FSG 1400-01 MENTAL HEALTH DISORDERS

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REFERENCES:

A. AMA 100-01 Medical Standards for CF Aircrew

B. CFP 154 – Medical Standards for the Canadian Forces

C. Canadian Network for Mood and Anxiety Treatments (CANMAT). 2016 Clinical guidelines for the treatment of Major Depressive Disorder. *Canadian Journal of Psychiatry*, Vol. 61:9. 2016 Depression Guidelines | CANMATalc

RECORD OF AMENDMENTS:

Date (M/YY)	Reason for Change	OPI/SME
07/2021	**Major revision of previous guideline**	**Aeromedical psychiatry**
01/2024	**Addition of section on medication tapering requirements** **Addition of section on psychotherapy as an intervention** **Addition of requirement for diagnostic assessment with psychologist or psychiatrist** **Addition of requirement for G factor restriction while on continuation therapy** **Return to Duty Disposition recommendations for diagnosis of depression have been updated**	**Aeromedical psychiatry**

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List of Acronyms

ADHD- Attention Deficit/Hyperactivity Disorder
AEC – Aerospace Environmental Controllers
ASCS - Aeromedical Standards and Consultation Service
AUMB - Aerospace and Undersea Medical Board
US-AUMB - Undersea Aerospace and Undersea Medical Board
BAvMed - Basic Aviation Medicine Provider
1 CAD - 1 Canadian Air Division
CFEME – Canadian Forces Environmental Medical Establishment
CFHIS- Canadian Forces Health Information System
FSG – Flight Surgeon Guideline

MELs- Medical Employment Limitations
OTC - Over-the-counter
SAR - Search and Rescue
SNRI – Selective Noradrenaline Reuptake Inhibitor
SSRI – Selective Serotonin Reuptake Inhibitor

I. Scope of this Guideline

1. This FSG replaces FSG 1400-01 "Use of SSRI/SNRI Medications in Aircrew" and now applies to a wider range of mental health conditions with the exception of Substance Use Disorders, which are elaborated on in FSG 1400-02. This document is intended to be used as a guide for assessment of aircrew presenting with select mental health conditions and to outline the process for return to duties.

2. This guidance should be read in conjunction with Ref A, which provides additional information on mental health diagnoses that may be disqualifying for aircrew.

II. Background

1. Mental health disorders are common in the general population with similar prevalence in aircrew. If left untreated, these illnesses can pose a significant threat to flight safety and have significant implications on the well-being and performance of the individual. The aeromedical risks of untreated mental illness are significant and may affect cognitive as well as physical performance. Mental health conditions may manifest acutely, or they may develop insidiously. All mental health conditions may threaten the safety and well-being of the individual as well as the crew and compromise operational effectiveness if not identified and treated.

2. There have been advances in the understanding of the treatment of mental health conditions and how this may impact flight safety and performance. Historically, aircrew were often reluctant to come forward to discuss symptoms with their Flight Surgeon for fear of career implications. Increasing experience with some of the second-generation antidepressants and select other approved medications have led to their consideration for the treatment of mental health conditions in aircrew while remaining on flight duty. Such an approach has been promoted to encourage aircrew suffering from mental symptoms to seek treatment without the fear of long- term grounding.

III. Aeromedical Risks

1. Carrying out flight or controlling duties requires the utilization of a complex set of physical and cognitive skills. Interference with any aspect of these skills and their coordination may have serious personal and public safety consequences.

2. Psychiatric conditions can cause an aircrew member to become acutely incapacitated, or may result in more insidious and subtle performance degradation. Psychiatric illnesses may affect cognition and judgment and have significant impact in safety-sensitive and safety-critical occupations.

3. Psychotropic medications used to treat mental health disorders often have side-effects of significant aeromedical concern and many are unsuitable for use in operational aircrew.

IV. Medications

A. Medication Choice

1. The use of psychotropic medications is widespread in the general population for the treatment of various mental health conditions. Our experience in treating aircrew using SSRIs as part of a comprehensive treatment plan has proven successful and has shown to be compatible with flying duties, allowing aircrew suffering from mental health disorders to seek treatment without the fear of long-term grounding or negative career implications. Medications should be chosen based on best practice recommendations, with additional occupational considerations for aircrew.

