HIMS Basic Education Seminar 2025 - WELCOME

CPT Craig Ohmsieder – Spirit Airlines – ALPA National HIMS Chairman
CPT Billy Petersen – Jet Blue Airlines – ALPA National HIMS Vice-Chairman
Quay Snyder, MD, MSPH – FAA / ALPA HIMS Program Manager

HIMS

2025 Basic Education Seminar
Sustaining Success – One Step at a Time

September 15 – 17, 2025
Westin DIA - Denver, CO

HIMS Goals

Provide a structure within which pilots afflicted by the disease of substance abuse/dependence can be identified, treated, and returned to duty - saving lives and careers

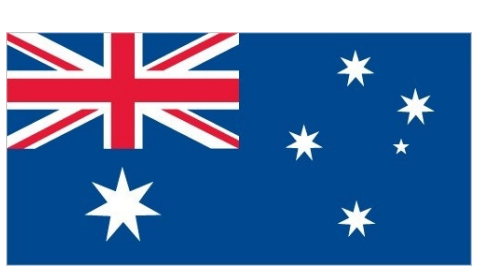
Attendees

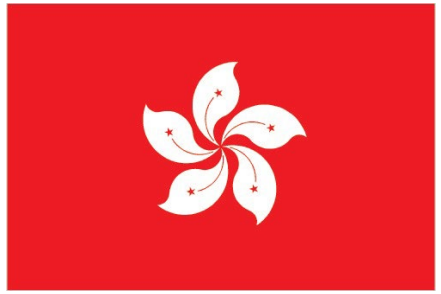
Pilot Volunteers	106	Speakers/AB	29
Airline Mgmt	65	HIMS Staff	6
AME's	21	International	26
P&P	30	First Timers P&P	57
FAA Staff	9	First Timers AME	31
General	28		

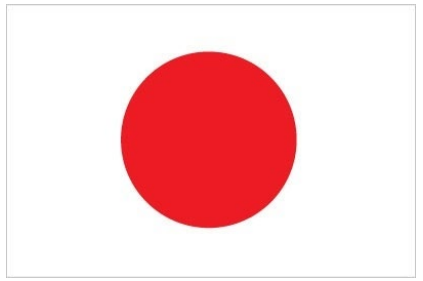
TOTAL ATTENDEES
425 88 1st

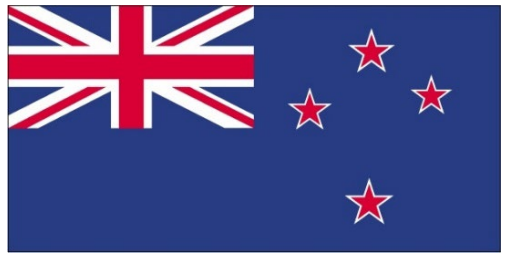
International Guests

- Australia
- Canada
- Columbia
- Hong Kong
- Ireland
- Japan
- Mexico
- Netherlands
- New Zealand
- Panama
- Saudi Arabia





Special Guests

- Dr. Susan Northrup – FAA Federal Air Surgeon
- Capt. Wendy Morse – ALPA 1st VP – Air Safety Organization

- FAA –
  - – Linda Johnson & Christi Risley– AME Test questions
  - – Melissa Duncan– AME and PNP HIMS Designation questions
  - – Brenda Smith & Christine Anderson - DUI Reporting Team
  - – Dr. Kathleen Jones, Nicole Alexander, Jane Stafford AAM-313
  - – Shawna Adkins - Huddle
  - - Birds of a Feather – Beth O. Al- Anon BOAF – Kim S.

Challenges - Diversity of Audience

- **Different**
  - Professions – Skill sets
  - Vocabularies
  - HIMS experience levels
  - FAA certification processes
  - National Civil Aviation Authorities / Cultures
  - Employer CBA’s, MOU’s, LOA’s
  - GA vs airline resources
- **Common Goal** – Aviation Safety, Save Lives

Information Resources

- Agenda
- Cvent App - David Evans
  - Agenda, Presentations, Surveys, CME & AME Tests
  - HIMS Resources
  - Attendee Networking
  - Westin and DIA links
- FAA Staff – AME's, P&P's, CME, Case Inquiries
- Dr. Joyce Fowler – Neuropsychologists - CE
- AMAS Staff
- www.HIMSprogram.com

HIMS Advocates

- Aerospace Medical Assn Mental Health Working Group
- FAA Reauthorization Act Sec 411 / 413 Work Groups
- FAA ARC - Mental Health & Aviation Medical Clearances
- MITRE Aeromedical Safety Team Project

- Clear Skies Ahead
- Pilot Mental Health Campaign
- Pilots for HIMS Reform

Critiques

Take Very Seriously → Improvements

- Speaker Tables – Lunch Day 2 – Map on App/ In Lobby
- More FAA Q& A / Breakouts / Private Meeting Rooms
- Improvements in AME and Pilot training breakouts
- AME Competency Testing / Pilot Compassionate Listening
- Presentations on www.HIMSprogram.com & HIMS App
- More Reference Documents / Books / Secular Info
- Longer Breaks – More Networking / Q&A
- Complete Critiques on App after every talk PLEASE!

Continuing Education

- AMA PRA & AAFP Cat 1 CME –Up to 14 hours
- Psychologist CE hours – ≤ 9 hrs in-person only
- All speakers have signed financial disclosures
  None had prohibited relationships to report
- FAA credit for HIMS AME Periodic Training (required every 3 years) – Melissa Duncan
  – Turn into FAA staff Using App
- Separate from AME Proficiency test
- Must attend ENTIRE seminar

FAA HIMS AME & PNP Listings

Visit the FAA information table near registration area.

Melissa Duncan Melissa.Duncan@FAA.gov

New HIMS providers –Complete FAA coversheet in person

Experienced HIMS providers – update sheet if info has changed

AMEs have two tests!

1) CME test completed online by midnight CST 9/23/2025 (Open Book)
2) AME proficiency test completed on Day #3 (Closed Book)

Meals and Transportation

Dinner Options

- Hotel Restaurant –Airport Outside Security – 6 Locations
- Airport Inside Security – 90 Locations www.flydenver.com/dine
  - Know Crew Member
  - Driver's License in AM
- Light Rail - $10.50 ($5.25/Free) daily pass to Denver LoDo
- Uber and Taxis
- Hotel shuttles to Tower Blvd
- Everything is posted in the app

Recovery Fellowship

Birds of a Feather / AA meetings

- Open Tuesday 0700– Maple
- Closed Monday/Wednesday 0700 – Maple

Al-Anon BOAF Meetings

- Open Monday 0700 – Boxelder
- Open Wednesday 0700 - Cherry

Answering Your Questions

- Speakers
  - 5 minutes at end of most presentations – 1-minute answers
  - Speakers have deep knowledge of areas
  - Challenge – Different Professions, level of Knowledge, Vocabularies
  - Available throughout Basic Education Seminar
- Attendees
  - Introduce yourself with Name, Organization, Position
  - Limit questions to 30 seconds – Allow others to ask
  - Avoid personal case inquires in Public Forum
    - Speakers available outside, private rooms, Day 2 Lunch tables
    - FAA AMCD staff – have release signed https://www.faa.gov/documentLibrary/media/Form/8065-2.pdf
  - Respectful and courteous to all
- No recording – slides will be available

Networking

- Breakouts and Joint sessions
- Rooms available – See the registration desk
- Messaging via the app (requires opt in)
- Tuesday Lunch with Speakers – Map in App
- Conversations outside away from doors
- Cell phones on SILENT
- In place, On time

HIMS
HUMAN INTERVENTION MOTIVATIONAL STUDY

Safety & Assistance

Exits and Meeting areas
Smoking areas

AMAS staff – **Red**
- Caitlin Bruton
- Marisa Zarlengo
- Jackie Churchill
- Catherine Cazorla
- Nicolle Lowe

AMAS®
AVIATION MEDICINE ADVISORY SERVICE

Encore App Staff – David Evans

House Rules

LEARN

Question the Experts & Faculty

SHARE

Engage Newcomers and Old-Timers

APPLY

Bring the Best to Your Airline or Practice

Fill out CRITIQUES After Every Session!


THANK YOU TO OUR 2025 SPONSORS!
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HIMS Overview, Database, Web Site Tour

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Three Main Questions

Why ?

What ?

How ?

Why do we need HIMS?

Why do we need HIMS?

FAR 67.107/207/307 list **Substance Dependence** and/or **Abuse** as a **Disqualifying Condition**

Why do we need HIMS?

10% of United States population is Chemically Dependent

Why do we need HIMS?

10% of United States population is Chemically Dependent

Are Pilots different? – Data suggested they were

Why do we need HIMS?

Early 1970’s – Human Intervention and Motivation Study

Why do we need HIMS?

Early 1970's – Human Intervention and Motivation Study

Pilots are the SAME – Just better at hiding it

Why do we need HIMS?

Early 1970's – Human Intervention and Motivation Study

Pilots are the SAME – Just better at hiding it

Desire to appear professional

Why do we need HIMS?

Early 1970's – Human Intervention and Motivation Study

Pilots are the SAME – Just better at hiding it

Loyalty among flight crews

Why do we need HIMS?

Early 1970's – Human Intervention and Motivation Study

Pilots are the SAME – Just better at hiding it

Pilot personality contributes to this - Can go without drinking to get the job done

Why do we need HIMS?

Early 1970's – Human Intervention and Motivation Study

Pilots are the SAME – Just better at hiding it

Pilot schedules promote binge drinking

Why do we need HIMS?

Early 1970's – Human Intervention and Motivation Study

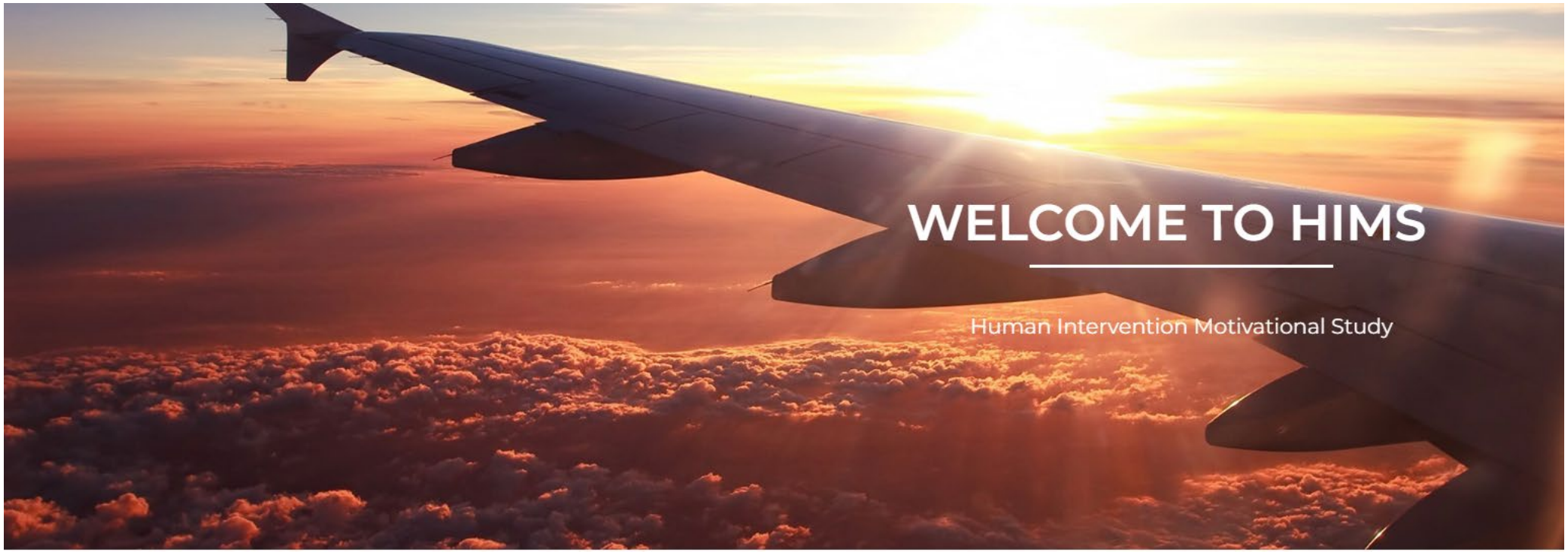
In 1974 the HIMS Program was established

What is HIMS?

What is HIMS?

HIMS is a Pilot Specific Model

A Safe and Effective way for Pilots with Substance Use Problems to get Help while Protecting their Flying Careers



What is HIMS?

HIMS is a Pilot Specific Model

HIMS is an occupational substance abuse treatment program, specific to pilots, that coordinates the identification, treatment, and return to work process for affected aviators. It is an industry-wide effort in which **Managers**, **Pilots, Healthcare Professionals**, and the **FAA** work together to preserve careers and enhance air safety.

What is HIMS?

HIMS is a SAFETY Program

Protect the Public / Flying Profession

Save the Life

Save the Family

Save the Career

What is HIMS?

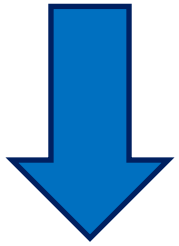
HIMS is a MONITORING and SUPPORT Program

The FAA and the Airline use HIMS to evaluate the Pilot's Recovery and Return to Flying

There is a built-in Support System to assist the Pilot through the entire HIMS Process

What is HIMS?

HIMS is a Process



How does HIMS work?

How does HIMS work?

How does HIMS work?

The HIMS PROCESS

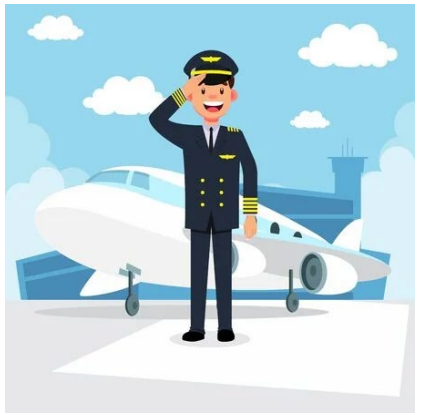
How does HIMS work?

The HIMS PROCESS

Identification / Evaluation

Identification / Evaluation

Who has the alcohol problem?



Identification / Evaluation

Health Issues

Sick Leave

- **Pilots Struggle with**
  - **Denial**
  - **Fear**
  - **Lack of Trust**
  - **Ego**
  - **Not Ready to Stop**

Failed Alcohol Test

Layover Incident

Peer Concerns

Family Problems

DUI

Training Issues

Identification / Evaluation

- ALL Addicts need ***Consequences*** to break delusion
  - Layover Incidents
  - Peer Concerns
  - DUI / Illegal Possession
  - Failed Alcohol / Drug Test
  - Sick Leave
  - Training Issues
  - Family Problems

Identification / Evaluation

My Goals

Get the pilot to see - there may be a “Problem”

Get the pilot to agree to a Professional HIMS Evaluation

Identification / Evaluation

Abuse vs Dependence

How does HIMS work?

The HIMS PROCESS

Identification / Evaluation

Treatment

Treatment

- A Comprehensive Program for the Dependent Pilot
  - In-Patient Residential
  - With other Pilots / Professionals
  - 28 Days +
  - Staff is Familiar with HIMS / Pilots
  - Prepares Pilot for Life in Recovery

How does HIMS work?

The HIMS PROCESS

Identification / Evaluation

Treatment

Mutual Group Support Recovery Program (AA/N and others)

Mutual Group Support Recovery Program

- A New Way of Life for the Pilot
  - Alcoholics Anonymous (AA) is best known but there are others
  - Requires Rigorous Honesty
  - Requires change in all aspects of Pilot's life
  - Requires the Pilot to open up to Others
  - Progress not Perfection

How does HIMS work?

The HIMS PROCESS

- Identification / Evaluation
- Treatment
- Recovery Program (AA/NA)
- **Aftercare**

Aftercare

- The Transition from Treatment to Sober Life
  - Group Setting
  - Professional Group Leader Familiar with HIMS / Pilots
  - With other Pilots / Professionals
  - Weekly Meetings
  - Reports sent to HIMS AME / IMS

How does HIMS work?

The HIMS PROCESS

- Identification / Evaluation
- Treatment
- Mutual Recovery Support Group
- Aftercare
- **No Notice Alcohol / Drug Testing**

No Notice Alcohol/Drug Testing

- Trust but Verify
  - Separate from Random DOT Testing
  - Minimum of 14 tests per 12 months
  - Windows test for Both On and Off Duty Use
  - Should adjust per individual dependent Pilot –
    - ETG Test
    - PEth
    - Hair/Nails
    - SoberLink
  - Is very accurate – But still <u>One</u> data point

How does HIMS work?

The HIMS PROCESS

- Identification / Evaluation
- Treatment
- Mutual Recovery Support Group
- Aftercare
- No Notice Alcohol / Drug Testing
- **Psychological & Psychiatric Evaluations**

Psychological & Psychiatric Evaluation

- Does their Mental Condition allow for a Safe Pilot?
  - Evaluations are by HIMS Trained Doctors
  - **Pilot should be well established in Recovery**
  - Should not begin evaluations if any residual effects of long-term alcohol use are present

How does HIMS work?

The HIMS PROCESS

- Identification / Evaluation
- Treatment
- Mutual Recovery Support Group
- Aftercare
- No Notice Alcohol / Drug Testing
- Psychological & Psychiatric Evaluations
- **Peer Pilot Monitoring**

Peer Pilot Monitoring

- A Trusted Volunteer
  - Must be HIMS Trained
  - Ideally has been through HIMS as well
  - Is a Resource and an Advocate
  - Must Hold Dependent Pilot Accountable
  - Reports sent to HIMS AME / IMS

How does HIMS work?

The HIMS PROCESS

- Identification / Evaluation
- Treatment
- Mutual Recovery Support Group
- Aftercare
- No Notice Alcohol / Drug Testing
- Psychological & Psychiatric Evaluations
- Peer Pilot Monitoring
- **Company Pilot Monitoring**

Company Pilot Monitoring

- A member of Airline Management
  - Ideally be HIMS Trained
  - Helps pilot adjust in Return to Flying
  - Is a Resource and an Advocate
  - Must Hold Dependent Pilot Accountable
  - Reports sent to HIMS AME / IMS

How does HIMS work?

The HIMS PROCESS

- Identification / Evaluation
- Treatment
- Mutual Recovery Support Group
- Aftercare
- No Notice Alcohol / Drug Testing
- Psychological & Psychiatric Evaluations
- Peer Pilot Monitoring
- Company Pilot Monitoring
- **The HIMS AME / IMS**

HIMS AME / IMS

- The Manager of the Team
  - Guides the HIMS Process
  - Collects all Reports on the HIMS Pilot
  - Evaluates the Pilot's Progress
  - Should establish a Relationship with the Pilot
  - Makes Final Decision on when to request Return to Flight status with the FAA

How does HIMS work?

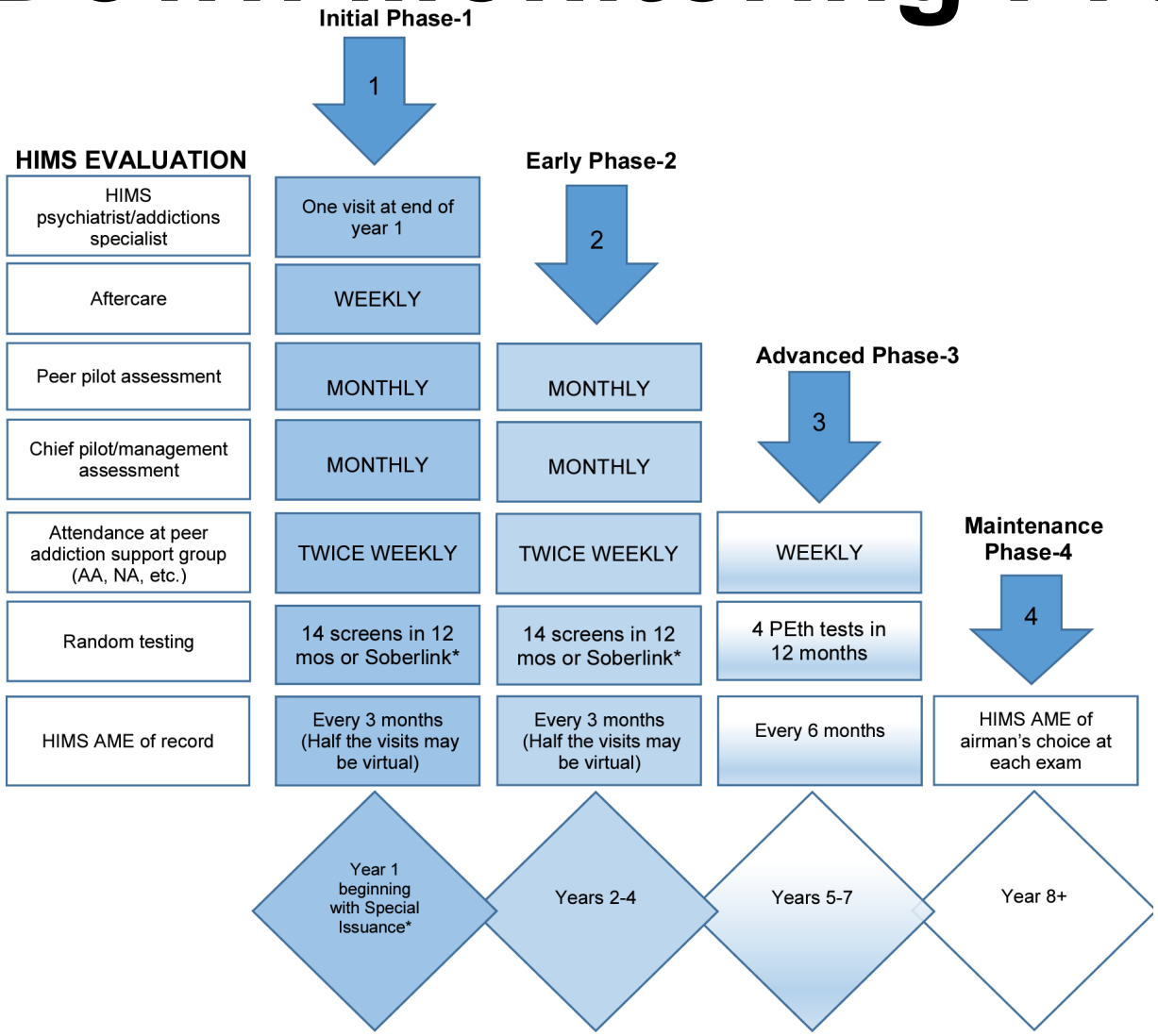
The HIMS PROCESS

- Identification / Evaluation
- Treatment
- **Mutual Recovery Support Group**
- **Aftercare**
- **No Notice Alcohol / Drug Testing**
- **Psychological & Psychiatric Evaluations**
- **Peer Pilot Monitoring**
- **Company Pilot Monitoring**
- **The HIMS AME / IMS**

Step-Down Monitoring Process

- Describes Monitoring after Pilot returns to Flying
  - Lifetime Abstinence is Required
  - Trust but Verify
  - Start with very strict requirements
  - Requirements are relaxed as Time and a Strong Foundation in Recovery are built

Step-Down Monitoring Process

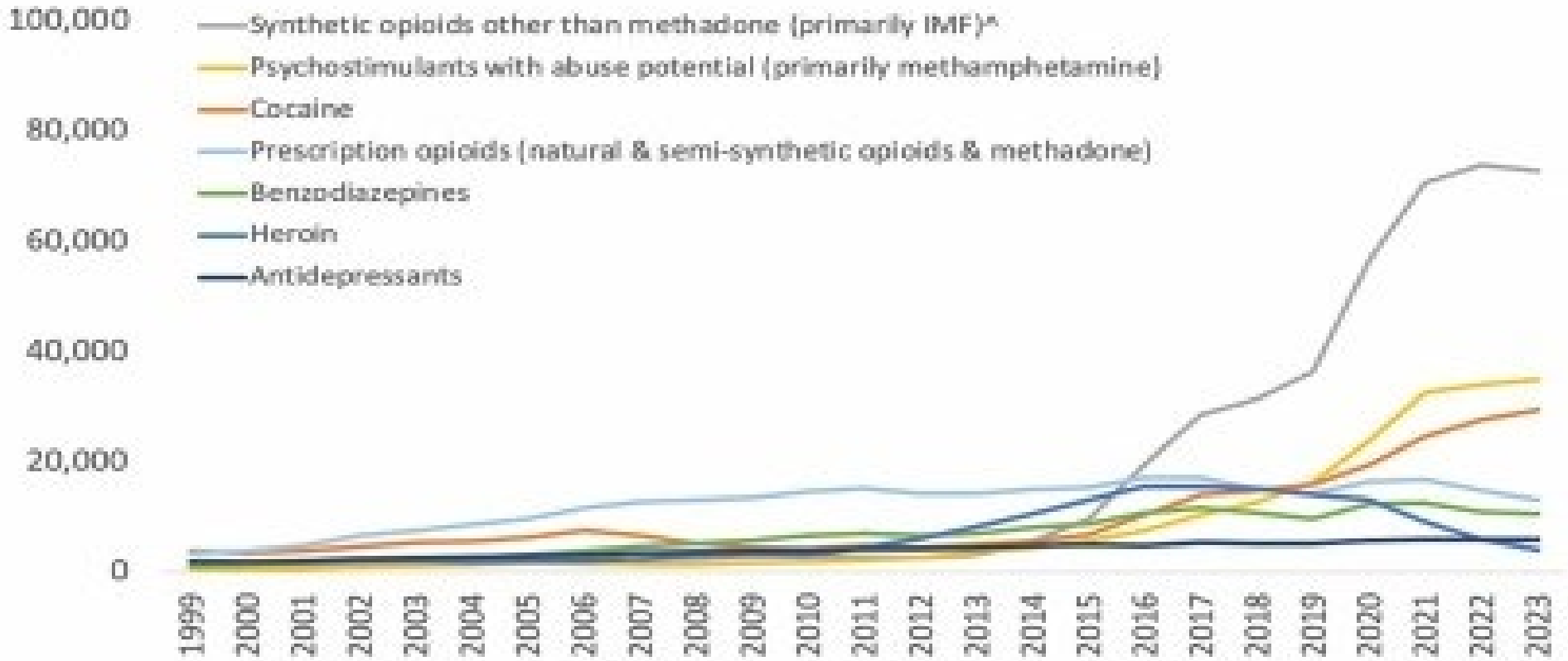


Does HIMS Work?

