Australia

The Civil Aviation Safety Authority of Australia (CASA) has allowed the supervised use of antidepressants by its pilot population since 1987.⁷⁴ This pioneering policy was introduced shortly after SSRIs became available despite the majority of other leading

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Ibid.

⁷³ Cameron Lanier et al, "Mental Health Caught in the Crossfire: Selective Serotonin Reuptake Inhibitors (SSRIs), Stigma, and the Political Debate" (2025) 59 *Annals of Pharmacology* 1128.

⁷⁴ Linda Werfelman, "Antidepressants in Aviation" (2008) *Flight Safety Foundation* 24. See also Alpo Vuorio, Tanja Laukkala, & Pooshan Navathe, "Major Depression and Fitness to Fly by Different Aviation Authorities" (2012) 83 *Aviation, Space, and Environmental Medicine* 909.

jurisdictions finding the use of antidepressants by active pilots as an automatic disqualification.⁷⁵ In their seminal study, Ross et al concluded that, there is a possibility that the early use of antidepressants might actually improve safety while allowing pilots to continue to fly.⁷⁶ The statistical evidence found that there were no adverse safety outcomes when commercial pilots were allowed to continue to fly while taking antidepressants if certain criteria were met and maintained.⁷⁷

Ross et al emphasize that educating pilots on antidepressant medication is fundamental to deepening pilot understanding of SSRIs to mitigate against factors and strategies that exacerbate side effects.⁷⁸ Although the primary function of this educational drive is for medical purposes, an opportunity presents itself for it to be used as a mechanism to raise awareness around pilot mental health and SSRI usage. This creates an environment where the treatment of mental health and voluntary or self – disclosure is encouraged.⁷⁹ Adequately and proactively treating pilot mental health, as the CASA is doing, raises safety standards by reducing non-disclosure rates and unsupervised self - medicating practices.

The CASA directs pilots who are seeking help to make use of peer support programs that connect them with trained peers who themselves are pilots.⁸⁰ The Australian regulator indicates that pilots can continue to fly if the pilot has a well-managed mild to moderate depression.⁸¹ The CASAs use of positive language and phrasing when

⁷⁵ James Ross et al, "Antidepressant Use and Safety in Civil Aviation: A Case-Control Study of 10 Years of Australian Data" (2007) 78 *Aviation, Space, and Environmental Medicine* 749.

⁷⁶ Ibid 753.

⁷⁷ Rui Correia, "The use of psychotropic medications and fitness to fly" in Robert Bor and more, eds, *Pilot mental Health Assessment and Support: A practitioners Guide* 1st Edition (London: Routledge, 2016) 238.

⁷⁸ Ibid.

⁷⁹ Harold Pinsky et al, "Psychiatry and Fitness to Fly After Germanwings" (2020) 48 *The Journal of American Academy of Psychiatry and the Law* 69.

⁸⁰ Australian Civil Aviation Authority "Depression fact sheet" (5 January 2026) online: <<https://www.casa.gov.au/resources-and-education/publications/aviation-medicine-fact-sheets-and-case-studies/depression-fact-sheet#Thestatistics>>.

⁸¹ Ibid.

communicating on the topic of mental health provides clarity on this crucial matter while also taking into account the sensitivities that pilots maybe be experiencing as they conduct research into avenues to seek professional help. A study shows that in the context of mental health, the use of negative words and phrases may translate into feelings of isolation, stigmatisation, and withdrawal while positive words convey dignity, empathy, and hope.⁸² Culture around the perception of mental health can significantly improve through intentional value-based communication.⁸³

A CASA web page on depression contains an embedded link that redirects traffic to the Black Dog Institute.⁸⁴ The page titled "Understanding depression" has several parts, the introductory section mentions that depression can affect anyone and highlights that the condition can be managed.⁸⁵ The second part contains a link to a free online mental health assessment that can be taken to screen for 10 different mental health conditions.⁸⁶ The assessment provides a full personalised report with recommendations and resources on how to seek professional help.⁸⁷ The final part of the web page includes testimonials shared by individuals who have been diagnosed with depression and anxiety and have received the necessary care to live a more fulfilling life.⁸⁸ These testimonials promote awareness and fosters a sense of community, both crucial factors to destigmatise mental health and the use of SSRIs.

6. The FAA and CASA in contrast

It was established under part four that the FAA went from an outright prohibition on the use of SSRI by its piloting population due to fears that they negatively impacted

⁸² Vervan Richards, "The Importance of language in mental health care" (2018) 5 Psychiatry 460.

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ Black Dog Institute, "Understanding Depression" online: <<https://www.blackdoginstitute.org.au/resources-support/depression/>>.

⁸⁶ Ibid.

⁸⁷ Ibid.

⁸⁸ Ibid.

aviation safety. In 2010, the FAA removed the outright ban by allowing pilots to use SSRIs under certain conditions. This included commercial pilots getting their class I medical certificates validated through the ASIMC process. While the ASIMC pathway is a legitimate route for commercial pilots to attain and maintain their privilege to fly as a licensed flight crew member, the process is extremely convoluted and cumbersome, demonstrated through an evaluation of the SSRI Decision Path I and II processes. The requirements are set out in a manner that is restrictive and communicated in a way that lacks the requisite empathetic tonality that takes into account the sensitivities of pilots experiencing symptoms associated with mental health disorders.

In contrast, the CASA has for a long time allowed the use of antidepressants and SSRIs by its piloting population. Although the CASA also has requirements in place for pilot use of SSRIs, they do so in a manner that is conducive and cognisant of the intricacies that come with mental health disorders. The CASA approaches pilot mental health through an educational and inclusive prism aiding in the facilitation of the dissemination of education around mental health, antidepressants, and avenues to seek professional help. The use of empathetic and hopeful language, when communicating to pilots about regulations and requirements regarding the use of SSRIs, positively influences rates of self or voluntary disclosure of mental health conditions while simultaneously encouraging pilots to seek the professional help that they need. Fully understanding the paradox that silencing pilots leads to diminished safety standards.

7. Conclusion

This paper set out to examine how the mental health of commercial pilots is regulated through the use of psychoactive substances, particularly SSRIs, and how this influences the validity of class I medical certificates. The ICAO SARPs pertaining to the issuance of class I medical certificates and the use of psychoactive substances were set out to determine the foundation that ICAO states rely on to mould their domestic

aeromedical regulations and policies off of in relation to pilot mental health. The paper compared two diverging jurisdictional approaches; the restrictive approach of the FAA in the USA and the proactive regulatory practices of the CASA in Australia. The paper holds that the latter approach of the CASA improves rates of self or voluntary disclosures by pilots, assists in destigmatising pilot mental health, and increases safety standards by actively promoting the use of SSRIs, to treat depression and anxiety, by active commercial line pilots.