2. The following table provides specific recommendations for medication choices in aircrew.

First Line Medications	Sertraline (Zoloft) Citalopram (Celexa) Escitalopram (Cipralex) Buproprion (Wellbutrin	These medications have had specific evaluations regarding their safe use in aircrew
Second Line Medications	Duloxetine (Cymbalta) Desvenlafaxine (Pristiq) Vortioxetine (Trintellix)	These medications have not had aeromedical specific evaluation but may be used if best clinical choice for the patient
Unacceptable Medications	Stimulants Benzodiazepines Antipsychotics (first and second generation) Mood stabilizers Venlafaxine (Effexor) Paroxetine (Paxil)	These medications are not approved for use in aircrew in active flight or control positions

Table 1. Medication options for use in aircrew with mental health disorders

B. Regimen Stabilization

1. Regardless of the medication chosen, dose optimization and therapeutic changes should be undertaken in accordance with best clinical practices and care of the patient.

2. In order for a reassessment of occupational aircrew status or for changes in medical employment limitations to be considered, the member they must have been clinically stable on the same dose of medication for a minimum of two months regardless of the diagnosis for which the psychotropic medication has been prescribed.

3. Information on aircrew management and disposition for select mental health disorders is discussed further on in this document.

C. Medication Tapering and Discontinuation

1. Medication tapering and discontinuation presents an increased risk period due to the potential for relapse of the underlying disorder as well as the possibility of antidepressant discontinuation syndrome occurring (Ref C).

2. Antidepressant discontinuation syndrome can occur with sudden discontinuation or with too rapid a taper of antidepressant medications. The symptom presentation is variable, with a broad range of possible somatic and neuropsychiatric symptoms. The most common four symptoms are dizziness, fatigue, headache, and nausea. Clinicians should enquire about any changes in health with medication steps downs. Screening for "FINISH" (Ref C) symptoms specifically (flu like symptoms, insomnia, nausea, imbalance, sensory disturbance and hyperarousal – eg. anxiety/agitation) may be helpful.

3. In order to mitigate these risks, the clinical evaluation and follow-up requirements for tapering aircrew on flying status off psychotropic medications are as follows:

    a. Prior to considering tapering off a psychotropic medication, a period of at least 6 months of clinical remission on a stable dose of medication is required.

    b. Tapering must be carried out under the medical supervision of either the flight surgeon or the psychiatrist, with advice from the aviation medicine provider.

    c. For each dose step-down a <u>2 week grounding period is required</u>.

        i. CANMAT 2016 guidelines recommend the best clinical practice to prevent recurrence of depression is a gradual taper over several weeks.

        ii. Aircrew in consultation with their flight surgeon and mental health team may choose to undergo a continuous dose taper with requisite block grounding period, or pursue a slower taper involving alternate periods of grounding with a return to flying prior to pursuing the next dose step down.

    d. If symptoms reoccur with a tapered dose, aircrew should resume their previous

dosage and may return to flight status after a minimum of two weeks on the resumed dosage with the approval of their flight surgeon.

e. Throughout the tapering period, a temporary G factor restriction is necessary to allow for appropriate follow-up to occur. The duration required will depend on the specific tapering period planned.

f. Aircrew should have a check in with an aviation medicine provider at 4-6 weeks and 12 weeks after complete discontinuation of the medication to assess for any relapse in symptoms.

g. Once these two check ins are completed, the TCAT can be lifted and regular aircrew follow-up can be resumed.

V. Psychotherapy

1. Psychotherapy is an evidence-based first line intervention for the majority of mental health disorders and may be used alone or in combination with pharmacotherapy depending upon the clinical circumstances and patient choice. It is important to consider that symptom burden and the clinical picture is what determines if an aircrew member can remain on flying or live controlling status while undergoing treatment for a mental health condition, not whether or not they have chosen to avoid medication treatment.

2. The active treatment phase of psychotherapy can result in symptom exacerbation that is not always predictable, and the majority of patients will require grounding or flight restrictions while this occurs.

3. Variability of presentation and symptom exacerbation is of particular concern for patients undertaking trauma focused therapy for Trauma and Stressor Related Disorders including PTSD and these patients must be grounded until the active treatment phase is completed. Return to flying or live controlling status for patients with trauma related disorders will require aeromedical psychiatry assessment.

VI. Clinical Approach to Aircrew with Mental Health Conditions

A. Initial Management

1. Aircrew with mental health disorders should be clinically managed at the wing level. When a mental health condition is suspected, a comprehensive assessment is the first step in management.

2. Initial assessment and management are done by the Flight Surgeon or BAvMed clinician, followed by a local referral for a Diagnostic Assessment with either a psychiatrist or clinical psychologist. Having a diagnostic assessment on file early in the course of treatment allows for appropriate planning for an eventual return to flight/control.