Drug & Alcohol Overdose Deaths 2022

- Total – 107,941 296 / Day
  - Opioids – 73,838
  - Stimulants ~ 20%
- Alcohol Overuse Deaths
  - 178,000 deaths in US ~ 5 M worldwide (5.3% of all deaths)
  - 488 deaths/day overall – 99,000 listed on death certificates 2020
  - 1/10 deaths age 20-64 13,524 additional MVA deaths in 2022
  - 22% Opioid/benzo OD's – ¼ of suicides alcohol related
  - 4th leading cause US Preventable Deaths
- https://www.cdc.gov/alcohol/facts-stats/index.html CDC accessed 8/23/2025

Figure 2. U.S. Overdose Deaths*, Select Drugs or Drug Categories, 1999-2023



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. ^Illicitly manufactured fentanyl. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2023 on CDC WONDER Online Database, released 1/2025.

Source: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#Fig2 Accessed 8/23/2025

Percentage Substance Usage US ≥ 26 y.o.

Substance	Lifetime	2020	Last Month	SUD
Alcohol	85.6	69.5	54.9	10.3
Illicit Drugs	52.9	22.2	12.6	5.6
Marijuana	48.9	16.3	10.8	5.2
Cocaine	16.5	1.7	0.6	0.5
Opioids/ates	n.r.	3.9	1.3	1.3
Hallucinogens	17.5	2.0	0.5	0.1
Methamph.	6.8	1.1	0.8	0.6
Rx Psycho	n.r.	5.6	2.0	1.3

Source: National Survey on Drug Use & Health 2020 and NIAAA Alcohol Facts

National Survey on Drug Use and Health - 2024

- Ages 12 and older in United States - Last month
  - **Alcohol:** 46.6% drank alcohol.
  - **Tobacco product:** 16.7% used a tobacco product.
  - **illicit drug:** 16.7% used an illicit drug.
- Last year
  - **Marijuana:** 22.3% used marijuana.
  - **Hallucinogens:** 3.6% used hallucinogens.
  - **Prescription opioid misuse:** 2.6% misused prescription opioids.
  - **Cocaine:** 1.5% used cocaine.

National Survey on Drug Use and Health - 2024

Substance Use Disorder Prevalence US 2024

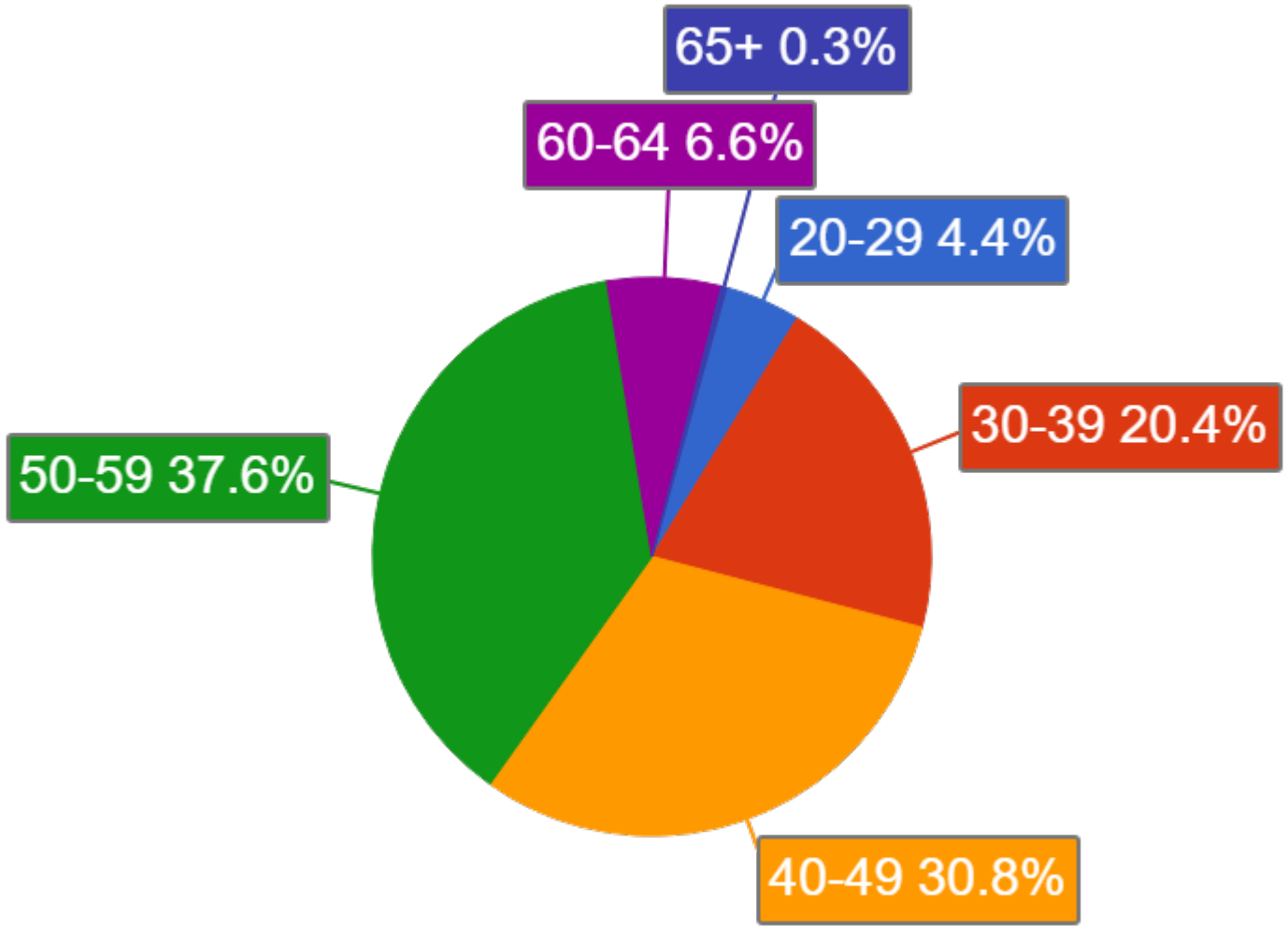
https://www.samhsa.gov/newsroom/press-announcements/20250728/samhsa-releases-annual-national-survey-on-drug-use-and-health#:~:text=Among%20the%204.8%20million%20people,treatment%20in%20the%20past%20year.

- **Total SUD:**
  16.8% (48.4 million people) had a past-year SUD.
- **Drug use disorder:**
  Increased from 8.7% in 2021 to 9.8% in 2024.
- **Alcohol use disorder:**
  Decreased from 10.6% in 2021 to 9.7% in 2024.
  - 54% of American adults used alcohol in last year
  - High risk drinking is higher in older adults

https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts

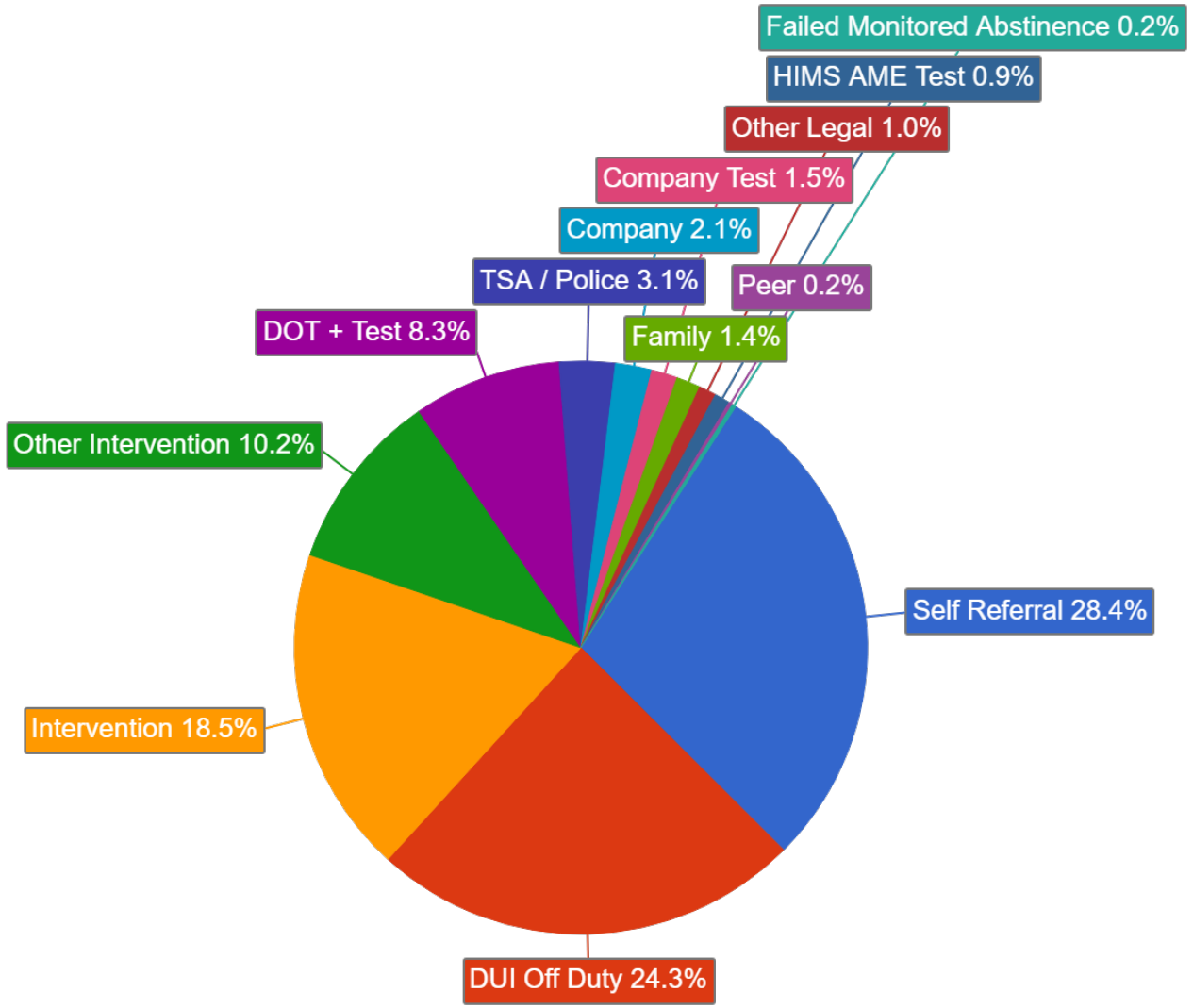
HIMS Database

Age Distribution



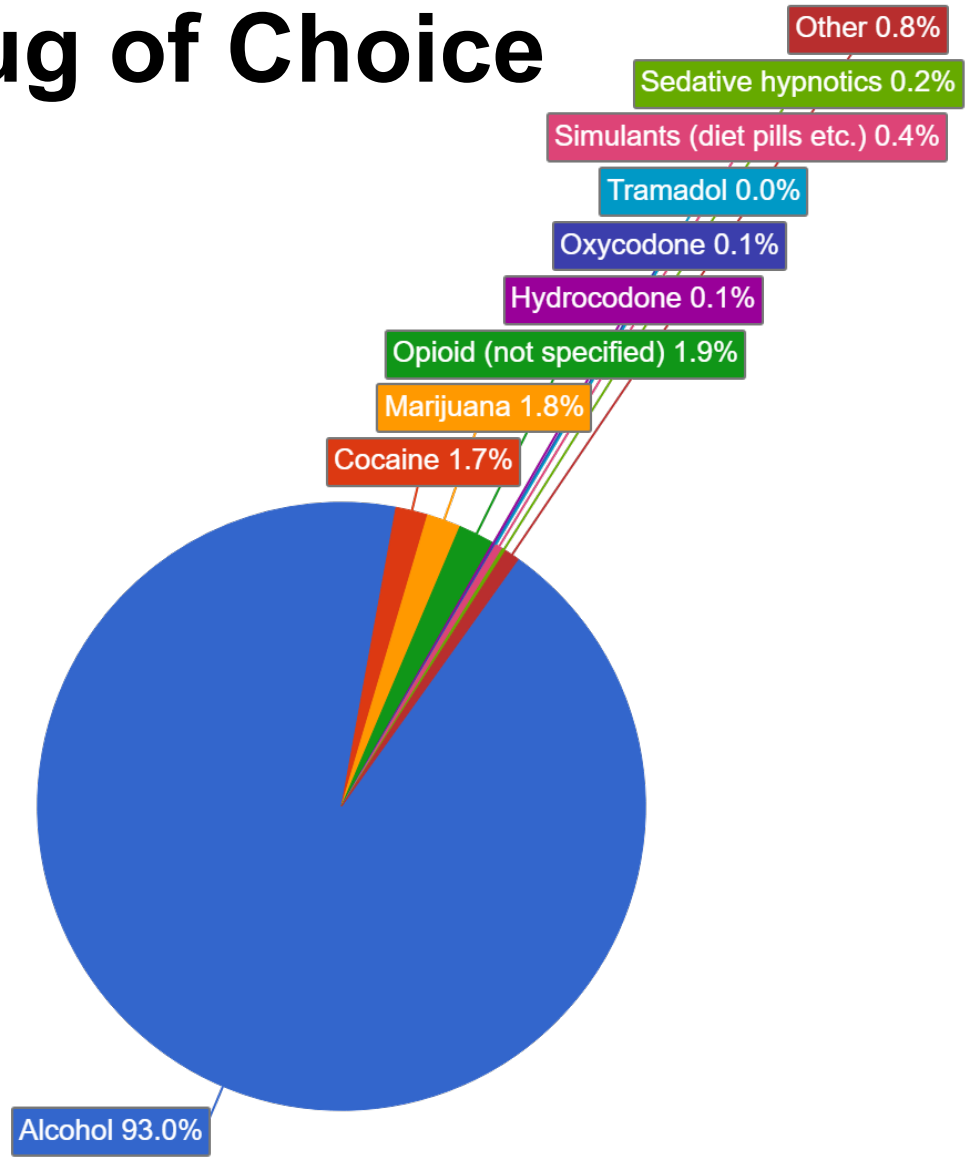
Age	Pilots	%
20-29	64	4.4
30-39	299	20.4
40-49	453	30.8
50-59	552	37.6
60-64	97	6.6
65+	4	0.3

How Entered Program



Discovery		%
Self-referral	523	28.4
DUI Off Duty	447	24.3
Intervention	341	18.5
Other Intervention	188	10.2
DOT + Test	154	8.4
TSA / Police	58	3.1
Company	38	2.1
HIMS AME	16	0.9
Family	25	0.4
Peer	4	0.2
Failed M.A.	4	0.2

Drug of Choice



Primary DOC 1,469 Pilots	#'s	%
Alcohol	1365	92.9
Opioid/Opiate	30	2.1
Cocaine	25	1.7
THC	26	1.8
Stimulants	6	0.4
Sedative Hypnotics	3	0.2
Other	12	0.8

Relapse Detection Data - Incidents

Discovery	EtOH	Cocaine	MJ	Opioid	Rx Narc	Sedat Hypnot	Stim Meth
Intervene	132	1	0	4	1	0	0
+ DOT Test	33	4	3	4	1	0	1
Off Duty	7	0	0	2	0	0	0
Self Report	133	2	0	11	0	0	1
TSA/Crew	12	0	0	0	0	0	0
DUI	113	0	0	3	1	0	0
Other	3	0	0	0	0	0	0
AME Test	16	0	0	0	0	0	0
Failed M.A.	1	0	0	0	0	0	0

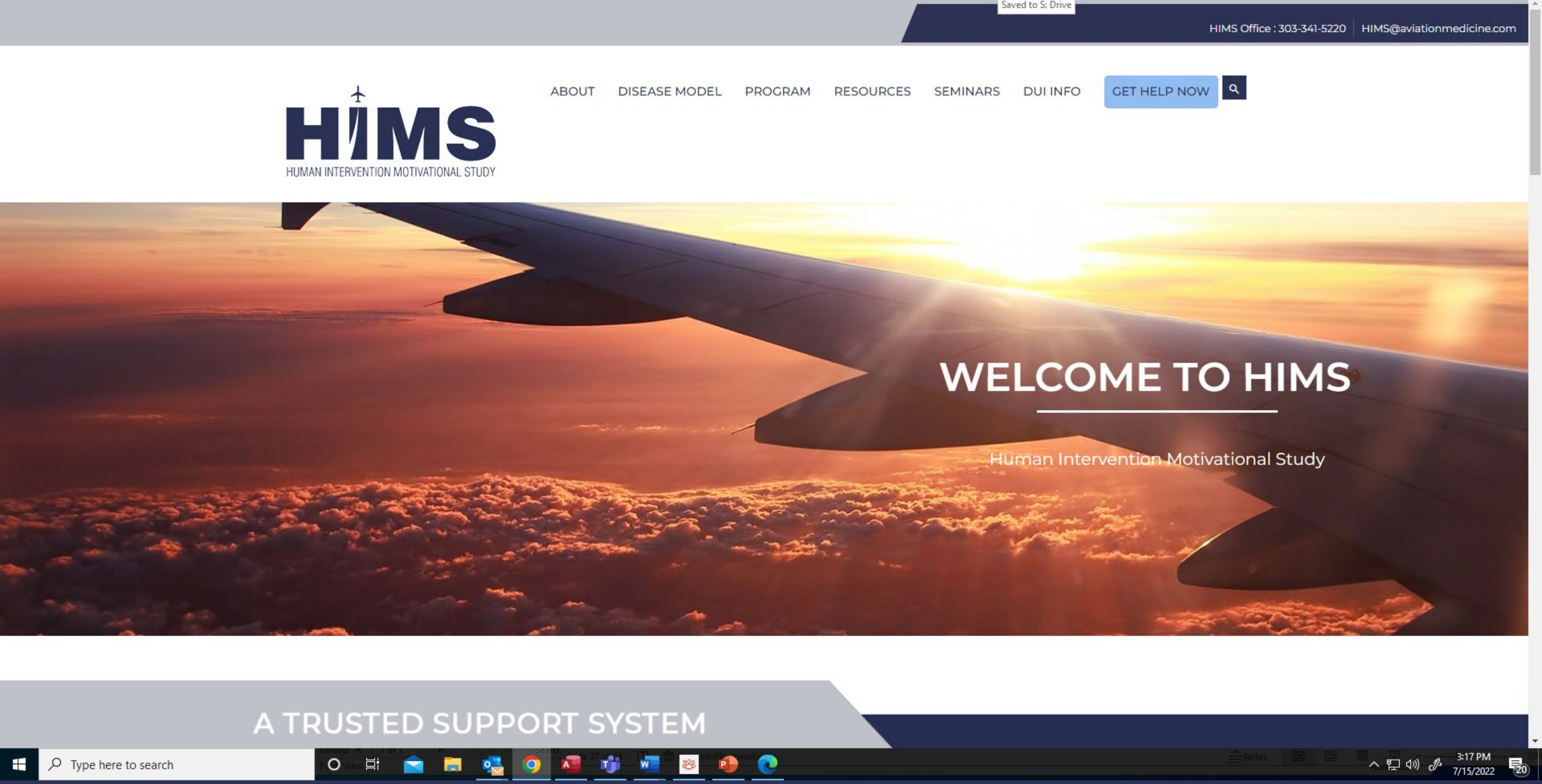
Relapse Rate by Drug of Choice

Drug of Choice	Relapse Rate
Alcohol	13.1 %
Cocaine	16.0 %
Cannabis	7.7 %
Opioids	39.3 %
Stimulants	0.0 %
Sedative Hypnotics	0.0 %
Other	8.3 %
Total	13.9%

FAA Special Issuances – Drugs, Alcohol & SSRI's

Diagnosis	1st	2nd	3rd	Total
Alcohol Abuse & dependence	3,165 1.07%	956 1.03%	1043 0.52%	5,164 0.88%
Drug Abuse & Dependence	1,730 0.59%	501 0.54%	589 0.29%	2,820 0.43%
Alcohol / Drug Monitored	2,366 0.80%	321 0.16%	329 0.07%	3,016 0.51%
Alcohol related offense	12,529 4.25%	5,522 5.93%	8,595 4.27%	26,646 4.52%
Drug related Offense/misuse	1,107 0.38%	475 0.51%	672 0.33%	2,254 0.38%
SSRI (MDD, Adj d/o w. depressed mood, dysthymia	510 0.17%	104 0.11%	414 0.21%	1,208 0.17%
SSRI Issued	336 0.11%	40 0.04%	187 0.09%	563 0.10%

Source: DOT/FAA/AAM-23-383 "2022 Aerospace Medical Certification Statistical Handbook",; November 2023 Page 32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HIMS Office : 303-341-5220
HIMS@aviationmedicine.com
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HUMAN INTERVENTION MOTIVATIONAL STUDY
ABOUT
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PROGRAM
RESOURCES
SEMINARS
DUI INFO
GET HELP NOW
WELCOME TO HIMS
Human Intervention Motivational Study
A TRUSTED SUPPORT SYSTEM
Type here to search
3:17 PM
7/15/2022

Questions??

Capt. Craig Ohmsieder
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HIMS
HUMAN INTERVENTION MOTIVATIONAL STUDY

www.himsprogram.com

Addiction: It’s a Brain Disease…. and it matters!

Navjyot Bedi, MD
Medical Director
Caron Aviation Assessment Program

HIMS

2025 Basic Education Seminar
Sustaining Success – One Step at a Time

September 15-17, 2025
The Westin Hotel – Denver, CO

Disclosures

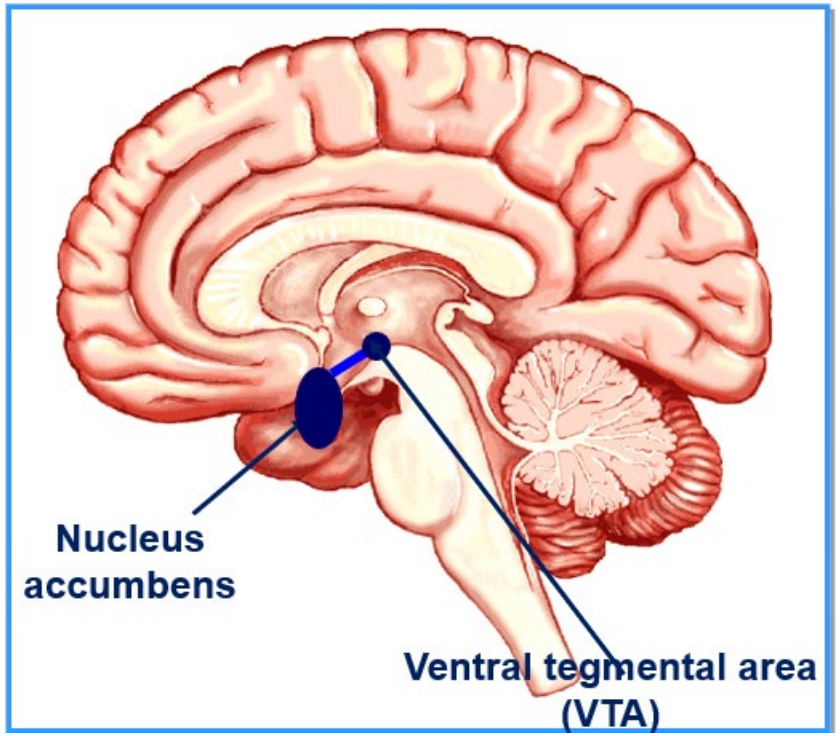
- I have no commercial relationships to disclose.
- I do not intend to discuss any off label use of any medication.

Objectives

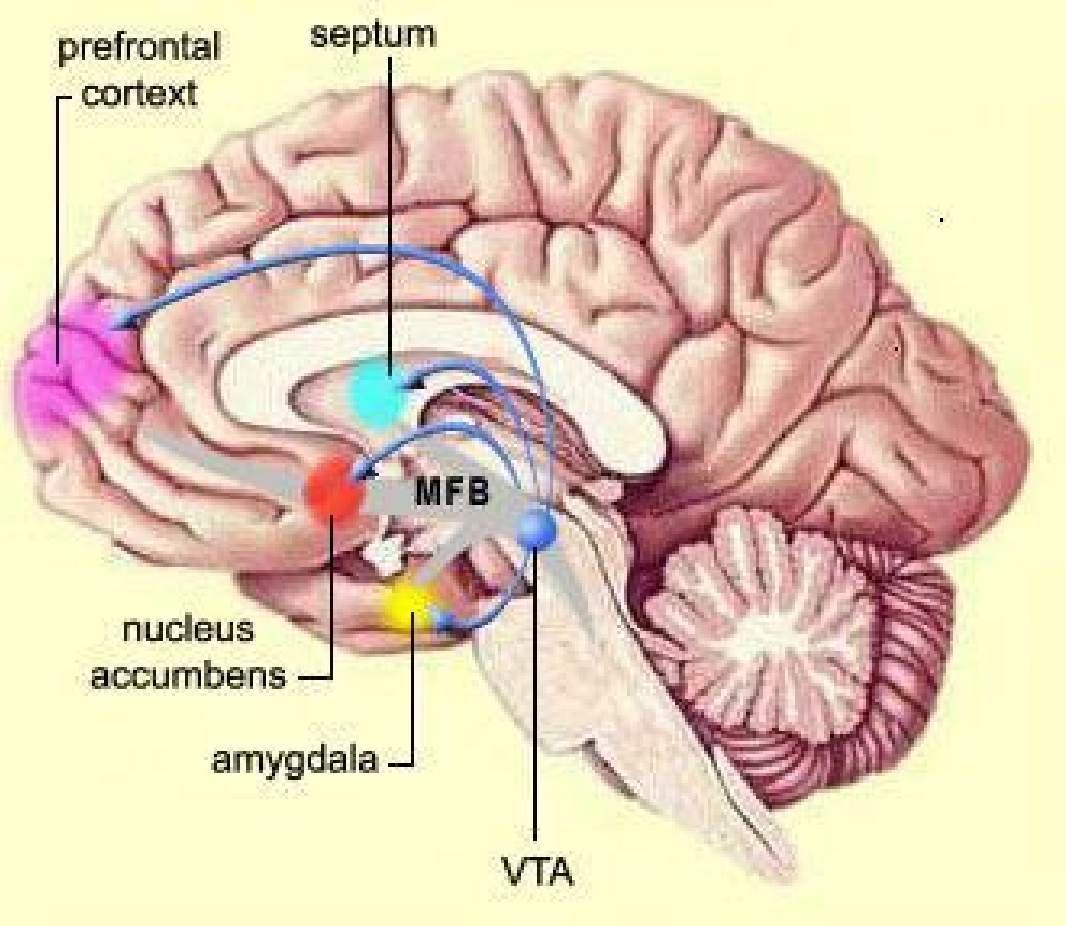
- To actively participate in exploring the biological basis of addiction.
- Understand and apply the core concept of addiction to understand natural history of addiction and loss of control.
- Understand Addiction as a Chronic medical condition.

WHY DO WE LIKE TO GET HIGH?

- <u>BRAIN REWARD PATHWAY</u>
- Exists to reward us for activities consistent with our survival
  - Food
  - Water
  - Sex
  - Child Rearing



THE POWER OF THE BRAIN REWARD PATHWAY

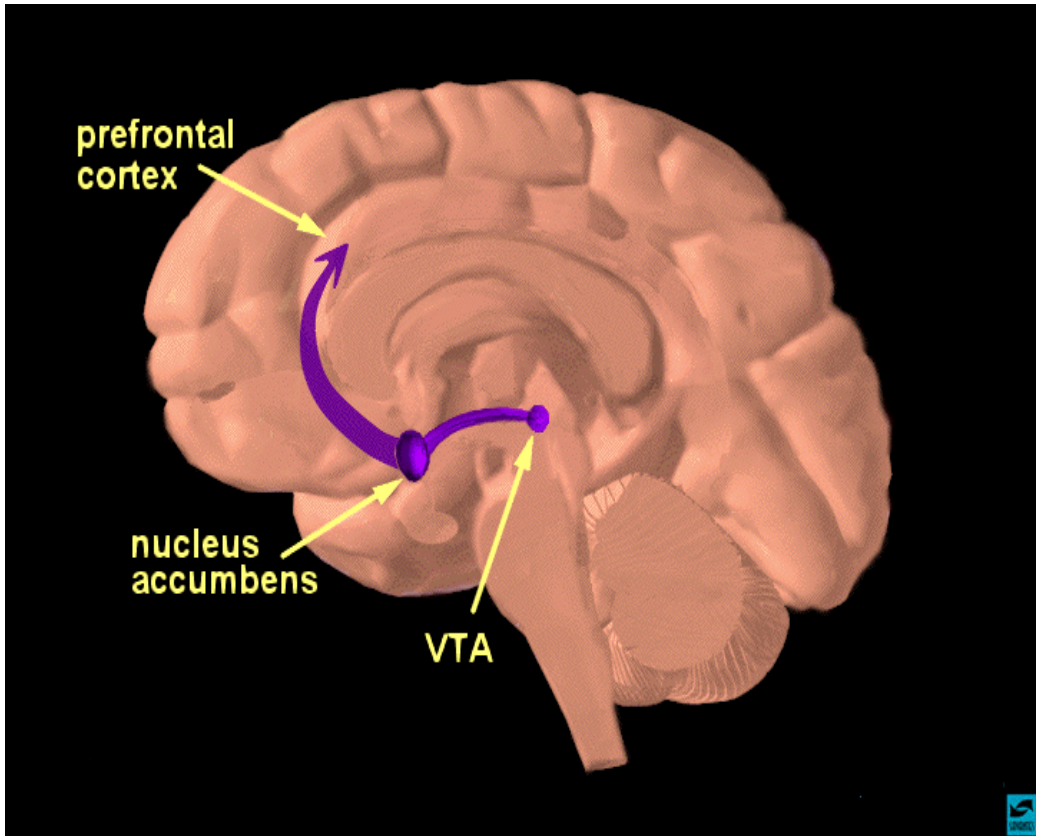


Exists to reward us for activities consistent with our survival

- **Food**
- **Water**
- **Sex**
- **Child Rearing**

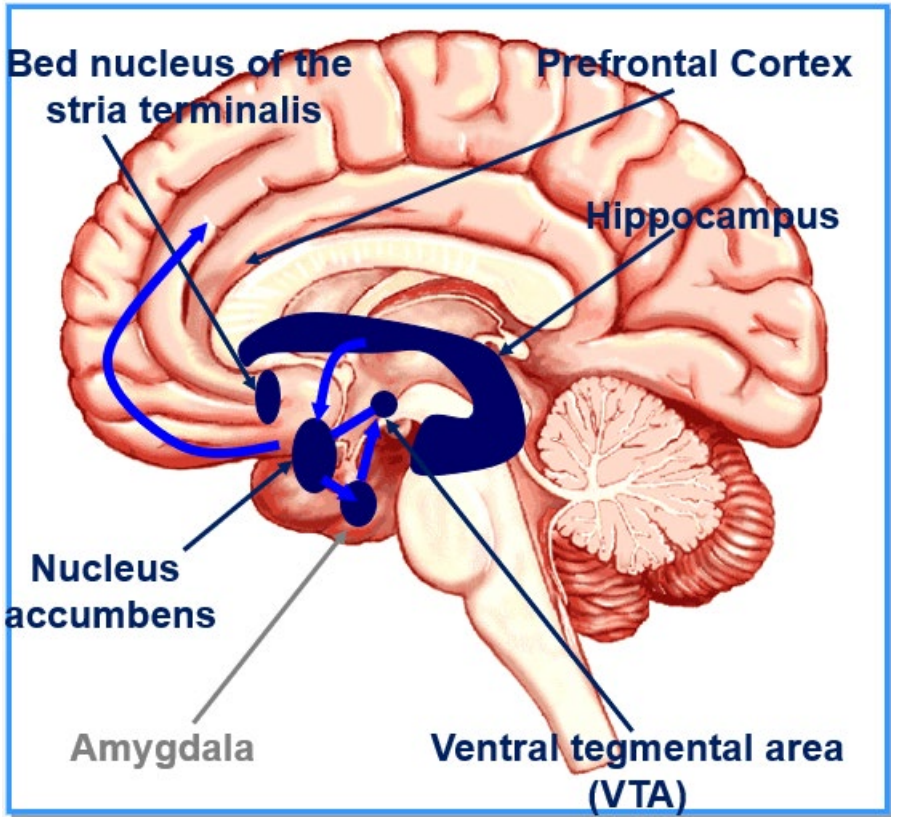
WHY DO WE USE DRUGS?

- <u>BRAIN REWARD PATHWAY</u>
  - I like
  - I want
  - NEUROADAPTATION
  - I need !!!
  - Brain hijacked



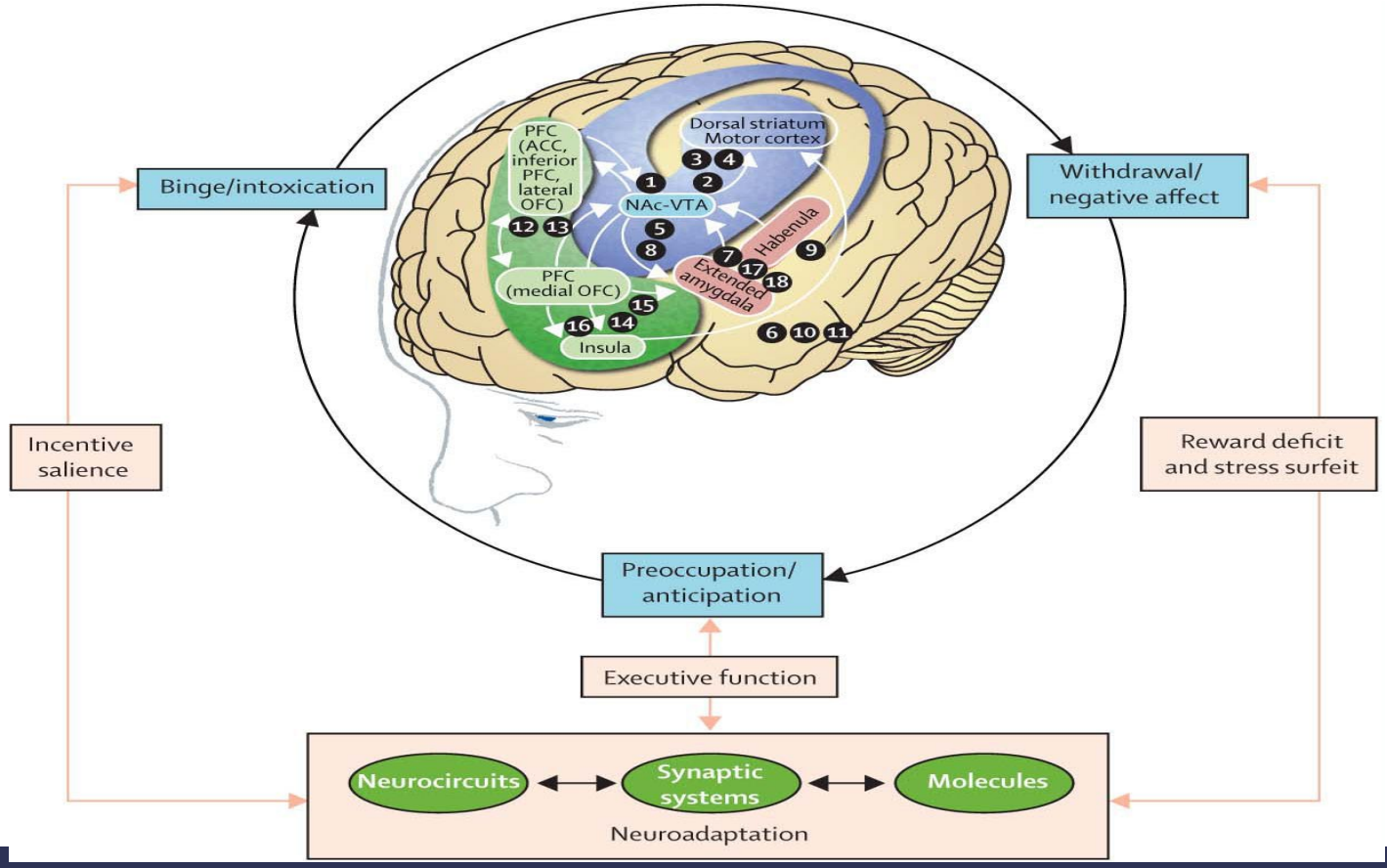
WHY DO WE USE DRUGS?

- <u>BRAIN REWARD PATHWAY</u>
- Exists to reward us for activities consistent with our survival
  - Food
  - Water
  - Sex
  - Child Rearing
  - DRUG of CHOICE



Neurobiology Of Addiction

- Koob et al; The Lancet Psychiatry; 2016
- Neurobiology of addiction: a neurocircuitry analysis; PMID: 2747576



Loss of control or Powerlessness?

- We just described the Neurobiological basis of the “First Step.”
- “We admitted we were powerless over alcohol – that our lives had become unmanageable.”

Why are some people more predisposed?

- Genetic predisposition.
- Social factors and availability of drug.
- Environmental factors, trauma.
- Co-occurring psychiatric disorders.
- Disabling medical conditions.
- Chronic pain.

Genetic Predisposition

- Sons of alcoholics are 3-4 times more likely to develop alcoholism
- Wired to get high
- Genetics alone does not explain it all.
- Many children of chemically dependent parents never develop addiction

Social factors and availability

- Drug availability
- Societal attitudes toward drug use
- Peer group attitudes toward drug use

Environmental factors and trauma

- Childhood abuse or neglect is a strong predictor
- Adult trauma including bereavement
- Trauma is near universal, how it gets handled is what determines impact
- Unaddressed , untreated trauma is highly correlated with addiction

Co-occurring psychiatric and medical conditions

- Major depression, Anxiety disorders and PTSD
- Bipolar disorder and Schizophrenia
- Personality Disorders
- Chronic pain
- Terminal medical conditions

Addiction is…..

- A chronic relapsing medical disorder with relapses and remissions, that needs treatment.
- Has complex genetic, environmental and individual influences.
- It is NOT a moral weakness.
- Characterized by loss of control.
- “Just say NO !” does NOT work.
- Treatment works.

It’s a Brain Disease…But where do we go from here?

- “I have not had a drink in 20 years, so I know I can have a drink now!”
- “I only have a problem with cocaine, so I can keep on drinking…right?”
- “I am having surgery. Do I need to tell my doctor I am an alcoholic?”

Thank You!

Navjyot S Bedi M.D.

Addiction Psychiatrist, Aviation Assessment program at Caron
Diplomate, American Board of Psychiatry & Neurology
in Psychiatry and Addiction Psychiatry
Diplomate, American Board of Preventive Medicine in Addiction Medicine
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Treatment

Navjyot Bedi, MD
Medical Director
Caron Aviation Assessment Program

HIMS

2025 Basic Education Seminar
Sustaining Success – One Step at a Time

September 15 -17, 2025
The Westin Hotel DIA, Denver, CO

Objectives

- Review core concept of Addiction as a Brain Disease and a chronic medical condition.
- Explain the process of Recovery.
- Describe the stages of treatment.
- Discuss special issues unique to Pilots.
- What do we learn from other Chronic medical conditions?

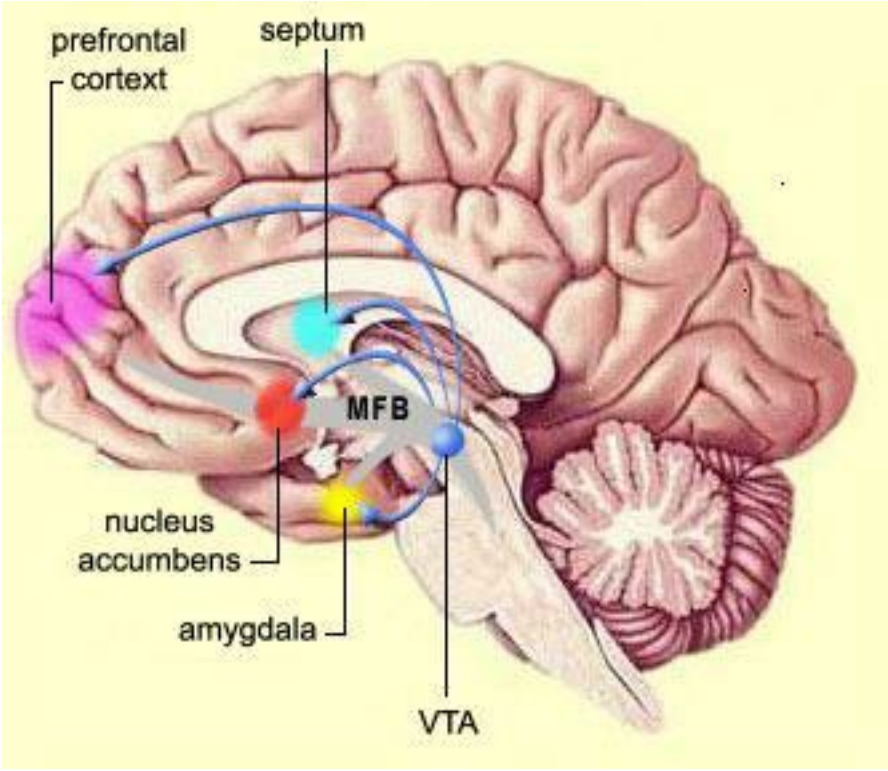
It's a Brain Disease…But where do we go from here?

- There is a part of our Brain that is trying to get us high!
- So how do you fight an enemy within?
- Are the 12 steps actually relevant?

So what happens in Treatment?

- The Brain is a self organizing system.

- Treatment facilitates this process by allowing the Cognitive and Behavioral changes necessary for Recovery to occur.



What does Recovery entail? (What steps?)

- It is process of self awareness and true appreciation of the problem. Addresses the inherent denial. (1)
- It invites the process of self examination. And Emotional integration- the painful place of recovery where the person with substance use disorder rethinks their past and takes responsibility for addiction-related behaviors and begins to invite help. (2,3 leading to 4)

What does Recovery entail?

- This leads to Cognitive awareness and recognition of need to change. (4, 5 and 6)
- Forces new set of behaviors that directly lead to improved coping and dealing with negative emotions, cravings and leads to self improvement. (7, 8 and 9)
- Self realization and self actualization follow. Also described as a spiritual awakening, this change produces a new awakening in the recovering addict about the meaning of their life. (10,11,12)

What is the role of treatment?

- Treatment is the path that facilitates and establishes these changes.
- It is unique and has to be individualized to each person.
- Cognitive, behavioral restructuring crucial.
- It is NOT a novel idea!
- AA or 12 step facilitation is a proven, effective, widely accepted and cheap means of doing so.

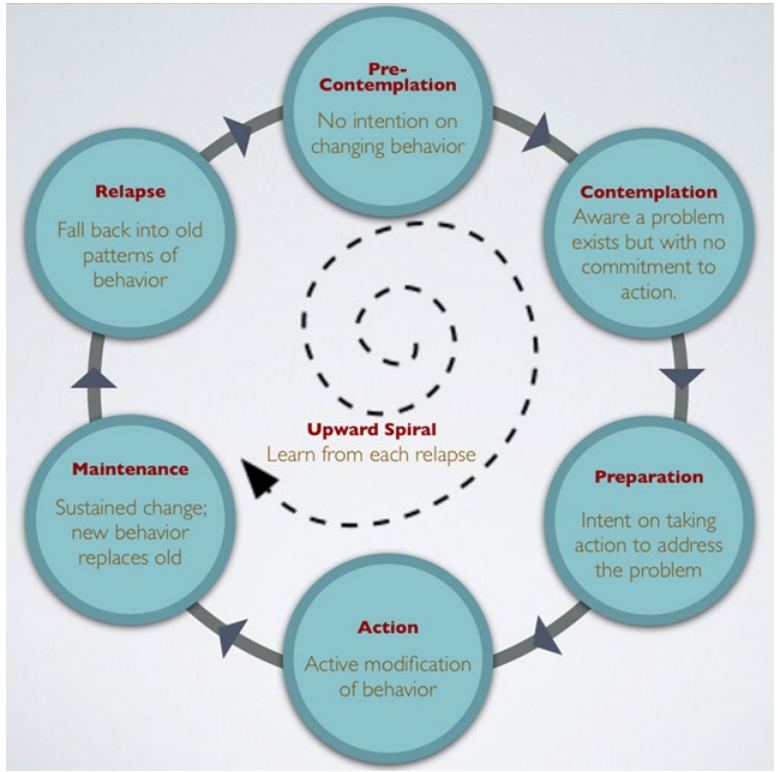
Phases of treatment: Comprehensive Assessment

- Addiction Assessment by Addiction Medicine physician skilled in working with addiction in professionals
- Psychiatric evaluation.
- Psychological and Neuro cognitive Testing
- Physical Examination
- Laboratory and fluid analysis as indicated
- Collection of collateral information
- Record review, medical, legal and workplace concerns
- Family assessment and input.
- Identify emotional , psychiatric, trauma, grief or personality related variables unique to patient.