3. If referring to a psychiatrist, the aviation medicine provider should advise the specialist of

the preferred medication list for use in aircrew.

4. The initial assessment should:

    a. Identify whether a mental health condition is present
    b. Determine the severity and functional impairment
    c. Identify any comorbid psychiatric and medical conditions that may require additional assessment and concurrent intervention including substance abuse
    d. Develop an appropriate treatment plan; and
    e. Determine MELs and aeromedical disposition.

5. During initial treatment and initiation of pharmacotherapy and/or psychotherapy, aircrew should be grounded with appropriate MELs:

    a. G4/G5 (T6) - Requires physician/specialist follow up more often than every six months.
    b. O4 (T6) – as appropriate based on presentation
    c. A7 (T6) – Unfit Aircrew Duties

6. Once the aircrew member is treated and has achieved clinical stability, they can be referred for a return to duty assessment.

B. Requirements for Return to Duty Assessment

1. The authority for a return to flight or controlling duty for all trained aircrew diagnosed with a mental health disorder is ASCS. CFEME is the authority for air factor dispositions on all untrained aircrew from selection until initiation of their first aircrew trades course.

2. <u>All aircrew trades</u> seeking a return to flight or controlling duty must meet the following requirements prior to submission to ASCS:

    a. Asymptomatic for a period of at least two months;

    b. Active treatment phase of psychotherapy completed for at least two months, confirmed by a written report from their psychotherapist. The continuation of maintenance therapy appointments is acceptable;

    c. No medication changes for at least two months;

    d. Current report from their mental health care provider on file supportive of their return to flight or controlling duties; and

    e. Aeromedical summary from their treating aviation medicine provider.

3. <u>Pilot, AEC, and SAR</u> personnel must also have, in addition to the above:

    a. Assessment completed with Aeromedical Psychiatry; and

b. Evaluation by CFEME Medical Consult Service which may include Cogscreen AE. To arrange, contact CFEME Med Techs through the +CFEME Military Medicine Section Inbox

4. ASCS will provide an aeromedical disposition after review of all available medical information. At the discretion of ASCS, some cases may require additional medical or psychological evaluation prior to determining the final disposition. Cases may be referred by ASCS for further discussion with the Aeromedical Psychiatry specialist group or the Aerospace and Undersea Medical Board (AUMB).

5. ASCS will document the final disposition in CFHIS.

VII. Recommendations for Specific Mental Health Conditions

A. DEPRESSIVE DISORDERS

A.1 Initial Assessment and Procedures

1. Aircrew with a depressive illness should initially be managed clinically at the wing level and a psychiatric consult sought to provide assessment and treatment recommendations. When referring aircrew for specialist consultation, Flight Surgeons should make the consultant Psychiatrist aware of the preferred medications, should psychotropic medications be recommended.

2. In cases not referred for a psychiatrist evaluation and medication assessment, a diagnostic assessment with a psychologist must be obtained.

3. During initial treatment and initiation of pharmacotherapy and/or psychotherapy, aircrew should be grounded with appropriate MELs:

    a. G4/G5 (T6) - Requires physician/specialist follow up more often than every six months.
    b. O4 (T6) – as appropriate based on presentation
    c. A7 (T6) – Unfit Aircrew Duties

4. Depression is a highly recurrent illness, and continuation treatment to help preserve remission and decrease the chances of relapse. Continuation treatment is recommended for at least 6 months after remission has been obtained (Ref C). Aircrew may or may not require an air factor or occupational restriction during continuation treatment, but a continued temporary G4 geographic limitation to allow monitoring for relapse will be required to allow for appropriate clinical follow-up and monitoring for relapse.

5. TCAT restrictions will also be required during the tapering and discontinuation of medication phase of treatment as previously outlined.

6. A history of attempted suicide or depression-related psychotic features is permanently disqualifying for aircrew duties.

7. Depressive disorders other than Major Depressive Disorder will be considered for trained aircrew on a case-by-case basis.