Medical Stabilization

- Detoxification if indicated.
- Physiological, emotional and cognitive elements are involved.
- Lasts 2 days to 3 weeks.
- Runs concurrently with assessment
- Lays the ground for the next phase.

Stages of Change Prochaska & DiClemente



- Social Work Tech https://socialworktech.com

Motivational enhancement and Engagement

- Address denial by support, respectful confrontation of defenses, and use of data. Impact letters are invaluable.
- A community of peers is very helpful, if not critical, for the process.
- Address grief, trauma, interpersonal and emotional issues identified.
- 12 step recovery process begins. Work steps from 1 to 3.

Practicing Recovery

- Continue group support
- Individual therapy to re focus and help reframe the cognitive process unfolding.
- Self monitor behavior and practice “rigorous honesty”.
- Steps 4-7 completed
- Aftercare planning and transition.

Aftercare and Monitoring

- At this stage recovery should be portable.
- Continue support group, identify home group, sponsor.
- Peer support group (Birds of Feather) for support and monitoring.
- Random monitored Urine drug screens.
- Stay visible, connected and accountable.

Challenges in treating Professional Pilots (and MDs)

- Tend to guard their workplace performance and reputations very carefully.
- Addiction tends to go on for years before it is detected.
- By the time work begins to get impacted, the disease is often far advanced.
- The same skill sets and personality variables that make them skilled at their jobs are used skillfully to cover up the addiction!

Addiction in Professional Pilots

- When drug or alcohol use occur in a professional pilot with emotional, home or work problems, the diagnosis is ***Addiction*** until proven otherwise.

- Courtesy: Dr. Paul Earley, GA PHP

Challenges in treating Professional Pilots

- A peer support group in treatment is vital to confront denial, promote understanding and address the shame and guilt of the professional.
- A pilot or MD can go through a conventional community Intensive outpatient program like a Graduate seminar.
- They will attempt to score an “A+” without internalizing any changes within. They are used to being in charge and have difficulty accepting feedback.

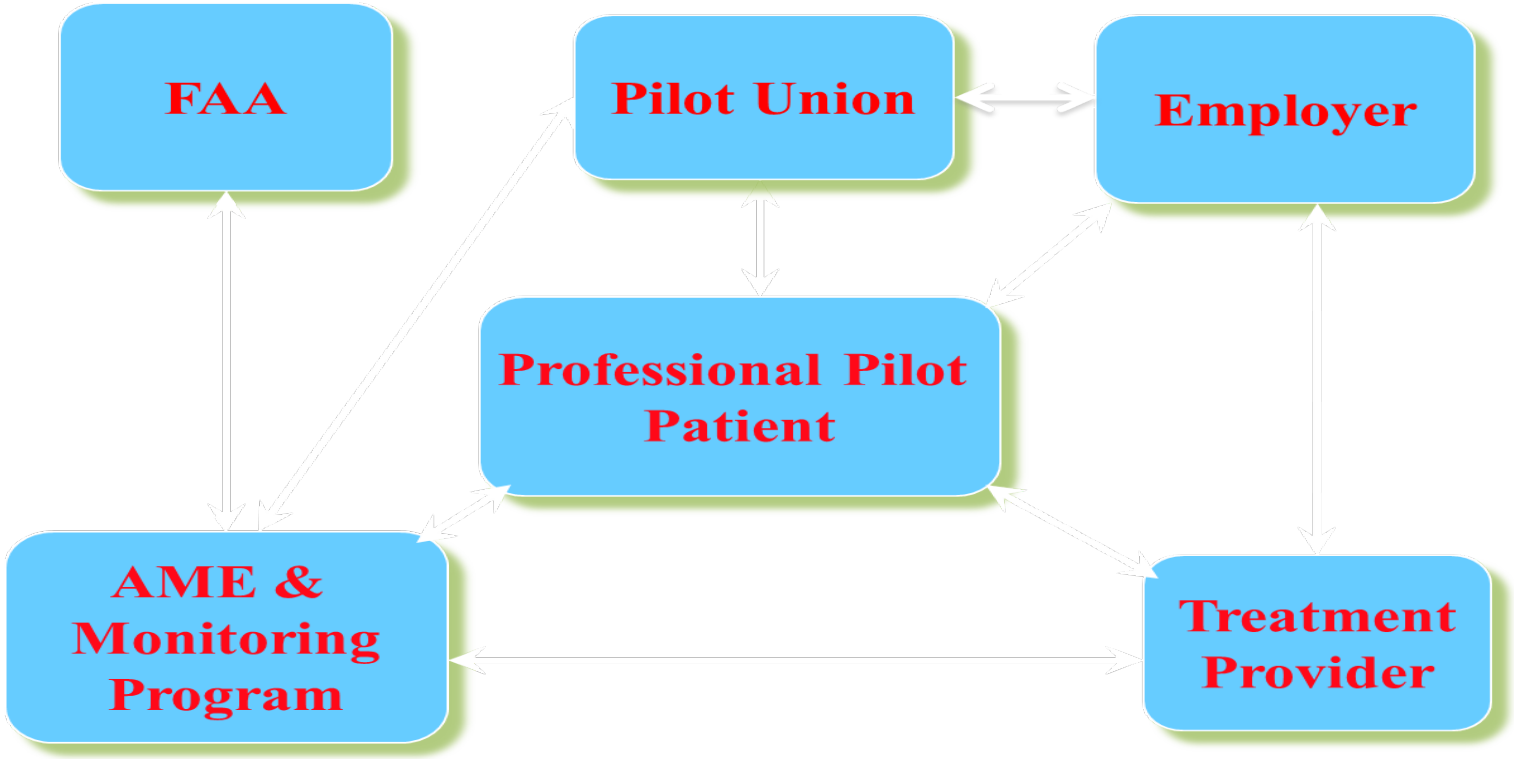
Why this level of care?

- Professionals who are in safety sensitive positions, need more intensive upfront care.
- Treatment should allow for them to be “full time patients.”
- Partial hospitalization with peer support is recommended.
- Works best if after care and return to work recommendations are seamless.

Treatment success lies in building a partnership.

- Pilots are very valuable assets to their Company. (Employer)
- Their health and well being has safety sensitive concerns. (FAA, AME and monitoring)
- They are highly specialized and need special understanding and consideration. (Peer support and Unions)
- Have unique treatment needs and often have advanced disease requiring special experience.
  (Treatment Provider)

Treatment is a Partnership



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Thank You!

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Office: 678.543.5718
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HIMS Certification Timeline

Quay Snyder, MD, MSPH
FAA / ALPA HIMS Program Manager

HIMS

2025 Basic Education Seminar

Sustaining Success – One Step at a Time

September 15-17, 2025
The Westin Hotel DIA, Denver, CO

Learning Objectives: Participants Will Be Able To:

- Complete an Initial HIMS package for submission to the FAA
- Know the minimum timeline for each stage of the initial HIMS certification process
- Understand the minimum timeline for requesting the next phase stepdown monitoring for pilots on HIMS SIA's

Timeline

There is NO universal timeline for:

- –HIMS certification
- –Step Down

Steps Prior to Submission - SA Evaluation Req'd

- Select Evaluation Facility / HIMS Trained Psychiatrist
  - Can be done by Airline HIMS Committee or AME / IMS
  - CAUTION: Local Substance Abuse Professional eval not adequate- Use FAR's

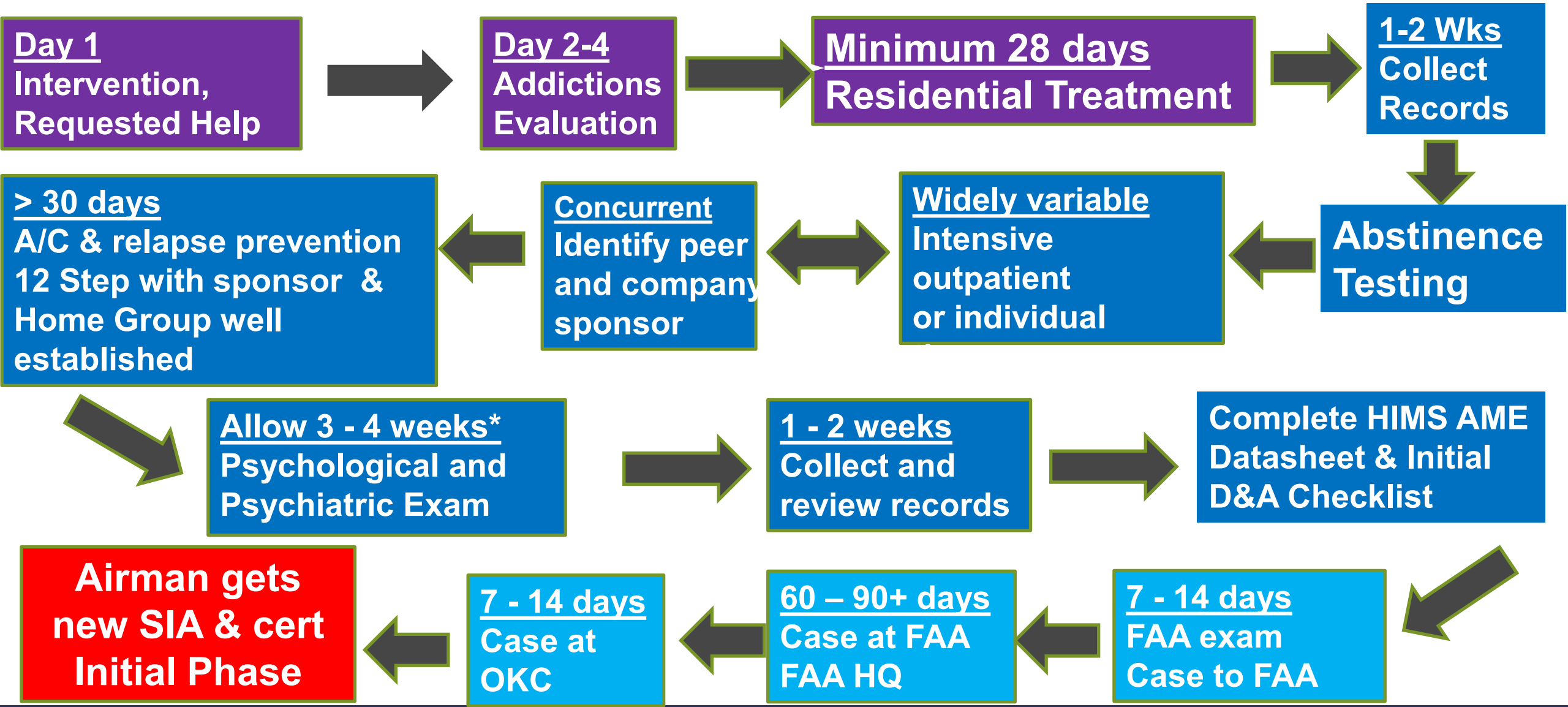
- Collateral Information
  - Driving / Police / Court Records
  - FAA Medical File
  - Relevant Medical Records*
  - Company Discipline Records*
  - Significant Relations

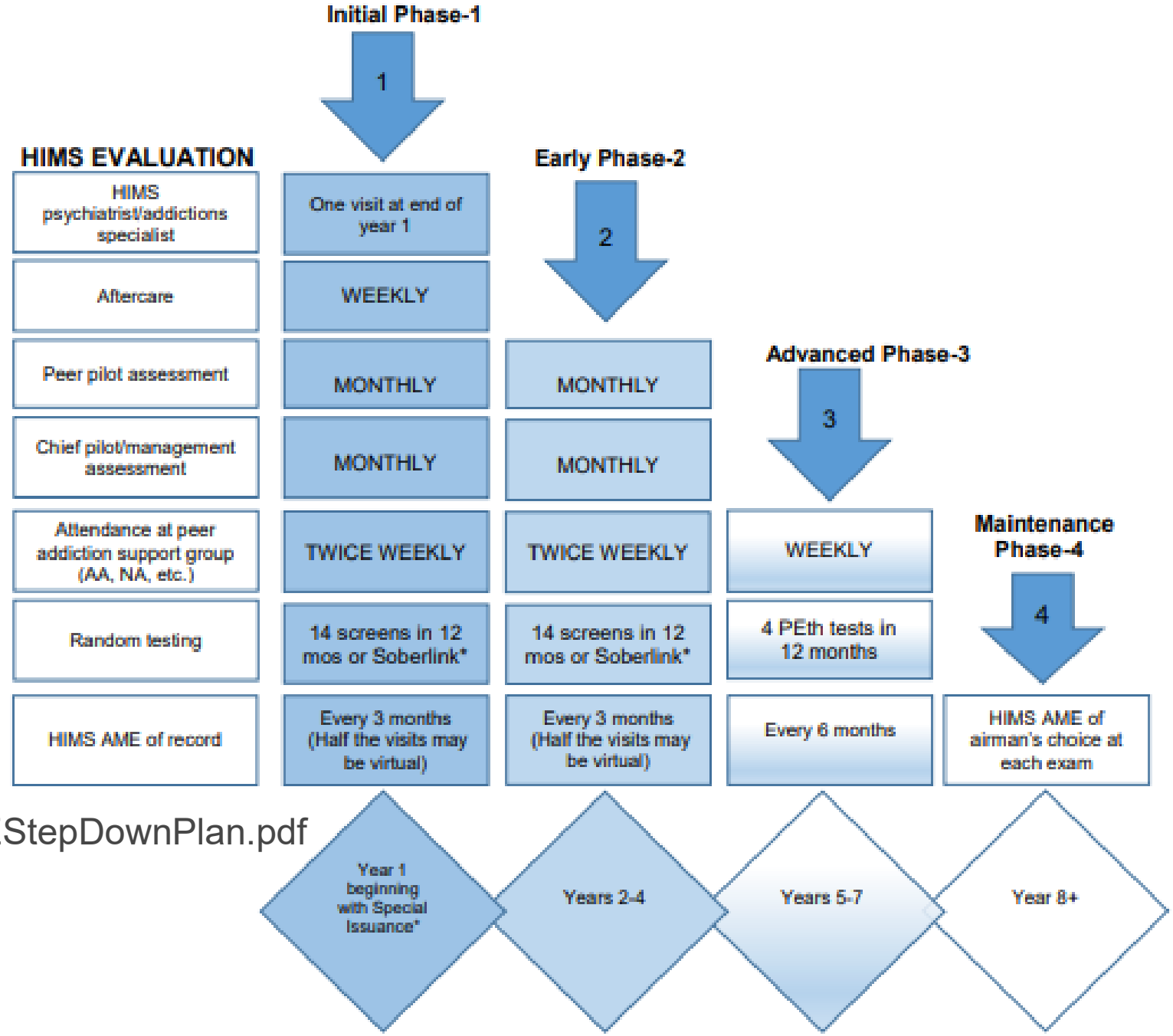
- Consents Signed for AME / IMS
  - Evaluator
  - Facility
  - HIMS Committee
  - Psychologist / Psychiatrist
  - FAA

Steps Prior to Submission – Direct to Treatment

- Collateral Information
  - Driving records / Police Records / Court Records
  - FAA Medical File
  - Relevant Medical Records*
  - Company Discipline Records*
- Consents Signed for AME / IMS
  - Facility
  - HIMS Committee
  - Psychiatrist & Neuropsychologist
  - FAA
  - Significant Relations

HIMS Certification Flow Sheet





www.faa.gov/ame_guide/media/HIMSAMEStepDownPlan.pdf

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

https://www.faa.gov/ame_guide/media/HIMSPilotStepDownPlan.pdf

HIMS AME	Testing	Addiction Support Group	Company Monitor	Peer Monitor	Aftercare	HIMS Psych	
Assigned 3 mo.	14+/yr Soberlink	2x Weekly	Monthly	Monthly	Weekly*	Annual*	Initial Year 1
Assigned 3 mo.	14+/yr Soberlink	2x Weekly	Monthly	Monthly			Early Years 2-4
Assigned 6 mo.	PeTH 4x/yr	Weekly					Advanced Years 5-7
Choice on exam							Maintenance Years 8+

Note: All Phase Durations, meeting frequencies and testing requirements are MINIMUMS. Additional requirements can be added by the FAA or AME / IMS.

Certification Timeline Factors – Admin Early

- Missing Data
  - Treatment Records
  - Aftercare Reports
  - Abstinence Testing History
  - Court / Police / Driving Records
- Cognitive Deficiencies
  - Older pilots seem to have less resiliency
  - Baseline Capabilities Vary
- Not meeting with AME / IMS Regularly

Certification Timeline Factors – Admin – AME → FAA

- Missing Data
  - Treatment Records
  - Aftercare Reports
  - Abstinence Testing History
  - Court / Police / Driving Records
- Submission
  - Not Using HIMS AME / IMS Checklist
  - Not Using Huddle System for Airline HIMS Pilots
  - Delays in Submission

Certification Timeline Factors - Pilot

- QUALITY OF RECOVERY
- Poor Participation in Recovery Activities
  - No Sponsor
  - No Home Group
  - Poor Mutual Support Group Participation
- Unfavorable Reports
  - Peer and Company Monitors
  - Aftercare
- Abstinence Testing
  - Missing Tests
  - Positive Tests

Monitored Abstinence Program - Misuse

- IS NOT HIMS!!! *No participation in Airline HIMS Program*
- Requires HIMS AME and many same steps Pre- SIA
- Only for diagnosis of Abuse (Misuse) by FAR's
- Required:
  - Abstinence Testing
  - Psychiatric evaluation
- Not required:
  - Treatment and Continuing Care
  - Company and Peer Monitors
- Duration – 1 – 3 years → General Eligibility with Warning

FAA Process

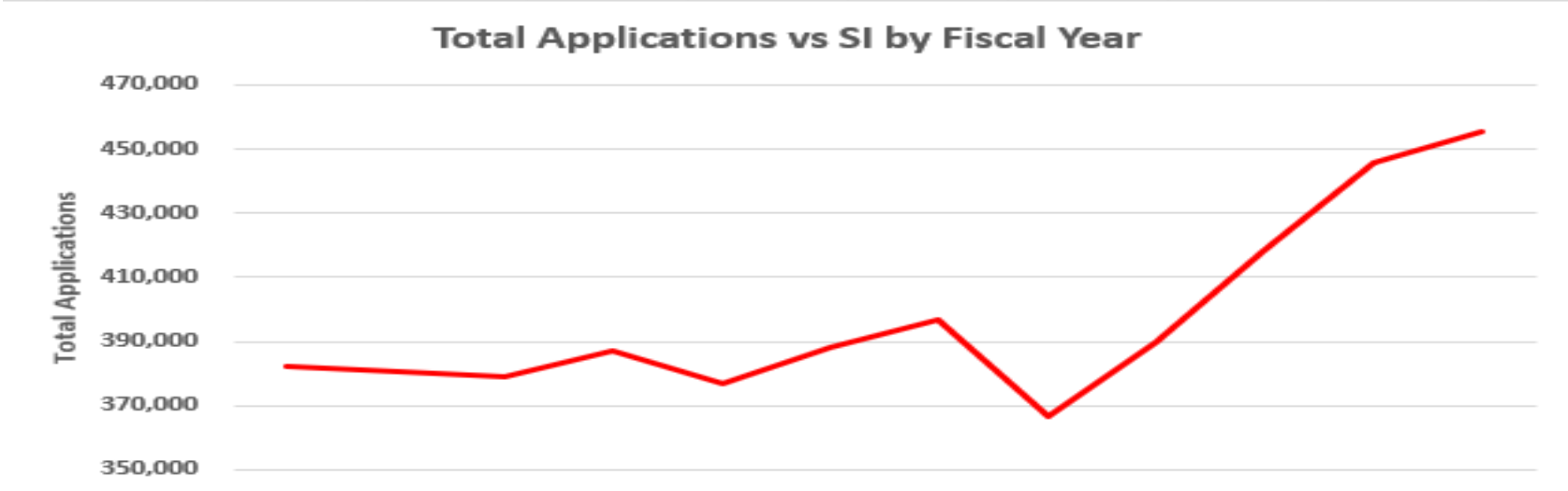
Presented to: HIMS Basic Seminar

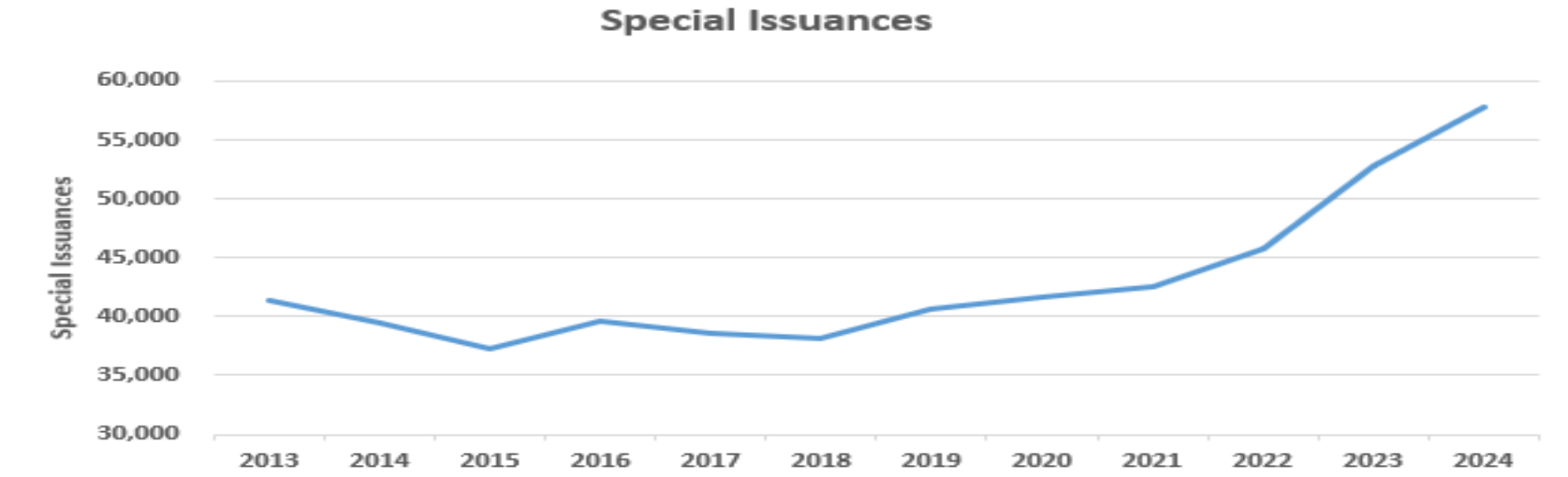
By: Penny Giovanetti, D.O. and Matthew Dumstorf, M.D.

Date: September 15, 2025

Job #1: Safety

Increasing Demand





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**

Role of FAA

- **Make a regulatory determination: dependence vs. abuse vs. one time stupid**
- **Safety risk assessment**
- **Risk mitigation**

Title 14, CFR Part 67.107(4)

Substance dependence…as evidenced by:

- **Increased tolerance, OR**
- **Manifestation of withdrawal symptoms, OR**
- **Impaired control of use, OR**
- **Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.**

DSM 5 - TR

- **11 diagnostic criteria**
  - 4 groups: physical dependence, risky use, social problems, impaired control
- **Severity**
  - Mild: 2-3 symptoms
  - Moderate: 4-5 symptoms
  - Severe: 6 or more symptoms

Title 14, CFR Part 67.107(4)(b)

No substance abuse within the preceding 2 years defined as:

- **Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous**
- **A verified positive DOT drug test result**
- **Misuse of a substance**

Title14, CFR Part 67.107(4)(b)

No substance abuse within the preceding 2 years defined as: (cont.)

(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…

Safety Risk Assessment

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

Risk Mitigation Strategy

- 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 solid recovery
- Maintain abstinence
- Step-down plan

HIMS Team

- Employers
- Pilot Unions
- FAA
- HIMS AMEs
- Treatment facilities
- Psychiatrists
- Families
- Peer support groups
- Sponsors
- Aftercare providers
- Peer pilots

Role of the HIMS AME

- Coordinate care
- Administratively manage case
- Meet regularly with pilot
- Oversee abstinence monitoring
- Evaluate the quality of the recovery
- Make a recommendation regarding safety for special issuance
- Move airman forward in stepdown after initial phase

Status of Formal HIMS Reviews

- **Cases pending = 20**
- **Timeframe: submitted in August, 2025**
- **Consultant review time 30 days**
- **FAA review time including correspondence preparation is 1-4 weeks**

AME Guide

HIMS trained AME Checklist – Drug and Alcohol MONITORING INITIAL Certification
(Updated 03/31/2021)

Airman Name _____ MID or PI#_____

Submit this **MANDATORY checklist** and **ALL** supporting information outlined below within 14 days of deferred exam. Use only ONE method to submit. Sending by multiple modes (or duplicates) will delay the review process.

Check one of the boxes below to indicate the method of the submission.

☐ **Electronic submission:** First and second class HIMS cases **ONLY** - **USE** HUDDLE

☐ **All others, mail to:**

Using regular mail US Postal Service:
Federal Aviation Administration
Civil Aerospace Medical Institute, Building 13
Aerospace Medical Certification Division AAM-313
PO Box 25082
Oklahoma City, OK 73125-9914

Using FedEx, UPS, etc.:
Federal Aviation Administration
Medical Appeals Section, AAM-313
Aerospace Medical Certification Division
6700 S. MacArthur Boulevard, Room B-13
Oklahoma City, OK 73169

The specific information required for each report type is detailed in the corresponding numbered (#) items on the FAA Certification Aid – HIMS Drug and Alcohol – INITIAL.

0.* HIMS-Trained AME Checklist - Drug and Alcohol MONITORING INITIAL Certification. *Use this checklist as a coversheet and submit the rest of the information, numbered and ordered as shown below:

	NA	Yes	No
1. HIMS AME Report FACE-TO-FACE, IN-OFFICE EVALUATION (narrative): • Signed and dated			
2. HIMS AME Data Sheet (N/A for third class airmen)	N/A	Yes	No
3. Drug and /or alcohol **TREATMENT RECORDS**: • Include any applicable psychotherapy notes and pre-treatment psychiatrist reports	N/A	Yes	No
4. PSYCHIATRIST EVALUATION: • HIMS-trained psychiatrist for most first and second class airmen • Most third class will require a board-certified psychiatrist.	N/A	Yes	No
5. NEUROPSYCHOLOGIST EVALUATION and RAW TESTING DATA • CogScreen results	N/A	Yes	No
6. ADDITIONAL RECORDS: • Aftercare Report (Group) • Airline Reports: Chief Pilot Report and Peer Pilot Letter (for commercial pilots 1st or 2nd-class; 3rd class N/A) • Airman's Personal Statement • Drug or Alcohol Testing • DUI Records (BAC, court records, driving/DMV records) Medical Records (List any other conditions relevant to this case) • SI Additional Reports (**Only when specified by the Authorization Letter**)	N/A	Yes	No

_____ _____
HIMS-trained AME Signature Date

MISSING OR INCOMPLETE ITEMS WILL CAUSE CERTIFICATION REVIEW DELAYS.

- Send all of the above information **AND this Checklist** in **ONE PACKAGE,** via electronic submission or mailed **to** the appropriate address listed above.
- Upon receipt and review of all of the above information, **additional information or action may be requested.**

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 AME Report

“The patient met criteria for alcohol abuse did not meet criteria for alcohol dependence. He did have tolerance.

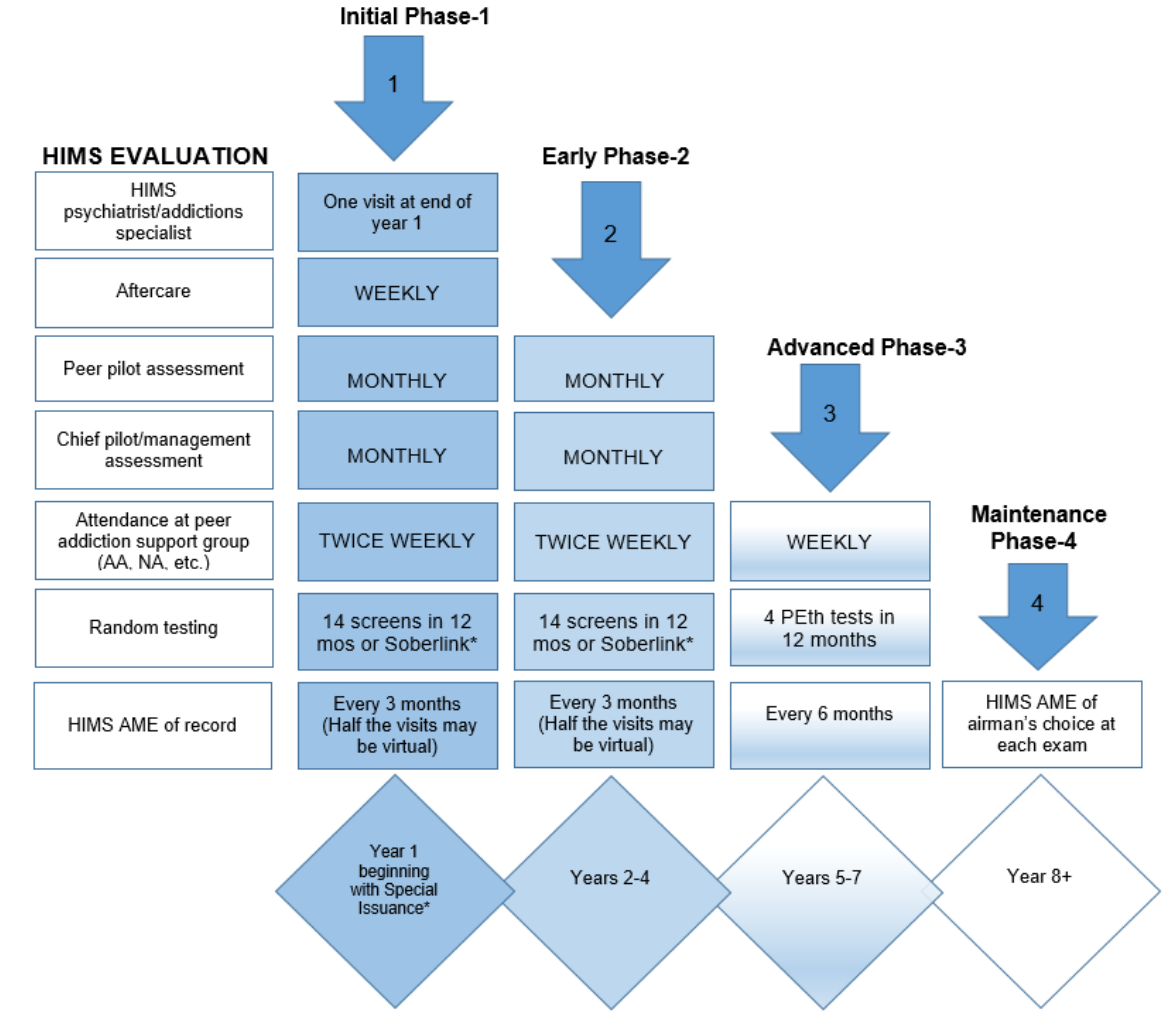
Cautions!

- **Incorrect regulatory determination**
- **Understand drug/alcohol monitoring tests**
  - Detection windows, cutoffs, etc.
  - Identify suspected breaches of collection protocol at the time of collection
  - Report positive test results to FAA immediately
- **Failure to use Huddle creates delays**
- **Failure to send complete packages creates delays**

HIMS Step Down Plan

- Released 8/17/2020
- Response to NTSB Safety Recommendation A-07-43
- Product of collaborative effort: FAA staff, addictions consultants, HIMS Chairs, literature review
- Extended monitoring consistent with other chronic, relapsing diseases
- Intensity of follow up adjusted for risk

AME Guide Online



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

Important caveats

Note that the time course listed is nominal and indicates usual, uncomplicated progression of recovery but may be modified on a case-by-case basis.

- Not all airmen will progress at the same rate.
- Progression is NOT guaranteed.
- An airman's progression is based on compliance, his or her individual evaluation by HIMS professionals, and **FAA review**.

Permanent abstinence from mind and mood altering substances is required for the duration of the flying career.

The testing frequencies listed are minimums and may be increased at the discretion of the HIMS AME.
AMEs should recommend a change in testing/evaluations when clinically appropriate and after the minimum time has passed in each stage.

Questions?

We’re all headed the same direction

Aviation Family Fund

Dana C. Archibald

HIMS

2025 Basic Education Seminar

Sustaining Success – One Step at a Time

September 16-18, 2024
The Westin Hotel DIA, Denver, CO

What is the Aviation Family Fund?

AFF assists in providing supplemental funding during the recovery process for alcohol and drug-related dependence, and mental health issues. We are available to anyone in the aviation industry.

Overview

- AFF created 2011
  - ***Since AFF's inception, over $925K granted!***
- IRS approved 501©3 nonprofit
- All donations are 100% tax deductible
- In 2024, AFF helped over 85 people with financial assistance
- ***Provided referrals, information and guidance to hundreds of people in 2024***

Overview

- Of all monies received, 95% went to approved applicants
- No money is issued directly to the approved applicant
- Money is issued directly to institutions
- The average grant is between $1500-$2500

What Do We Pay For?

- Inpatient
- Outpatient
- Aftercare
- COBRA
- Rent
- Electric
- Mortgage
- Water bill
- Doctor bills, (AME, P&P Certificates, etc.)
- Soberlink

~ We will not provide funding for luxury items ~

How Does Someone Apply?

Aviation Family Fund
APPLICATION FOR ASSISTANCE

CONTACT INFORMATION		
Name:		
Street Address:		
City:	State:	Zip:
Home Telephone:		Fax:
Cell Phone:		E-mail:
Preferred method of contact: ❑ Home ❑ Cell		
Date of Birth:		SSN: - -
Emergency Contact Name:		
Telephone:	Relationship: ❑ Spouse/Partner ❑ Parent ❑ Sibling ❑ Friend ❑ Adult Child	

INSURANCE INFORMATION	
Primary Insurance Provider:	
Please list the name of the insurance holder:	
ID Number:	Group Number:
Telephone Number:	
Secondary Insurance Provider:	
ID Number:	Group Number:
Telephone Number:	
Please list the name of the insurance holder:	

GENERAL QUESTIONS
What is the best time to reach you?
What other finances are available to you?
What is the primary purposes of this grant if you qualify?
Are you currently employed? ❑ Yes ❑ No
Do you have a treatment plan / Are you following a program (brief description):

AGREEMENT
1. All of the information provided above is true and current to my knowledge.
2. If accepted by Aviation Family Fund for assistance, I understand that all financials will be distributed to treatment centers/companies that I am requested financial assistance for, and not to me directly.
3. In keeping with the principles of recovery, I also understand that a more, in-depth, detailed conversation will accompany my application after submission.

SIGNATURE	
Signed:	Date:

Please submit your completed application to:

Aviation Family Fund
311 Homestead Park Drive
Apex, NC 27502

Applications may be emailed to: Info@aviationfamilyfund.org

AVIATION FAMILY FUND

Southwest®

Ruben Vazquez
Lead HIMS Peer,
Southwest Airlines

Nick Arnfelt
HIMS Chairman,
Sun Country Airlines

AVIATION FAMILY FUND

FRONTIER AIRLINES

Troy Dejean
Chief Pilot, Frontier Airlines

AVIATION FAMILY FUND

SkyWest AIRLINES®

John Denando
HIMS Chairman,
SkyWest Airlines

How Does One Donate?

Monthly, through your bank's bill pay venmo

Personal or business check mailed to the address on website

PayPal

Stock Donations

How Does One Donate?

Monthly, through your bank's bill pay

Text: AFFHOPE to 44321

Personal or business check mailed to the address on website

PayPal

venmo

In-Kind Donations

Providers may offer discounted fees off of standard charges for evaluations and services; tax deductible receipts are sent for all donations and in-kind donations

Providers may limit the number of discounted cases, or receive referrals, or continue to receive referrals (for existing providers).

For documentation purposes, we can provide our tax ID number. This can be for P&P, HIMS, after care, AME, etc.

Apply via website: www.aviationfamilyfund.org

In Conclusion

- Aviation Family Fund is a ***true*** Nonprofit
- *NO* salaries
- *NO* expense accounts
- *NO* corporate jet

- *Quickbooks & professional accountant services only*

Questions?

Contact Information:

aviationfamilyfund.org

Dana Archibald, President

(919)-608-1735

Dual Diagnosis

Daniel Danczyk, MD, MPH

HIMS

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Agenda

- Introduction – A Story to Set the Stage
- Historical Background & Relevance
- Definition & Prevalence
- Overview of FAA Certification
- Case Example
- Conclusion – Trends and Updates

A Story…

- …of when I was first challenged about the meaning of dual diagnosis in residency.

Occupational Alcohol Addiction Treatment Program (1970s)

HIMS
HUMAN INTERVENTION MOTIVATIONAL STUDY
www.himsprogram.com

Drugs of Abuse

Alcohol / Drug Monitoring

"HIMS" today

"Programmatic"

- Union/Airline formalized support
- FAA / HIMS AMEs

"Non-Programmatic"

- **Quality of treatment / aftercare**
- **Peer support group**

Occupational Alcohol Addiction Treatment Program (1970s)

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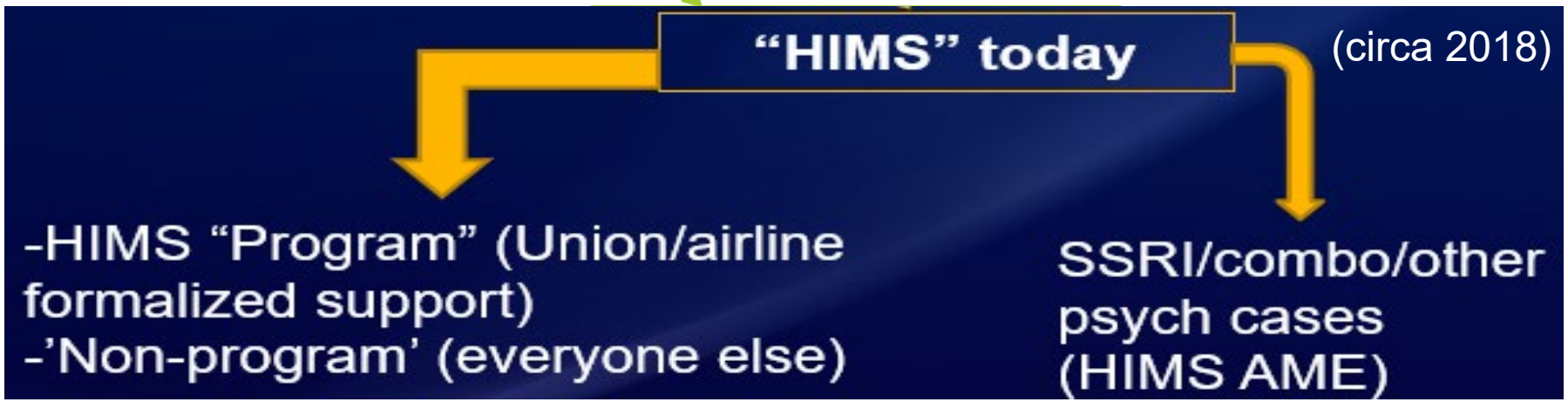
www.himsprogram.com

Drugs of Abuse

Alcohol / Drug Monitoring

4 SSRIs (2010)



Occupational Alcohol Addiction Treatment Program (1970s)

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www.himsprogram.com

Drugs of Abuse

Alcohol / Drug Monitoring

4 SSRIs (2010)

So, what does “HIMS” mean”?

Words matter, but differing labels

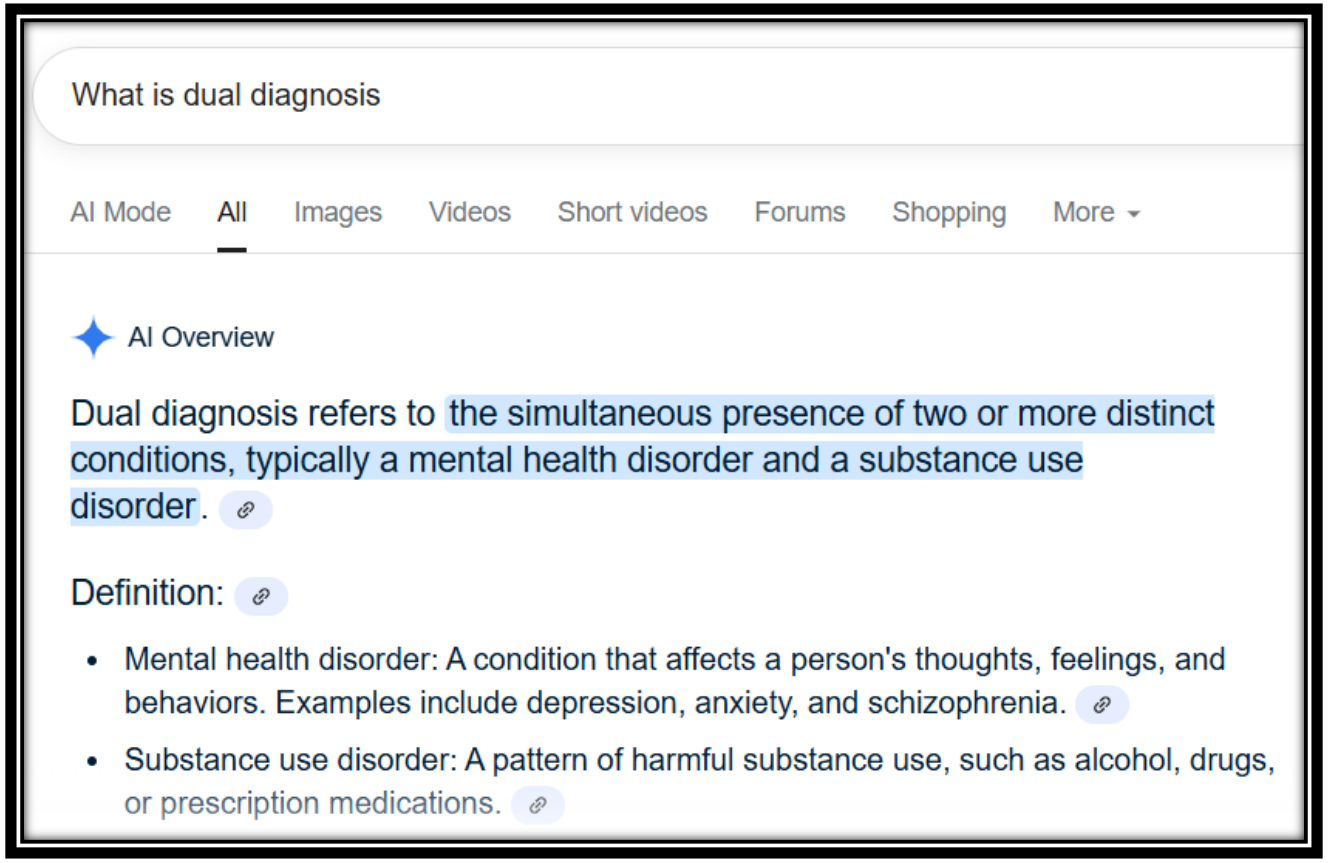
- Label for provider credential, label for a protocol, etc

Context matters

- “I’m in the HIMS program”
  - ATP on SI for Substance Dependence (with or without mental health comorbidity), followed by employer
- “I’m seeing a HIMS AME”
  - Private pilot on SI under Antidepressant Protocol, followed by 2-3 HIMS providers (AME, psychiatrist, neuropsychologist)

Definition

- Dual Diagnosis
  - Mental health disorder + substance use disorder
  - Another term: “MICD”
  - 2 broad buckets to qualify differentiating pathology
  - Misrepresentative of label



Prevalence

- ~25.8% of adults with a mental health disorder also have a substance use disorder, based on a 2022 national study*
- ~36.5% of adults with a substance use disorder also have a mental health disorder*

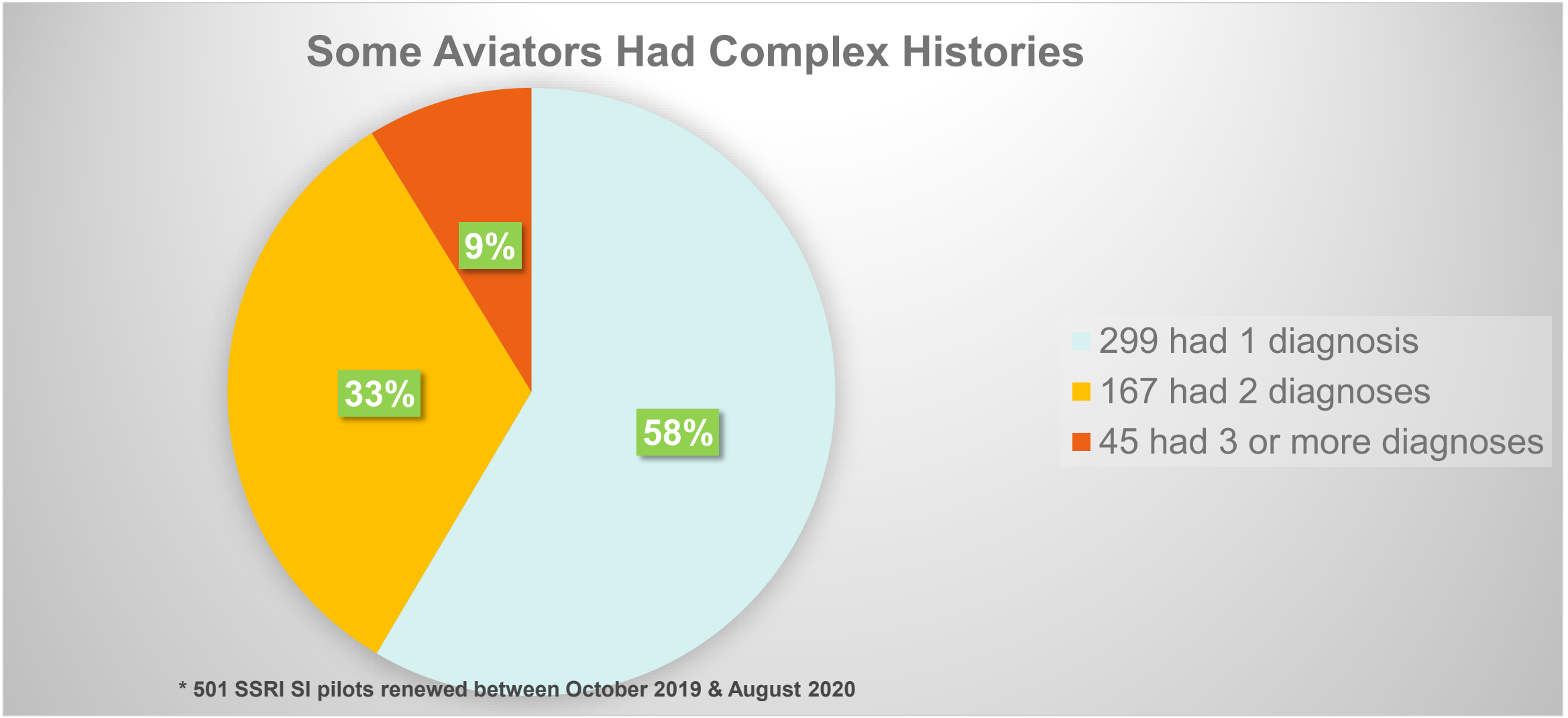
*Jegede et al. Rates and correlates of dual diagnosis among adults with psychiatric and substance use disorders in a nationally representative U.S sample. Psychiatry Res. 2022 Sep;315:114720.