A.2 Major Depressive Disorder, single episode – mild, moderate

1. Aircrew can be considered for a return to flying with the applicable trade relevant MELs no sooner than 2 months after achieving symptomatic remission on a stable treatment regimen, including treatment with medication, psychotherapy, or both.
2. Files are to be submitted to the appropriate disposition authority (ASCS or CFEME) as per the requirements listed previously in section V.B
3. Stable treatment is defined as no changes in medication regimen and maintenance or supportive psychotherapy only. A longer period of stability may also be required depending upon clinical circumstances.
4. Pilots, AEC, and SAR will require Aeromedical Psychiatry assessment. SAR will also require CDSM review for diving fitness.
5. Monthly follow-up for at minimum for the next 4 months will be required with the flight surgeon and/or mental health care team to monitor clinical stability.
6. Psychometric measurement tools such as the PHQ-9 and Hamilton Depression scale should be used to assess symptom burden.
7. Pilots, AEC and SAR:
    a. can be considered for an unrestricted return to flight/controlling after 6 months of remission on stable treatment with monotherapy medication regimen, psychotherapy, or both. An Aeromedical Psychiatry assessment will be required.
    b. Aircrew in these trades who require treatment with more than one psychotropic medication are not eligible for a return to unrestricted flying or controlling duties.
8. Continuation treatment and extension of temporary G and O factors will also be required for an additional 6 months after clinical remission has been obtained.
9. Should the aircrew member elect to discontinue their medication, the medication tapering procedure outlined earlier in this document must be followed.

Pilots, AEC, SAR	After two months of clinical remission on stable treatment regimen of medication, psychotherapy, or both: A3 – with or as copilot only (pilot) A3 – no solo live controlling; unfit AWACs (AEC)	After six months of remission on stable treatment with monotherapy medication regimen, psychotherapy, or both: A1 – fit to fly as pilot A4 – fit AEC

	A3 – fit SAR training to include para and dive (if clinically appropriate); no operational SAR (SAR)	A4 – fit SAR TCAT G factor restrictions and follow-up will be required for another 6 months of continuation treatment and through the medication tapering period as outlined in section IV.C
All Other Aircrew (except Pilot, AEC, SAR)	After two months of clinical remission on stable treatment regimen of medication, psychotherapy, or both: A2 – fit for flying duties A4 – fit for flight/controlling duties TCAT G factor restrictions and follow-up will be required for another 6 months of continuation treatment and through the medication tapering period as outlined in section IV.C	

Table 2 Disposition of aircrew with Major Depression, single episode, uncomplicated

A.3 Major Depressive Disorder, Single episode Severe, Recurrent, or with Comorbidities

1. A recommendation for a return to flying with temporary or permanent restrictions can be considered no sooner than 6 months after achieving symptomatic remission on a stable treatment regimen, including treatment with medication, psychotherapy, or both.
2. Pilots, AEC, and SAR will require Aeromedical Psychiatry assessment. SAR will also require assessment by the CDSM for diving fitness.
3. Stable treatment is defined as no changes in medication regimen and maintenance or supportive psychotherapy only. A longer period of stability may also be required depending upon the clinical circumstances.
4. Monthly follow-up for at minimum for the next 6 months will be required by the flight surgeon and/or mental health care team to monitor clinical stability.
5. Psychometric measurement tools such as the PHQ-9 and Hamilton Depression scale should be used to assess symptom burden.
6. Continuation of temporary G and O factors will also be required for at least 6 months after clinical remission has been obtained, followed by assessment for a permanent medical category. Recommended PCAT MEL will vary with clinical circumstances, but at minimum, the following MEL are required:
    a. Permanent G3 – requires clinical follow-up at 6 month intervals, with annual follow-up with the flight surgeon;
    b. Permanent air factor determination and need for a permanent A3 will vary with

clinical scenario and trade.

B. ANXIETY DISORDERS AND TRAUMA AND STRESSOR-RELATED DISORDERS

B.1 Initial Assessment and Procedures

1. Aircrew with symptoms of an anxiety disorder or a trauma and stressor-related disorder should initially be managed clinically at the wing level and a psychiatric consult sought to provide a diagnostic assessment and treatment recommendations.

2. When referring aircrew for specialist consultation, Flight Surgeons and BAvMed clinicians should make the consultant Psychiatrist aware of the preferred medications, should psychotropic medications be recommended.

3. In cases not referred for a psychiatrist evaluation and medication assessment, a diagnostic assessment with a psychologist must be obtained.

4. During initial treatment and initiation of pharmacotherapy and/or psychotherapy, aircrew should be grounded with appropriate MELs:

    a. G4/G5 (T6) - Requires physician/specialist follow up more often than every six months.
    b. O4 (T6) – as appropriate based on presentation
    c. A7 (T6) – Unfit Aircrew Duties

5. Stress-related and anxiety disorders exist on a spectrum. Aeromedical disposition will be evaluated on a case-by-case basis, however anxiety disorders other than uncomplicated, mild Generalized Anxiety Disorder, Social Anxiety Disorder, or Specific Phobia are generally disqualifying.