Aviators (N=150*) from March-December 2020

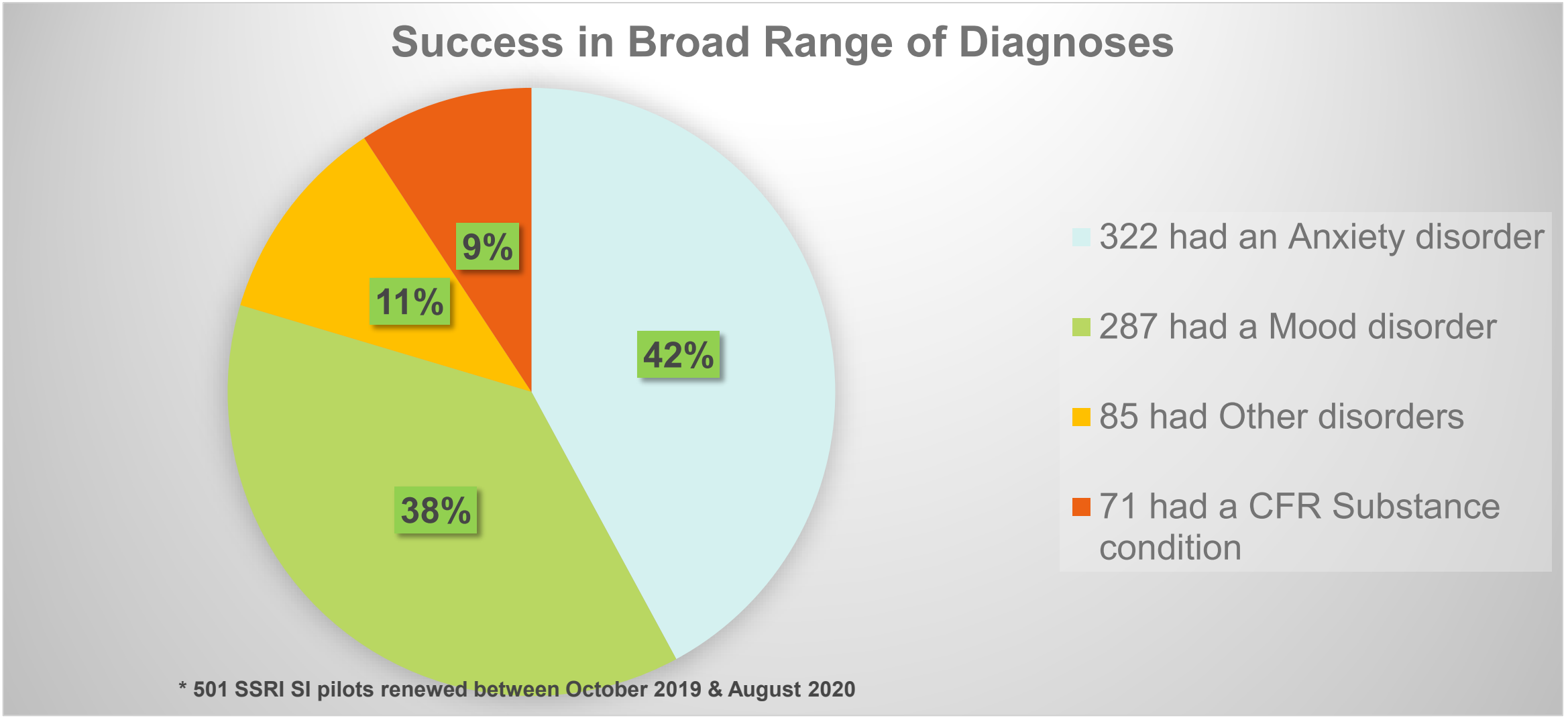
- Average continuous antidepressant use was 8.8 years
- Average flying hours were 5785
- 48 (32%) had taken an SSRI before 2010
- Class 1: 62%, Class 2: 7 %, Class 3: 31%
- 46 (30%) had the following in their history: suicidal ideation, hospitalization, incorrect bipolar diagnosis, multiple medications used for treatment

*** 150 consecutive SSRI SI pilots between March & December 2020, a subset of the 501 pilots**

Aviators (N=501*) from October 2019 to August 2020



Aviators (N=501*) from October 2019 to August 2020



Four Disposition Tables

- Anxiety, Depression, and Related Conditions
- PTSD
- Situational Depression
- ADHD

Anxiety, Depression, & Related Conditions

Allows AMEs to clear uncomplicated anxiety and depression conditions

Encourages treatment and prevention (including previous antidepressant monotherapy)

Allows for the individual to be in psychotherapy at the time of their AME exam

AME defers individuals with psychiatric risk factors (see decision tool)

Up to TWO of the following

Anxiety

- Unspecified anxiety
- Generalized Anxiety Disorder
- Situational anxiety (also called adjustment disorder with anxiety)
- Social Anxiety Disorder

Depression

- Unspecified depression
- Postpartum depression
- Situational depression* (also called adjustment disorder with depressed mood)
  - Note*: For Situational Depression - AME can use this table or the Situational Depression Disposition Table.
- Situational Anxiety and Depression (adjustment disorder with mixed anxiety and depressed mood)

Other

- Obsessive Compulsive disorder (OCD)
- Post Traumatic Stress Disorder (PTSD)
- V code^ (DSM)/Z code (ICD-10) table items → (NEXT SLIDE)

Note^: V code (DSM)/Z code (ICD-10) table includes:

- Uncomplicated Bereavement;
- Relationship distress with spouse or intimate partner;
- Parent-Child relational problem; and/or
- Phase of Life Problem (problems adjusting to major life transitions such as newly retired, getting married, empty-nest, new career, becoming a parent, etc.

Antidepressant Protocol (10 meds)

- Citalopram / Escitalopram
- Sertraline
- Fluoxetine
- Venlafaxine / Desvenlafaxine
- Duloxetine
- Bupropion 12-hr and 24-hr (not IR)
- Vilazodone

Commonly required additional documentation:

- Personal statement
- Treatment records
- Summary letter from prescriber
- Psychiatry evaluation
- Neuropsychological evaluation
  - HIMS-trained → Cog Screen +/-
- Agreement to notify FAA of change in airman's psychological status / stability
- Other documentation depending on Class

NEWSFLASH: No longer required for routine SI Recertification

Case Example

- 38 y/o ATP 5,900 hours; medical certificate request after DUI
- HIMS psychiatrist eval: DUI, BAL 0.205; reported drinking 2-4 drinks wkly, CFR Dependence & Anxiety NOS. Rec: SI in ongoing recovery program
- Neuropsychology eval: solid cognitive abilities, elevated MMPI-2 scale
- Airman reports:
  - Escitalopram inconsistently used from 2011-17 by PCP, dx GAD
  - Drinking since college; now participating in recovery & urine monitoring
  - No history of illicit substance use
- HQ's Disposition = Yes: SI in HIMS program:
- AA x 2 weekly, Aftercare x 2 monthly, Testing 14/12 months
- HIMS AME every 3 months, HIMS psychiatrist annual x1
- Peer and Chief Pilot notes monthly (professional pilot)

Trends and Updates

A shift toward integrated Disposition tables

Empowering AME, increasing issuance in-office (when appropriate)

Movement toward psychotherapy as an option for first line treatment (access and education)

Trends and Updates

A focus on diagnosis and its status (not just how long “on” or “off” medication)

“SSRI Rule-outs” as invitations for detailed assessment (not automatic disqualifiers)

SSRI program expanded to 10 medications and renamed “Antidepressant Protocol”

Antidepressants can also be used for other medical conditions

Questions?

HIMS Psychiatric and Psychological Evaluation

Paul Sargent M.D., FAPA
Psychiatry, Brain Injury Medicine

Dan DaSilva, Ph.D.
Aviation and Pediatric Neuropsychology

HIMS

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Learning Objectives:

- Developing a **collaborative approach** to evaluation / consultation.
- Improved familiarity / **FAA guidelines;** 14CFR67.
- **Differences** between DSM-IV, DSM 5, and 14CFR67 in diagnoses.
- "Rules of Engagement" for **independent** evaluations.
- Gathering **collateral history and evidence** to support conclusions.
- Evaluating the **quality** of a recovery program and **risk** for relapse.
- Developing an **effective** plan for follow up and monitoring.

The Role of the HIMS Psychiatrist

- Eyes, Ears, Critical Thinking all engaged.
- Independent stance. Not advocacy.
- Knowledge of psychopathology, prognostics,

  and regulations. Ability to integrate all 3.
- Conducting both initial SUD and/or P&P.
- Part of TEAM which includes Neuropsychologist, AME, Aftercare provider, Supervisors, and FAA medical staff.

FAA Medical Standards 14CFR67.107/ .207/ .307- Mental

- No medical history or clinical diagnosis of any of the following:
  - Personality Disorder “repeated overt acts”
  - Psychosis
  - Bipolar Disorder
  - Substance Dependence (unless 2 yrs. of solid recovery)
  - No other personality disorder, neurosis, or other mental condition that may make the person unable to safely perform the duties of an airman.
  - Substance Abuse within the last 2 years.

Broad Definition of Substance Abuse

- Repeated use of a substance in a physically hazardous situation

- Positive DOT test for drug or alcohol (BAC 0.04%)

- Misuse of a substance which the Federal Air Surgeon finds make the user unable to safely perform the duties of an airman, or may reasonably be expected to make the person unable to perform those duties in the future.

Disambiguation of Classification Systems:

DSM-5 “Substance Use Disorder” (2 of 11)	14 C.F.R. part 67 “Substance Dependence” (1 of 4)
Larger amounts, longer period than intended	Impaired Control of Use
Desire/ unsuccessful effort to cut down or stop	Impaired Control of Use
Great deal of time spent in substance use and its effects	Continued Use Despite Damage
Craving	Leads to Impaired Control of Use
Recurrent use causing failure of obligations	Continued Use Despite Damage
Continued use despite interpersonal problems	Continued Use Despite Damage
Important actives given up due to use	Continued Use Despite Damage
Recurrent use in physically hazardous situations	Continued Use Despite Damage -OR- Impaired Control of Use
Continued use despite physical/ psychological consequences	Continued Use Despite Damage
Tolerance	Increased Tolerance
Withdrawal	Manifestation of Withdrawal

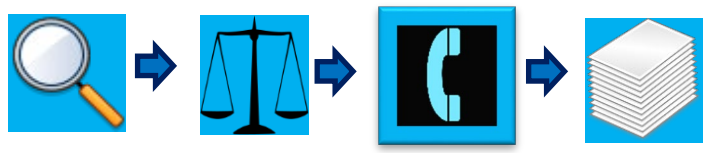
Case Review - SUD referral

- 30-year-old male seeking first class medical certificate
- Age 18-23. Binge drinking once per week on weekend. 6-8 beers. One ARI on record. MIP. Reduction in rank. Successfully completed enlistment in USMC. Honorable discharge.
- Age 24-27. Binge drinking while in college. 5-6 beers, 2-3 days per week. No blackouts. No problem with relationships or academic performance. Graduated on time with 2.9 GPA.
- Age 28 DUI (BAC 0.13%)
- Age 29 second DUI (BAC 0.21%)

“Rules of Engagement” for an Independent Evaluation.

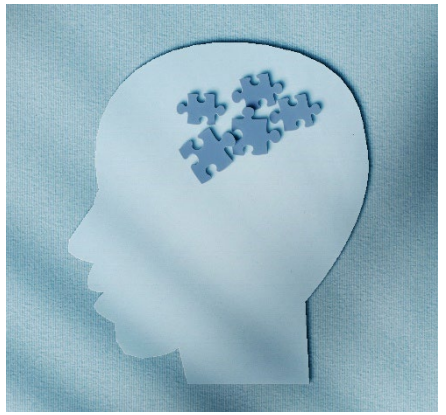
Be candid right up front. Verbally AND in in writing.

- There is no “Treatment Relationship,” confidentiality modified.
- Regardless of who pays the bill, you do not work for the client.
- You also do not technically work for the FAA.
- Your job is to gather information, understand the situation, and apply FAA criteria, The FAA will make the disposition.
- Any information revealed in records, interview, or by collateral sources then it will be in the report.



Gathering Collateral History and Evidence

- Have client request FAA records **BEFORE** you schedule the appointment.
- Get police reports or ER records if BAC not documented in FAA record.
- Get releases of information up front, usually eliciting information more than providing it.
- **Information gathering and documentation must be comprehensive and will likely take several hours.**



Evaluate QUALITY of recovery program.

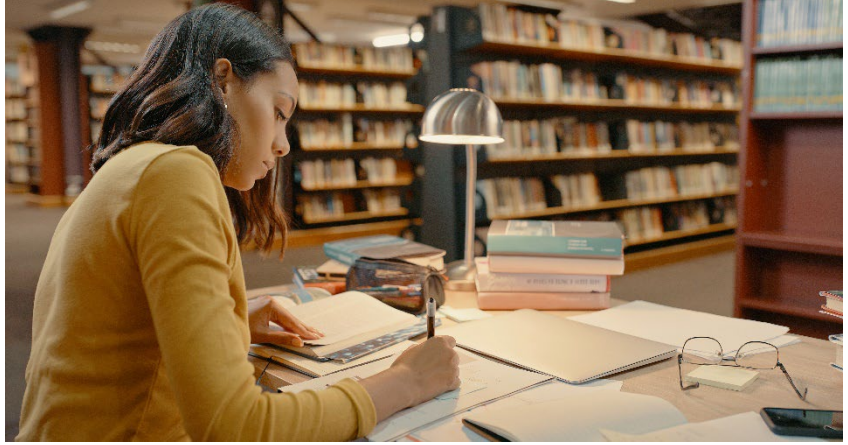
S.T.R.O.N.G. P.R.O.G.R.A.M.

- Sponsor
- Three Mtgs./wk.
- Reading the Book/ Working the Steps
- OWN IT!
- Ninety in Ninety
- Group (Home)
- Professional/ Recovery balanced
- Resentments (dealing with)
- Outlets (fitness/ hobbies)
- Growth Mindset
- Relationships
- Aftercare
- Monitoring

FACTORS WHICH AFFECT RISK FOR RELAPSE

- **Past relapses, Compulsive behaviors, co-morbid psychiatric disorders, Life Stressors, non-acceptance of diagnosis, lack of "bonding" with 12 step program**

Report Writing



- Forensic Quality. Typically takes several hours to write.
- Write like you expect it will be reviewed in a hearing, and that you may be called upon to defend your position.
- Expect that it will be reviewed by other experts who will disagree with some aspect of your assessment.

Use a collaborative approach:

- Do not be afraid to consult with an experienced colleague
- Do not be afraid to consult with an FAA SME
- This never ends no matter how senior you become.

- **Disagreements are best handled verbally before doing so in writing. Team has the SAME GOAL…..SAFETY!**

Cross Check Report Prior to Submission:

- HAVE I CLEARLY…..?
- Made or confirmed a clinical diagnosis for the FAA
- Ruled out any disqualifying psychiatric conditions
- Assessed the quality of the airman’s recovery program
- Maintained a neutral stance
- Addressed rule out conditions which would be disqualifying (Psychosis, suicidal ideation, ECT treatment, need for multiple medications)
- Made all appropriate recommendations for additional treatments and monitoring issues (Meds? Random Testing? Psychotherapy?)

Purpose of the Neuropsychological Evaluation

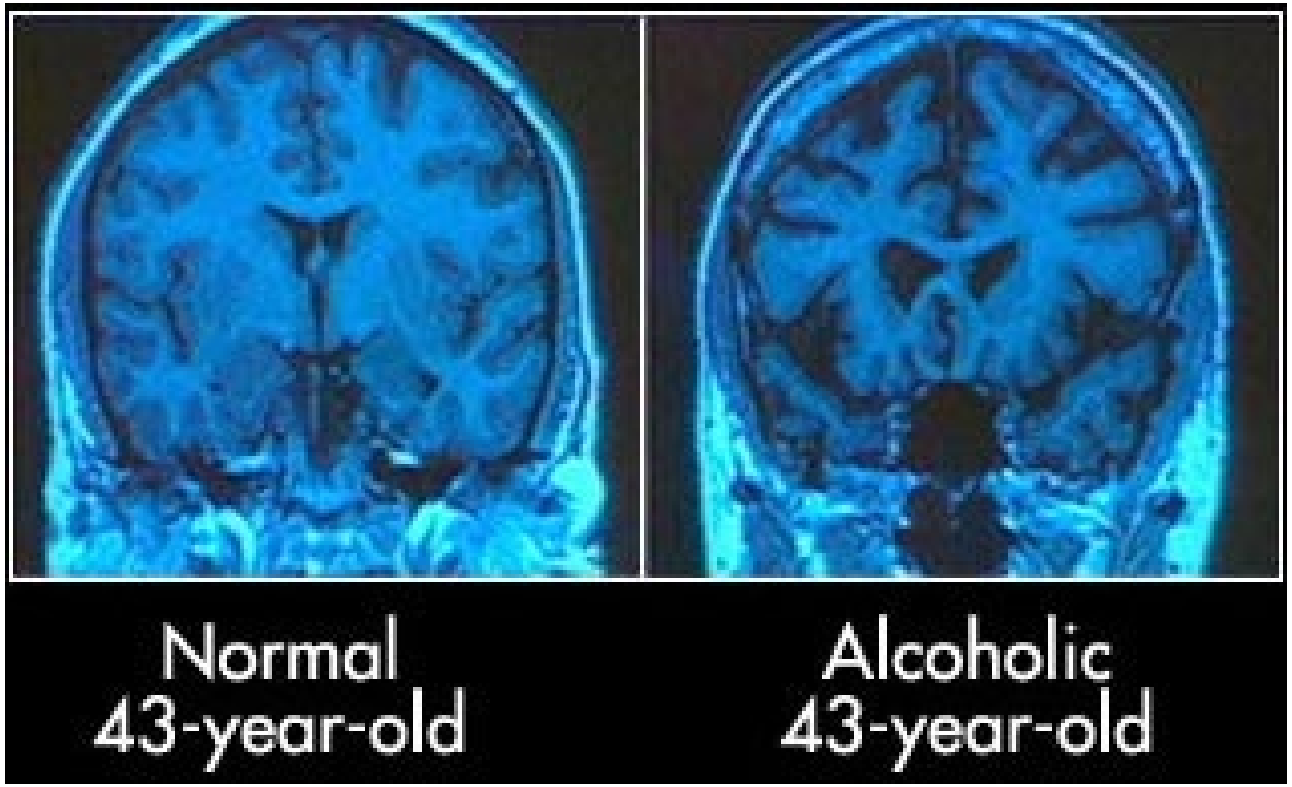
- Primarily, to assess for aeromedically significant neurocognitive deficits secondary to substance abuse.
- Alcoholism affects brain functioning. Important to be aware of those functions most sensitive to the impact of chronic/sustained substance abuse.
- Assess quality of recovery program/investment in recovery

Demands may differ but the standards are the same…

- NOT an assessment of airman proficiency
  - Proficiency as a pilot is assumed based on their certificates and flight time.
- Part 67 of FAR's addresses medical eligibility with criteria that apply regardless of flight hours or aircraft type.

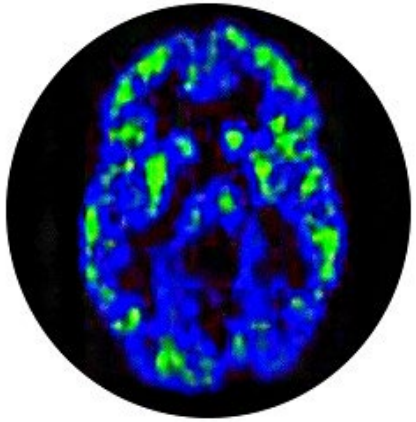
- Alcohol damages frontal/limbic systems
  - Extent varies from individual to individual
  - In most cases, the damage is reversible

The deficits we see are consistent with the "reversible" concept.


Normal
43-year-old
Alcoholic
43-year-old

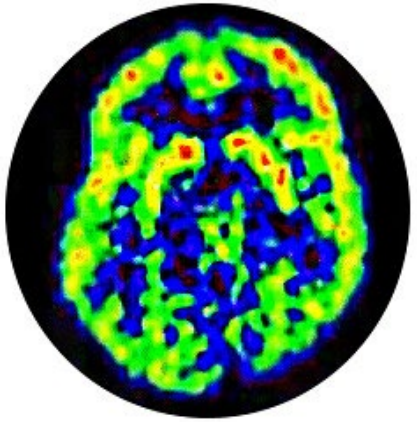
Alcohol-related Impairments

- Executive Functioning
  - Cognitive Flexibility
  - Deductive Reasoning
- Memory
  - Learning
  - Recall
- Visuospatial abilities



ALCOHOLIC

DARKER COLOURING INDICATES DEPRESSED BRAIN ACTIVITY



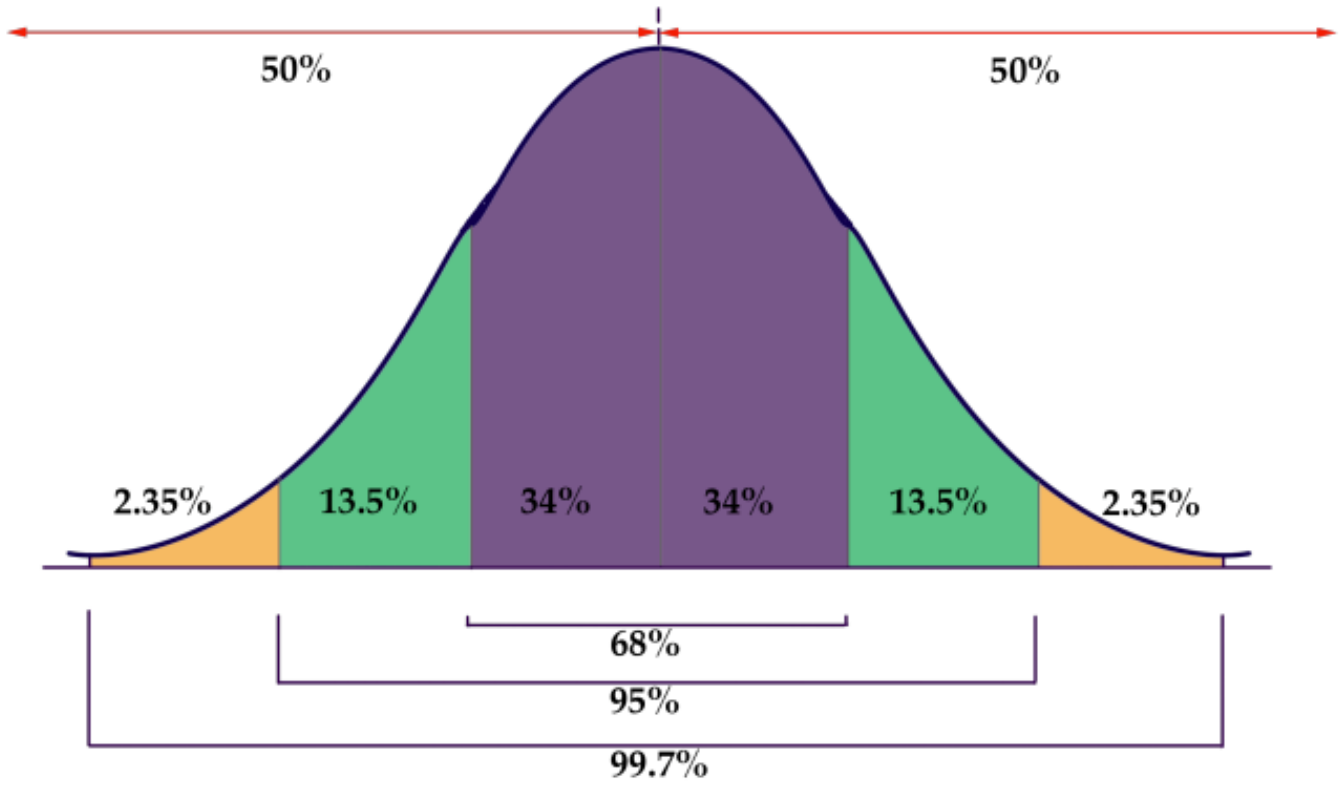
NORMAL

HEALTHY LEVELS OF BRAIN ACTIVITY

Why a Standardized Battery?

- Establishes standardization
  - Essential domains are always assessed
  - Regardless of where the evaluation is performed and regardless of neuropsychologist, every pilot gets the same battery
  - selection of valid tests that are sensitive to the alcohol-related deficits and the recovery
  - Facilitates determination by reviewer

The Bell Curve

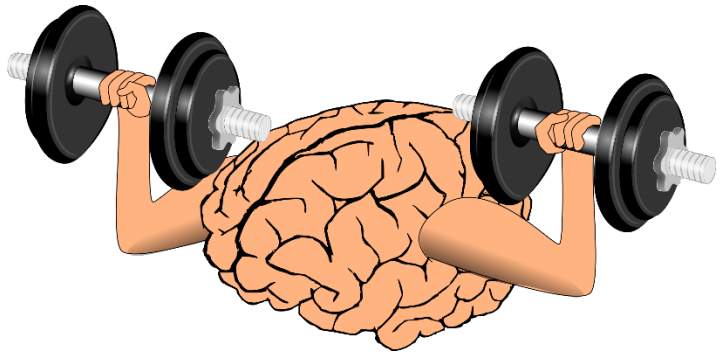


Issues to Consider at the Time of Referral

- Is the pilot ready?
  - At the time of initial contact…
    - Has the pilot been diagnosed (cart before the horse)?
    - Has the pilot been in treatment?
    - Is the pilot monitored/random drug/alcohol screens?


©KINCAID
Pens?
Check.
Crossword?
Check.
Sudoku?
Check.
www.jetlaggedcomic.com
Pre-Flight Check List

How Should the Pilot Prepare



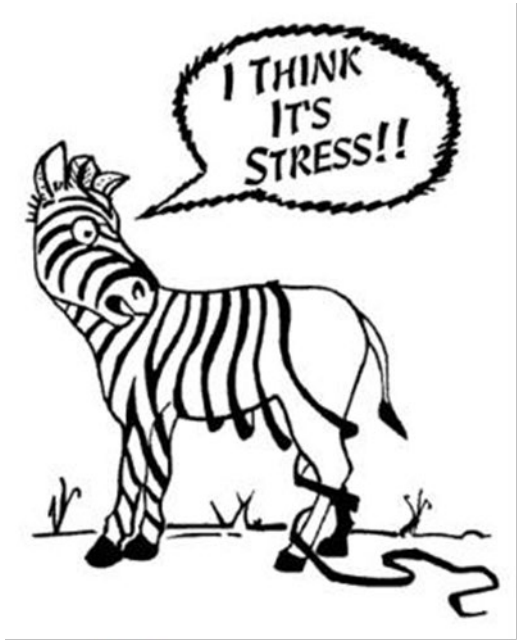
- Work the Program
- Rest
- Proper nutrition
- Exercise
- Continued engagement in treatment and supports
- Websites to practice cognitive tasks (Lumosity, Elevate, Happy Neuron etc.)
  - Anxiety reducer

The day of the testing…

- One or two days
- Approximately seven hours of testing +/-
- Style will differ from one examiner to the next
- Psychologist should assess the pilot's readiness for the assessment.
  - Proper rest?
  - Proper nutrition
  - Level of anxiety
  - Other distracting factors

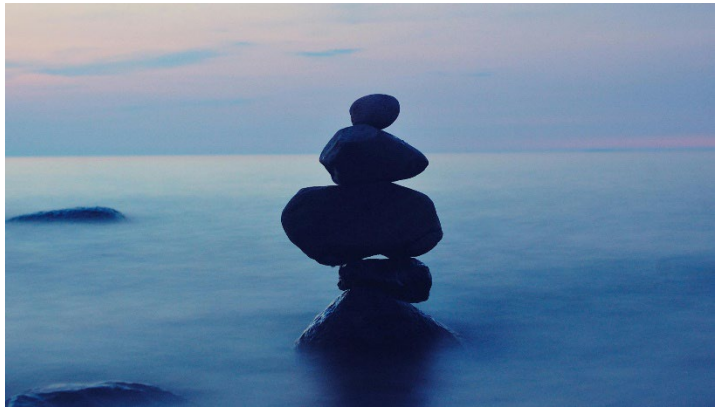
Effects on testing results…

- Lack of sufficient rest – Fatigue
- Anxiety – What is appropriate level, normal?
  - Similar to a normal checkride?
- Learning disabilities, dyslexia, Etc.
- Cultural, educational and language variations



What if there are issues?

- Usually, need for more recovery time
  - For older (aging) pilots
  - For pilots with comorbidities
  - For pilots with more severe disease



What if there are issues?

- Timeline for retest – Discretion of Neuropsychologist?
- Cognitive Rehabilitation?
  - Healthy living!
  - Online and purchasable software (not proven but some efficacy shown in academic research).
  - Reduced anxiety and sense of increased control


Questions

This Networking Break is Sponsored by:

NETJETS® | NJASAP

Next session to begin at 3:45 PM

The Legal Framework for DOT and Non-DOT Alcohol and Drug Testing

Suzanne Kalfus, Esq.

HIMS

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DOT TESTING

- Omnibus Employee Testing Act
- Safety-sensitive employees in various transportation modes
- Trucking, rail, mass transit, pipeline industry and aviation
- Over 6.5 million DOT-regulated tests per year

Testing Act Statutory Requirements

- Specific employee safeguards (e.g., split samples)
- Requires following Department of Health and Human Services (HHS) Guidelines on scientific matters
- Certain mandatory sanctions
- Implemented in Agency Regulations

HHS SCIENTIFIC GUIDELINES

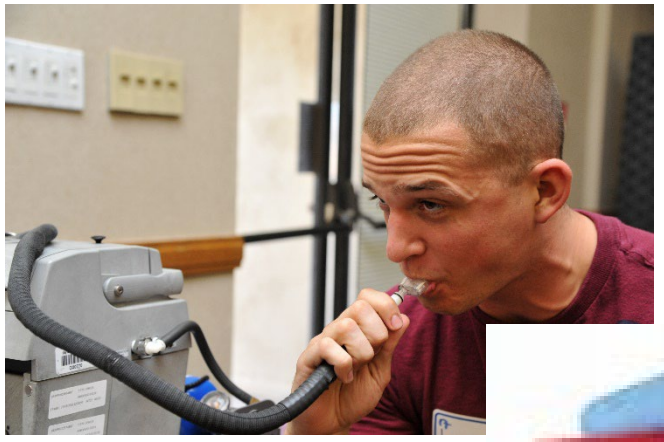
- Addresses: drugs to be tested, types of tests authorized cannot go beyond HHS authorization (e.g., blood testing, hair testing, particular drugs tested)

- Protections: laboratory certification program, lab standards, testing protocols, etc.

- DOT procedures in 49 CFR Part 40

- Changes via notice–and–comment rule making?

TYPES OF TESTS



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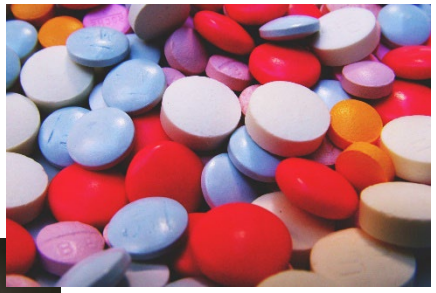
CATEGORIES OF TESTING:

- Pre-employment (only drug testing required)
- Random
- Post-accident
- Reasonable cause
- Return-to-duty
- Follow-up (at least 6 tests in first 12 months; not longer than 60 months)

CONFIRMED ALCOHOL TESTS – ONLY BREATH CURRENTLY PERMITTED

- Initial test, waiting period, must be confirmed on EBT
- No blood testing
- No urine testing

DRUGS CURRENTLY AUTHORIZED FOR DOT TESTING – "NIDA 5"



- Amphetamines
- Marijuana (THC)
- Cocaine
- Phencyclidine (PCP)
- Opioids / Opiates
  - Semi-synthetic (prescription) opioids (added to DOT testing Jan. 2018)
  - Synthetic opioids
    - DOT proposes to add fentanyl/norfentanyl (NPRM Sept 2, 2025)
    - Follows HHS

MEDICAL REVIEW REQUIRED FOR LAB REPORTED URINE TEST RESULTS

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- DOT Procedures require Medical Review Officer (MRO) Review
- MRO must give employee opportunity to provide a “legitimate medical explanation” for a drug test reported by the lab as positive (or adulterated, substituted or invalid)
- Only reported as “verified” positive test after that opportunity
- If there is a “legitimate medical explanation,” test must be reported as negative
- Valid prescription can provide legitimate medical explanation

VALID PRESCRIPTION?

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- “Legally valid” prescription under the Controlled Substances Act (CSA)
- Employee has own doctor provide to MRO
- Test reported positive if no valid prescription /legitimate medical explanation

- Valid script for a medication does not mean it is legal to fly while taking it
- Pilots are prohibited entirely from flying while taking certain drugs
- Other medications have specific waiting periods
- Must also consider whether underlying medical condition is disqualifying

MEDICAL MARIJUANA

- Marijuana is still a controlled substance under Federal law

- A positive test for marijuana is a “positive” DOT/FAA test

CONSEQUENCES

- Consequences under Testing Act
- Under Testing Regulations
- FAA Enforcement Action
- Pilot Medical Certificate Implications
- Employer consequences

Consequences under the Testing Regulations

- Employees must be immediately removed from safety-sensitive functions
- Cannot return until evaluated by a “Substance Abuse Professional” – “SAP”
- Employees who test 0.02 – 0.039 must be removed from safety-sensitive functions until they test below 0.02 or until eight hours have passed before next safety-sensitive duty

- Must comply with SAP’s recommendations
- Must pass a DOT/FAA return-to-duty test
- Must be subject to DOT/FAA “follow-up” testing (at least 6 tests in 12 months; no more than 60 months)
- Wholly independent from special issuance requirements

DOT/FAA Random Alcohol Testing

- Far less successful tool than HIMS to identify alcoholic pilots
  - Random alcohol test violation rate – 0.035% (20 yr. average – 2003-2022)
  - Positive results: 35 100ths of one percent
- Not cost-effective identifier
  - Average cost to detect single violation (20 yr. average)
  - $193,283

Back-Up Data for DOT/FAA Alcohol Test Statistics

Flight Crewmember Alcohol Test Statistics (2003-2012)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Number of FAA-Regulated Safety Sensitive Employees	375,508	366,683	371,925	368,442	395,114	397,960	377,222	376,023	384,429	383,318
Number of Flight Crewmembers	93,033	92,502	94,349	94,352	101,661	101,394	98,086	98,466	100,345	99,522
Total # of alcohol test results										
Pre-Employment	119	146	120	108	298	434	284	421	431	328
Random	10,484	11,092	10,799	11,044	11,610	11,835	12,120	11,757	11,352	11,529
Reasonable Cause	24	15	19	28	16	16	12	22	14	12
Post Accident	104	90	112	110	135	102	85	92	90	103
Positive alcohol test violations										
Pre-Employment	-	-	-	-	-	-	-	-	-	-
Random	5	3	4	2	-	6	4	4	5	6
Reasonable Cause	7	4	5	7	7	6	4	5	5	5
Post Accident	-	-	-	-	-	-	-	-	-	-

Flight Crewmember Alcohol Test Statistics (2013-2022)

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total Number of FAA-Regulated Safety Sensitive Employees	383,784	390,069	424,273	434,494	447,526	464,727	478,169	434,017	429,734	459,818
Number of Flight Crewmembers	98,303	99,670	107,858	111,770	115,727	121,578	125,548	119,252	118,421	124,901
Total # of alcohol test results										
Pre-Employment	588	478	497	438	496	688	454	678	429	479
Random	11,683	11,301	12,587	12,792	13,041	14,411	15,173	12,744	13,400	14,918
Reasonable Cause	18	11	24	25	23	24	24	9	16	18
Post Accident	97	93	90	80	97	132	103	78	76	89
Positive alcohol test violations										
Pre-Employment	-	-	-	-	-	-	-	-	-	1
Random	1	6	3	6	7	-	7	8	6	2
Reasonable Cause	4	1	7	7	10	10	9	3	5	4
Post Accident	-	-	-	-	-	-	-	-	-	-

Alcohol Random vs. Reasonable Cause Violations (Number of violations and violation rate, 2003-2012)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Random Alcohol Tests	10,484	11,092	10,799	11,044	11,610	11,835	12,120	11,757	11,352	11,529
Random Alcohol Violations	5	3	4	2	0	6	4	4	5	6
Random Alcohol Violation %	0.048%	0.027%	0.037%	0.018%	0.000%	0.051%	0.033%	0.034%	0.044%	0.052%
Reasonable Cause Alcohol Tests	24	15	19	28	16	16	12	22	14	12
Reasonable Cause Violations	7	4	5	7	7	6	4	5	5	5
Reasonable Cause Alcohol Violation %	29.2%	26.7%	26.3%	25.0%	43.8%	37.5%	33.3%	22.7%	35.7%	41.7%

Alcohol Random vs. Reasonable Cause Violations (Number of violations and violation rate, 2013-2022)

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Random Alcohol Tests	11,683	11,301	12,587	12,792	13,041	14,411	15,173	12,744	13,400	14,918
Random Alcohol Violations	1	6	3	6	7	0	7	8	6	2
Random Alcohol Violation %	0.009%	0.053%	0.024%	0.047%	0.054%	0.000%	0.046%	0.063%	0.045%	0.013%
Reasonable Cause Alcohol Tests	18	11	24	25	23	24	24	9	16	18
Reasonable Cause Violations	4	1	7	7	10	10	9	3	5	4
Reasonable Cause Alcohol Violation %	22.2%	9.1%	29.2%	28.0%	43.5%	41.7%	37.5%	33.3%	31.25%	22.22%

Random alcohol test violation rate, 20 Year average: 0.035%
(35 100ths of one percent)

Costs to Detect Random vs. Reasonable Cause Violations (2003-2012)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Random Alcohol Tests	10,484	11,092	10,799	11,044	11,610	11,835	12,120	11,757	11,352	11,529
*Estimated Cost of Random Alcohol Tests	$660,492	$698,796	$680,337	$695,772	$731,430	$745,605	$763,560	$740,691	$715,176	$726,327
Number of violations found	5	3	4	2	-	6	4	4	5	6
Estimated Cost to detect single violation (Random testing)	$132,098	$232,932	$170,084	$347,886	No violation	$124,268	$190,890	$185,173	$143,035	$121,055
Reasonable Cause Alcohol Tests	24	15	19	28	16	16	12	22	14	12
*Estimated Cost of Reasonable Cause Tests	$1,512	$945	$1,197	$1,764	$1,008	$1,008	$756	$1,386	$882	$756
Number of violations found	7	4	5	7	7	6	4	5	5	5
Estimated Cost to detect single violation (Reasonable Cause testing)	$216	$236	$239	$252	$144	$168	$189	$277	$176	$151

Estimated Cost per Event: $63

Costs to Detect Random vs. Reasonable Cause Violations (2013-2022)

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Random Alcohol Tests	11,683	11,301	12,587	12,792	13,041	14,411	15,173	12,744	13,400	14,918
*Estimated Cost of Random Alcohol Tests	$736,029	$711,963	$792,981	$805,896	$821,583	$907,893	$955,899	$802,872	$844,200	$939,834
Number of violations found	1	6	3	6	7	-	7	8	6	2
Estimated Cost to detect single violation (Random testing)	$736,029	$118,661	$264,327	$134,316	$117,369	No violation	$136,557	$100,359	$140,700	$469,917
Reasonable Cause Alcohol Tests	18	11	24	25	23	24	24	9	16	18
*Estimated Cost of Reasonable Cause Tests	$1,134	$693	$1,512	$1,575	$1,449	$1,512	$1,512	$567	$1,008	$1,134
Number of violations found	4	1	7	7	10	10	9	3	5	4
Estimated Cost to detect single violation (Reasonable Cause testing)	$284	$693	$216	$225	$145	$151	$168	$189	$202	$284

Estimated Cost per Event: $63

Cost Per violation – Random Alcohol Screening
(2003-2012)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
# of Flight Crewmember Random tests	10,484	11,092	10,799	11,044	11,610	11,835	12,120	11,757	11,352	11,529
*Estimated cost spent on Random Crewmember alcohol testing	$660,492	$698,796	$680,337	$695,772	$731,430	$745,605	$763,560	$740,691	$715,176	$726,327
Number of violations found	5	3	4	2	-	6	4	4	5	6
Estimated Cost to detect single violation (Random screening)	$132,098	$232,932	$170,084	$347,886	No violation	$124,268	$190,890	$185,173	$143,035	$121,055

Cost Per violation – Random Alcohol Screening
(2013-2022)

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
# of Flight Crewmember Random tests	11,683	11,301	12,587	12,792	13,041	14,411	15,173	12,744	13,400	14,918
*Estimated cost spent on Random Crewmember alcohol testing	$736,029	$711,963	$792,981	$805,896	$821,583	$907,893	$955,899	$802,872	$844,200	$939,834
Number of violations found	1	6	3	6	7	-	7	8	6	2
Estimated Cost to detect single violation (Random screening)	$736,029	$118,661	$264,327	$134,316	$117,369	No violation	$136,557	$100,359	$140,700	$469,917

20 Year average cost to detect single violation: $193,283

Estimated spend of $15.5M from 2003-2022 (using $63 per event), 85 violations

DOT TESTING - RECENT UPDATES – Oral fluid testing for Drugs

- DOT procedures amended to authorize oral fluid (saliva) testing for drugs – not effective before 6/1/23
- Follows HHS guidelines – authorized effective 1/1/20
- No implementation until HHS certifies at least two labs for oral fluid testing
- Still none certified – not effective

ORAL FLUID TESTING KEY POINTS

- HHS says has same scientific and forensic supportability as urine testing under its standards
- Split samples required
- Oral fluid testing is to detect drug “use” – not impairment (like urine testing)
- Rule allows but does not require oral fluid specimen testing as an alternative method (whether and under what circumstance is employer determination; or per negotiated agreement)

BENEFITS OF ORAL FLUID TESTING CITED BY DOT

- Collection is directly observed - reducing risks of adulteration and substitution
- Less invasive of individual privacy than urine testing
- Good alternative for employees with “shy bladders”
- Fewer collection site requirements, enabling prompter collections of samples
- Detects more recent drug use than urine specimens (though not reporting impairment)

NON-DOT TESTING

Image 1 Unknown Author, licensed under CC BY.
Image 2 Unknown Author, licensed under creative commons.

Pilots can be directed to alcohol or drug testing under authority other than the Federal testing regulations.

- Company Authorized
- HIMS AME/IMS Directed

Authority for Company Directed Non-DOT Testing

- Authority for Non-DOT Testing
  - Collective Bargaining Agreement
  - Company Policy
  - Last Chance Agreement
  - Other legal document

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Company Directed Non-DOT Testing (con't)

- Different standards from DOT testing
- Varies from airline to airline
- Who directs the testing
- Frequency of tests
- Substances identified in testing
- Types of tests administered
- Consequences of positive test

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HIMS AME/IMS Directed Testing

- May occur regardless of Company-ordered abstinence verification testing
- Authorization for Special Issuance provides authority

This Photo by

DIFFERENCES BETWEEN TESTS

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Differences Between DOT vs. HIMS Non-DOT tests

- Population subject to testing
- DOT testing must comply with statutory & reg standards
  - Custody & Control Form identifies as DOT test
  - Split sample to different, certified lab for urine drug specimens (and oral fluid drug testing)
  - MRO review

Differences Between DOT vs. HIMS Non-DOT tests (con't)

- HHS Scientific Guidelines determine which drugs, cut-off levels, etc.

- Labs must be certified, inspected, meet quality review standards (Proficiency Testing, blind specimen testing for yrs, etc.)

- Testing devices on approved list (e.g., EBTs)

- No-Notice HIMS testing should comply with IMS and/or Employer requirements
  - Non-DOT test – lab determines protocols
  - IMS – determines drug(s), alcohol tested; frequency & type of test consistent with SI reqs & other FAA guidance
  - Employer directed – same as IMS, and complying with any CBA, Airline-specific HIMS Program reqs, LOAs, MOUs, etc.

RESOURCES

DOT Office of Drug Enforcement and Program Compliance

- Office of Drug Enforcement and Program Compliance
  - *https://www.dot.gov/ost/dapc*
  - (800) 225-3784
- Misuse Provisions: 14 CFR § 120 Subpart D: *https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/drug_alcohol/regulations/*
- DOT Testing Regulations: 49 CFR Part 40: *https://www.transportation.gov/odapc/part40*
- Conforming Products Lists: 82 Fed. Reg. 50940 (Nov. 2, 2017)
- DHHS-certified laboratory list: *https://www.samhsa.gov/workplace/resources/drug-testing/certified-lab-list*

QUESTIONS

Drug & Alcohol Monitoring
Myth Busters & Testing Strategies

Quay Snyder, MD, MSPH

HIMS

2025 Basic Education Seminar

Sustaining Success – One Step at a Time

September 15 -17, 2025
The Westin Hotel DIA, Denver, CO

Learning Objectives :

- Explain advantages and disadvantages of different abstinence testing media
- Relate windows of detection and frequency of testing with timeliness of relapse detection
- Identify high risk times for relapse
- Develop strategy for individualized testing

Flight Plan

- Purpose of Testing
- Types of Testing
- Windows
- Ethics
- Strategies
- References

We are either working on our RECOVERY
or
We are working on our RELAPSE

Purposes of Abstinence Compliance Testing

- Meeting requirements of FAA
  - Special Issuance Authorization
- Assessing Recovery
- Reinforcing Recovery
- Documentation of Abstinence – Not PROOF

SIA Requirements

- At LEAST 14 x per 12 Month Interval (Initial + Early) - EtG
- At LEAST 4 PEth's annually + indicated drugs (Advanced)
- Undergo **Random Unannounced**
  Drug and/or Alcohol Testing
- Directed by IMS / HIMS AME – May Coordinate w/ TPA
- Discretion to require Supplemental Testing
- This is NOT DOT Testing!!!
  - Consequences are vastly different!