6. Preoccupation with, or the presence of distracting symptoms; a feeling of perpetual anxiety, impaired cognition which may result in the inability to focus or concentrate; or panic attacks associated with a mental health condition will require thorough evaluation but will generally be disqualifying for aircrew duties.

B.2 Return to Duty Considerations

1. Stress-related and anxiety disorders may require long term therapy due to the chronicity of these disorders. In certain cases, long-term or lifelong treatment may be clinically recommended. Evaluations are considered case by case but many aircrew with stress-related and anxiety disorders are likely to require long term MEL once their treatment is stabilized:

    a. G3 - Requires medical follow up at 6-month intervals. Requires annual follow up with Flight Surgeon
    b. O – as appropriate based on condition and potential occupational

exposures/triggers.

c. Air Factor – Aircrew may require an operational aircrew restriction or may be returned to unrestricted duties based on review by ASCS with review and recommendations from AUMB as appropriate

2. Factors to be taken into consideration include an individual's level of care needs including ongoing specialist care and formal mental health support (psychotherapy), response to treatment, tolerance and ongoing need for medications, the risk of recurrence, and prognosis.

    a. Aircrew who are diagnosed with Posttraumatic Stress Disorder, Other Specified Trauma and Stressor- Related Disorder, or an anxiety disorder other than mild Generalized Anxiety Disorder or Social Phobia will be assessed on a case-by-case basis.

    b. Panic Disorder is disqualifying for continued aircrew duties, due to the unpredictability of recurrence and the risk of experiencing a suddenly incapacitating event.

3. Aircrew can be considered for a return to flying with the applicable trade relevant MELs no sooner than 2 months after achieving symptomatic remission on a stable treatment regimen, including treatment with medication, psychotherapy, or both. A longer period of clinical stability may be required depending on clinical circumstances.

4. Pilots, AEC, and SAR will require Aeromedical Psychiatry assessment. SAR will also require CDSM review for diving fitness.

5. Stable treatment is defined as no changes in medication regimen and maintenance or supportive psychotherapy only. A longer period of stability may also be required depending upon clinical circumstances.

6. Trained aircrew with PTSD or Other Specified Trauma and Stressor-Related Disorder who have completed treatment and achieved stabilization with minimal symptoms but not full remission can be considered for a return to flying with applicable trade relevant MELs on a case-by-case basis in consultation with Aeromedical Psychiatry.

7. While tapering off medications during discontinuation, the medication tapering procedure outlined earlier in this document must be followed.

8. For aircrew taking medications, individuals must demonstrate the ability to perform their duties without functional impairment due to anxiety and remain on a stable dose of medication. At the discretion of Aeromedical Psychiatry and/or ASCS a consult with the MCS at CFEME may be required.

C. ADJUSTMENT DISORDERS

1. Adjustment disorders (ADs) are maladaptive responses to psychosocial stressors related to a stressful psychosocial event or situation. Given the stressors associated with military life and operations, adjustment disorders are common in Canadian Forces personnel

including aircrew. Symptoms may include depressive symptoms, anxiety, and traumatic stress symptoms related to the specific situation or event.

2. Unlike major depression, an Adjustment Disorder may be precipitated by an outside stressor and may resolve once the situation resolves and/or the individual is able to adapt to the situation.

3. Adjustment Disorders resolve within six months once the stressor or its consequences have terminated. Failure to resolve in the expected timeframe should trigger reassessment and reconsideration of the diagnosis. In most cases, aircrew can be returned to full duties.

4. ADs with more complex presentations may be disqualifying if any of the following conditions are met:

    a. Active suicidal ideation or a documented attempt;
    b. Hospitalization was required;
    c. Three or more episodes have occurred;
    d. Adjustment Disorder treated with psychotropic medications.
    e. Presence of or a history of Panic Attacks

5. Aircrew presenting for mental health support with symptoms related to a particular event or situation should be referred for mental health support and a diagnostic assessment should be carried out.

6. Aircrew diagnosed with an Adjustment Disorder should be temporarily grounded. Upon clinical resolution of the Adjustment Disorder, the case should be referred to ASCS for review, which may include further assessment by Aeromedical Psychiatry.

D. ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

1. Mild ADHD that can be managed with non-pharmacologic treatment sufficient to ensure the safe conduct of aircrew duties does not require MEL once treatment has been stabilized.

2. ADHD requiring pharmacotherapy for management is disqualifying for aircrew duties for all aircrew trades.

Figure 1. Management of Aircrew with Mental Health Disorders