Assessing, Reinforcing, Documenting

- Assess - Primary DOC and Other Mood-Altering Chemicals
  - Intentional Use for Effect
  - Unintentional – prescribed by HCP, unknown ingestion
  - Education Issue for AME, Treatment Centers
- Reinforcing - Potential Deterrent, Comprehensive Program
- Documentation
  - Protection against False Accusations
  - Aftercare - ELISA Screens w/o Confirmations

Types of Testing

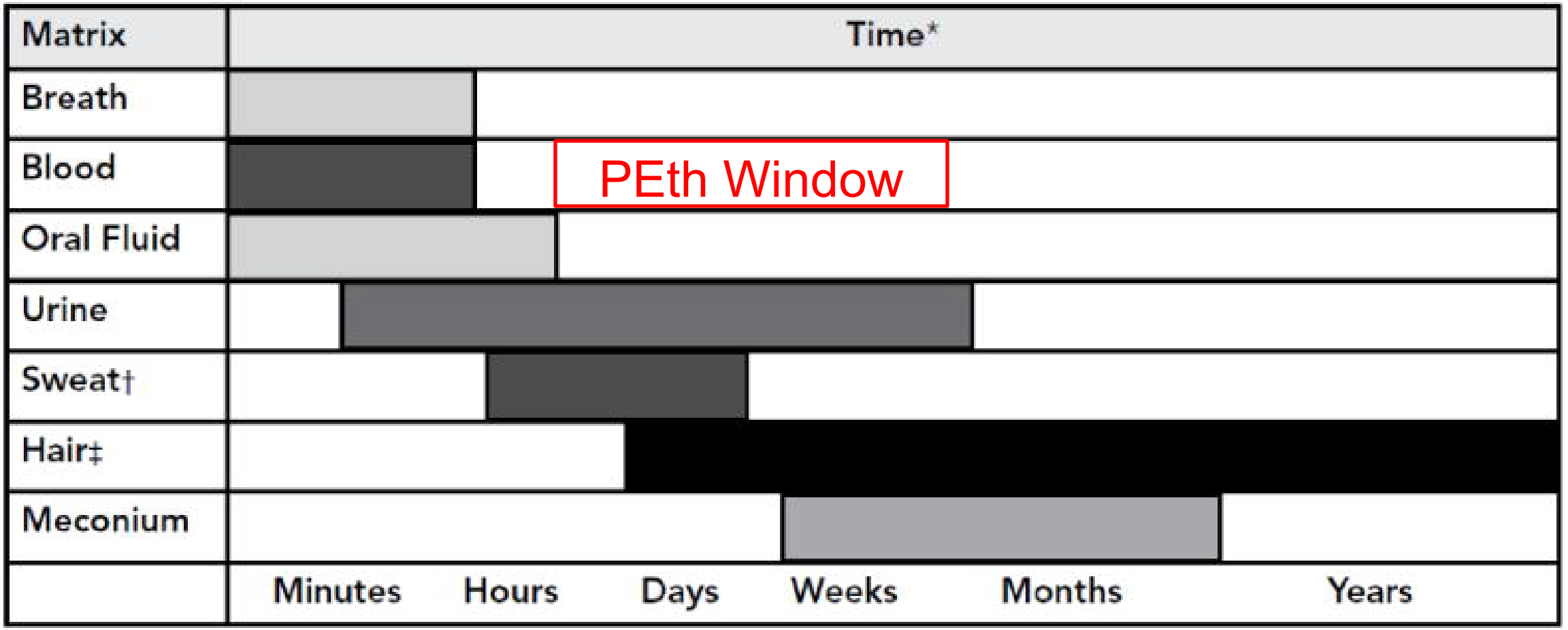
- Screening (Presumptive)
  - ELISA – Enzyme Linked Immunoassay
  - Cross-reactivity with many analogues / similar chemical structures
  - Need Confirmatory testing for ELISA Positives / Can have Negatives
  - “Non-Negative” ≠ “Positive”
  - Below Detection Limits will be Negative
- Confirmatory (Definitive)
  - GC/MS LC/MS GC/MS-MS LC/MS-MS
  - Specific for individual substance or metabolite
  - Below Detection Limits or Chosen Cutoffs will be Negative

Media for Testing

- Breath – Alcohol Only, Volume & Time Dependent
- Urine – Metabolites, Longer Detection Windows
- Blood – Drug or Metabolites, Shorter Detection Window
- Hair – Very Long Detection Window, False + / -, Exposures
- Nails – Very Long Detection Window, More Specific
- Sweat – Continuous Monitoring – Patch or Bracelet
- Saliva – Very Short Detection Window – better for impairment testing than for abstinence testing

NO ONE TEST IS COMPREHENSIVE!!!

Testing Windows



Objective Testing – Urine and Drug Tests, Hadland SF, Levy S Child Adolesc Psychiatr Clin N Am. 2016 Jul; 25(3): 549–565.Published online 2016 Mar 30. doi: 10.1016/j.chc.2016.02.005

Breath Testing

- SoberLink® is Primary Device used in HIMS
  - Not a DOT Evidentiary Breath Test Device
  - Individual photograph and GPS location
  - Electronic notification w/ optional testing windows
  - "Non-Compliant Test" retest every 15 min up to 3 hours
    - Declined Identity (Facial Recognition) or Positive Ethanol
  - Device Cost + subscription -
  - Convenient, cell phone connection (Cellular) or pairs with smartphone (Connect)
- Alcohol Only!
- Alternatives – BAC Track, Intoxalock, keepr

Urine Testing

- Most Common, Cheapest, Most Substances
- Metabolites Primary Tested
- For Alcohol – Uses EtG and EtS
- Many Options for Panels – Know what you are getting!
- Immunoassay screen, negatives only
- Non-Negatives confirmed by GC/MS/MS & LC/MS/MS → Positive
- Various Thresholds for Non-Negative Tests
- Adulterants, Dilution, Substitution

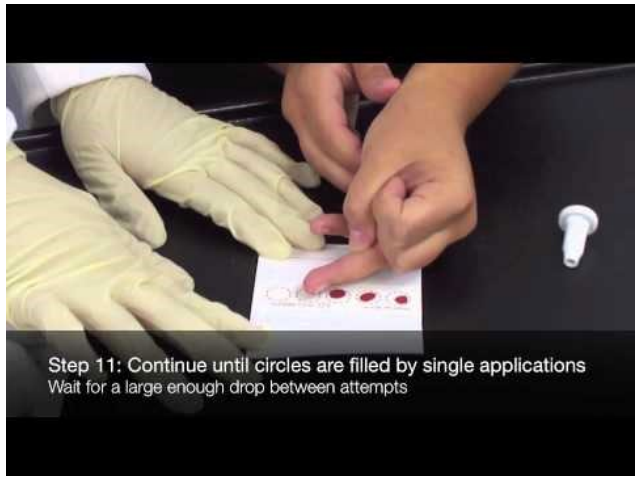
Urine Detection Windows

• Amphetamines	• 2 – 3 days
• Cannabis (1x, 3x/wk, daily, heavy)	• 2 days, 2 weeks, 2-4 wk, 4-6 wk
• Cocaine / BZG metabolite	• 1 – 5 hr, 2 -4 days metabolite
• Heroin / Morphine	• 2 - 3 days
• Opioids	• 1 – 2 days, CR form 3-4 days
• EtG – alcohol metabolite	• 1-3 days (Single Drink)

ETG Nail Testing

- Higher Cost
- ETG positive up to 3 months
- Detectable in 1 -2 weeks after use
- Not affected by Cosmetic treatments
- Not affected by Incidental Exposures (Drugs Only)
- More Concentrated than in Hair

Blood PEth Testing



- Direct Biomarker of Alcohol
- Not sensitive to single drink
- Not variable by Age, Gender, Incidental Exposures (Mouthwash, Skin Agents)
- Requires up to several drinks for several days for Positive
- Detection Window
  (2 – 4 weeks with 28 days abstinence after heavy drinking)
- Dried Blood Spot and Whole Blood options
- Handout in back - USDTL DBS Collection Instructions

“False Positives”

- Unknown Ingestion
  - Alcohol containing products e.g. Kombucha (commercial vs home brew) Vanilla Extract – 70 proof, Unwashed poppy seeds, mouthwash
- Collection Procedure Errors
  - Mixed up samples
  - PEth exposure to alcohol, skin/air
  - Urine not refrigerated
- Immunoassays
- See handouts/app/web site for PEth, Urine DOT guidance
- If something does not seem right, CALL BEFORE LEAVING FACILITY!

Frequency Study of 48 Hour Detection Window (Mean/SD to positive urine)

Drug Use	DT 2X a week	DT 1X a week	DT 2X a month	DT 1X a month	8X a year
Every Day	3 +/- 2	7 +/- 2	15 +/- 10	30 +/-13	46 +/- 40
Every other day	5 +/- 3	9 +/- 5	21 +/- 14	41 +/- 24	61 +/- 52
2X a week	7 +/- 6	14 +/- 10	30 +/- 24	63 +/- 48	91 +/- 81
1X a week	12 +/- 12	25 +/- 22	56 +/- 47	111 +/- 92	168 +/- 158
2X a month	27 +/- 28	56 +/- 50	134 +/- 133	222 +/- 190	379 +/- 320
1X a month	53 +/- 56	102 +/- 96	212 +/- 190	463 +/- 474	806 +/- 817

Ross Crosby, Gregory Carlson, Sheila Specker: Journal of Addictive Diseases, Vol. 22(3) 2003.

Drug Testing Limitations

- Drug testing can be a useful tool, but it should not be the only tool for making decisions. Drug testing results should be considered alongside a patient's self-reports, treatment history, psychosocial assessment, physical examination, and a practitioner's clinical judgment.[2,18] https://nida.nih.gov/research-topics/drug-testing#limitations

- **NIDA Asks** What do drug tests really tell us?
- https://nida.nih.gov/news-events/nida-asks/what-do-drug-tests-really-tell-us

Suspicious Testing Behaviors

- Continuous low creatinine or dilute urines
- Similar creatinine, pH or specific gravity with > one test
- Lack of communication on schedule changes
- Hesitance to do extra testing like PEth etc.
- Constant requests for out-of-town travels while not working
- Constant concern and questioning of frequency of testing

ASAM appropriate Use of Drug Testing in Clinical Addiction Medicine

- It is important not to over-interpret a negative test result. A negative result does not mean that a patient has not used substances; it merely means that the patient has not used the substance(s) targeted by the test within the window of detection or used an amount less than the test is capable of detecting. of a drug test result
- https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/the-asam-appropriate-use-of-drug-testing-in-clinical-addiction-medicine-full-document.pdf?sfvrsn=700a7bc2_0
- **SAMSHA Pocket Guide to ASAM Drug Testing**
- https://eguideline.guidelinecentral.com/i/840070-drug-testing-pocket-guide/7?

One Idea, Many Options

- Early Recovery
  - ETG 20-30 times a year,
    - Include Drug Panel 5 -6 times / yr, every test if DOC not alcohol
    - Test day after vacations, holidays, reunions or a previous test
  - SoberLink optional – useful, esp. w/ travel and on-duty
  - PETH – if SoberLink not used, 2 – 3 times a year
  - Nails / Hair – for poor recovery or accusation (after 3 mo. “sobriety”)
- Reduce Frequency and Scope with Sustained Recovery

Basis of Testing Strategies

- FAA Minimum – 14 times per year, ETG or non-specified
- FAA Mins + plus other substances – “XX panel + ETG ”
- Increased Frequency
- Off-Duty, Non-Office Visits*
- Special Events Triggers – Surgery, Reunions, Vacations, Accusations
- Multiple Media – Overlapping Tests
- Stage of Recovery – Pre SIA, Initial, Early, Advanced, Maintenance
- Special Substances – Synthetic Cannabinoids, Benzos, Soma, Z-drugs, Ambien, GHB, Bath Salts, Designer drugs (nothing for inhalants)

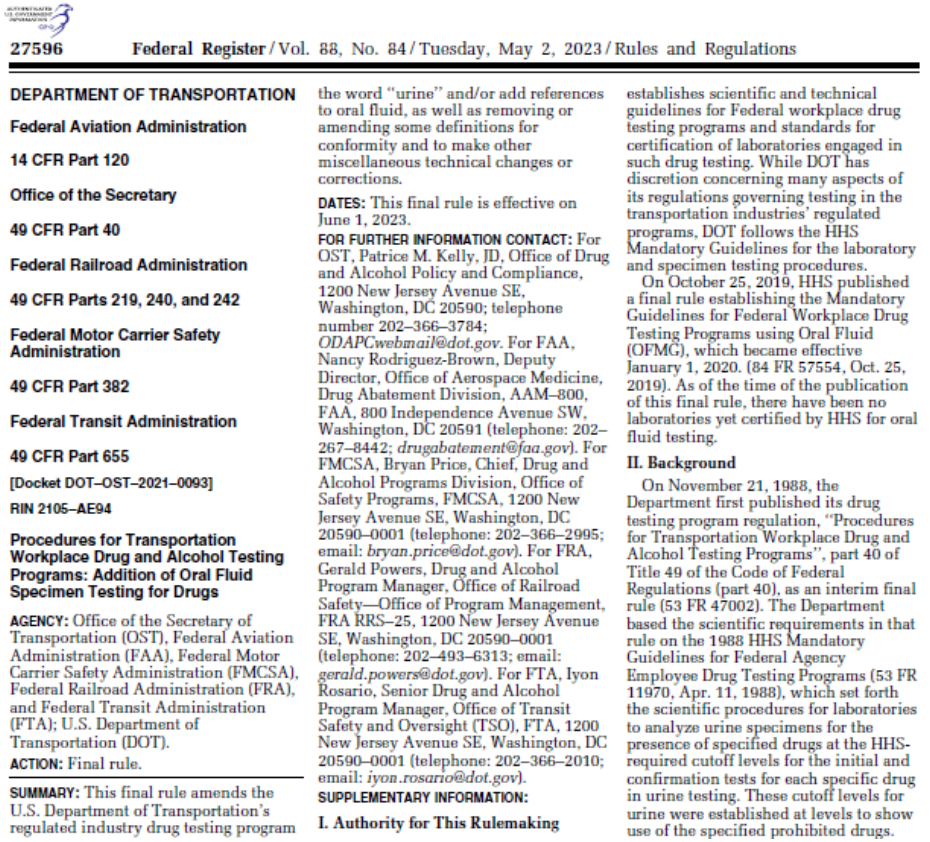
No One Answer is Right

- Company policy may be driven by CBA / LOA / HIMS Committee
  - Type of Testing
  - Who Pays? What is Covered? / Alternative Arrangements
  - Off-Duty / On-Duty (DON'T CONFUSE with DOT Tests) / Rest Rules

- IMS / AME - Different Strategies / Resources
  - Internal Office Testing or Local Collection Sites – Chain of Custody
  - TPA's
  - Knowledge of Pilot Disease / Life Events / Quality of Recovery

DOT – Oral Testing/Saliva

- Oral Fluid Testing for DOT tests
- Alternative to Urine Testing
- Direct Observation – Less Substitution, Adulteration
- Cheaper, Less Privacy Invasion, Convenient
- Technology used for 20 years – law enforcement
- Saliva has shorter detection window than urine
- “Shy Bladder” avoided
- More an indicator of impairment vs past use
- Federal Law 5/02/2023



27596 Federal Register / Vol. 88, No. 84 / Tuesday, May 2, 2023 / Rules and Regulations

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 120

Office of the Secretary

49 CFR Part 40

Federal Railroad Administration

49 CFR Parts 219, 240, and 242

Federal Motor Carrier Safety Administration

49 CFR Part 382

Federal Transit Administration

49 CFR Part 655

[Docket DOT–OST–2021–0093]

RIN 2105–AE94

Procedures for Transportation Workplace Drug and Alcohol Testing Programs: Addition of Oral Fluid Specimen Testing for Drugs

AGENCY: Office of the Secretary of Transportation (OST), Federal Aviation Administration (FAA), Federal Motor Carrier Safety Administration (FMCSA), Federal Railroad Administration (FRA), and Federal Transit Administration (FTA); U.S. Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: This final rule amends the U.S. Department of Transportation's regulated industry drug testing program the word "urine" and/or add references to oral fluid, as well as removing or amending some definitions for conformity and to make other miscellaneous technical changes or corrections.

DATES: This final rule is effective on June 1, 2023.

FOR FURTHER INFORMATION CONTACT: For OST, Patrice M. Kelly, JD, Office of Drug and Alcohol Policy and Compliance, 1200 New Jersey Avenue SE, Washington, DC 20590; telephone number 202–366–3784; *ODAPCwebmail@dot.gov*. For FAA, Nancy Rodriguez-Brown, Deputy Director, Office of Aerospace Medicine, Drug Abatement Division, AAM–800, FAA, 800 Independence Avenue SW, Washington, DC 20591 (telephone: 202–267–8442; *drugabatement@faa.gov*). For FMCSA, Bryan Price, Chief, Drug and Alcohol Programs Division, Office of Safety Programs, FMCSA, 1200 New Jersey Avenue SE, Washington, DC 20590–0001 (telephone: 202–366–2995; email: *bryan.price@dot.gov*). For FRA, Gerald Powers, Drug and Alcohol Program Manager, Office of Railroad Safety—Office of Program Management, FRA RRS–25, 1200 New Jersey Avenue SE, Washington, DC 20590–0001 (telephone: 202–493–6313; email: *gerald.powers@dot.gov*). For FTA, Iyon Rosario, Senior Drug and Alcohol Program Manager, Office of Transit Safety and Oversight (TSO), FTA, 1200 New Jersey Avenue SE, Washington, DC 20590–0001 (telephone: 202–366–2010; email: *iyon.rosario@dot.gov*).

SUPPLEMENTARY INFORMATION:

I. Authority for This Rulemaking

establishes scientific and technical guidelines for Federal workplace drug testing programs and standards for certification of laboratories engaged in such drug testing. While DOT has discretion concerning many aspects of its regulations governing testing in the transportation industries' regulated programs, DOT follows the HHS Mandatory Guidelines for the laboratory and specimen testing procedures.

On October 25, 2019, HHS published a final rule establishing the Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid (OFMG), which became effective January 1, 2020. (84 FR 57554, Oct. 25, 2019). As of the time of the publication of this final rule, there have been no laboratories yet certified by HHS for oral fluid testing.

II. Background

On November 21, 1988, the Department first published its drug testing program regulation, "Procedures for Transportation Workplace Drug and Alcohol Testing Programs", part 40 of Title 49 of the Code of Federal Regulations (part 40), as an interim final rule (53 FR 47002). The Department based the scientific requirements in that rule on the 1988 HHS Mandatory Guidelines for Federal Agency Employee Drug Testing Programs (53 FR 11970, Apr. 11, 1988), which set forth the scientific procedures for laboratories to analyze urine specimens for the presence of specified drugs at the HHS-required cutoff levels for the initial and confirmation tests for each specific drug in urine testing. These cutoff levels for urine were established at levels to show use of the specified prohibited drugs.

References

- Alcohol Biomarkers in Clinical & Forensic Contexts | Dtsch Arztebl Int 2018; 115: 309–15 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5987059/
- Kale, N “Urine Drug Tests: Ordering and Interpretation” *Am Fam Physician*. 2019; 99 (1): 33-39 https://www.aafp.org/afp/2019/0101/p33.html
- Biomarkers of Alcohol Misuse: Recent Advances and Future Prospects (2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4916243/
- Alcohol Biomarkers in Clinical and Forensic Contexts (2018) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5987059/
- Biomarkers for Alcohol Use and Abuse - A Summary, Karen Peterson, Ph.D. (2004) https://pubs.niaaa.nih.gov/publications/arh28-1/30-37.pdf
- The Role of Biomarkers in the Treatment of Alcohol Use Disorders (SAMSHA 2012) http://adaiclearinghouse.org/downloads/Advisory-The-Role-of-Biomarkers-in-the-Treatment-of-Alcohol-Use-Disorders-434.pdf
- Objective Testing – Urine and Drug Tests, Hadland SF, Levy S Child Adolesc Psychiatr Clin N Am. 2016 Jul; 25(3): 549–565

References, Cont.

- HIMS Program – Monitoring Monitoring | HIMS (himsprogram.com) https://HIMSprogram.com/monitoring

- Oral Fluid Testing Final Rule 49 CFR Part 40 [Docket DOT–OST–2021–0093] https://www.federalregister.gov/documents/2023/05/02/2023-08041/procedures-for-transportation-workplace-drug-and-alcohol-testing-programs-addition-of-oral-fluid

- ASAM Appropriate Use of Drug Testing in Clinical Medicine (April 2017) https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/the-asam-appropriate-use-of-drug-testing-in-clinical-addiction-medicine-full-document.pdf?sfvrsn=700a7bc2_0

Audience Questions

Thank you very much!

Trust but Verify!

AA, BOAF &Addiction Mutual Support Groups

Captain Tim Markley

– NetJets Pilot Assistance Program – NJASAP Union Chairman / Governance Board Member

Quay Snyder, MD MSPH, HIMS Program Manager

HIMS

2025 Basic Education Seminar

Sustaining Success – One Step at a Time

September 15-17, 2025
The Westin Hotel – Denver, CO

What is a Peer-Based Recovery Support Group?

"Peer-based recovery support, known as mutual-help organizations (or self-help groups) – are free, peer-led (i.e., non-professional) organizations that developed to help individuals with substance use disorders and other addiction-related problems."

"Peer-Based Recovery Support." *Recovery Research Institute*, 15 Nov. 2024, www.recoveryanswers.org/resource/peer-based-recovery-support/.

Types of Peer-Support Groups

- "**Twelve-Step** like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)."
- "**Secular (Non-Twelve-Step)**, which are growing but smaller entities, such as SMART Recovery, Women for Sobriety, and LifeRing."
- "**Religious**, such as Celebrate Recovery."

"Peer-Based Recovery Support." *Recovery Research Institute*, 15 Nov. 2024, www.recoveryanswers.org/resource/peer-based-recovery-support/.

Setting the Stage- Viewpoint for Comparison

- Disease Model of Addiction
  (Primary, Chronic, Brain Disorder)
- Recovery does not occur in isolation
- Action is required to overcome addiction
  (Psychic change)
- Stages of Change (treatment model)

Stages of Change - Prochaska

- Precontemplation – Denial (Don't have a problem, not interested in change)
- Contemplation – "Might have a problem"- Consideration
- Preparation – I want to change – How do I do that?
- Action – Committed to the change process - uncomfortable
- Maintenance – Use the tools for new situations – six months
- Relapse – can re-enter at any above stage

https://www.ncbi.nlm.nih.gov/books/NBK556005/ https://smartrecovery.org/the-stages-of-change

Recovery Program Review / Analysis

- Alcoholics Anonymous
- Self-Management and Recovery Training (SMART)
- Celebrate Recovery
- Refuge Recovery

Analysis – Areas of Focus

- Framing of the Problem (disease, allergy, addiction)
- Recovery Process – Tool box / change process
- Promises or expected outcomes
- Meetings / Accessibility

Pew Research Center – Religious Landscape Study 2024

- Christian 63%
  - Protestant – 40%
  - Catholic -19%
  - Other - 4%
- Non- Christian
  - Jewish - 2%
  - Muslim - 1%
  - Hindu - 1%
  - Buddhist - 1%

- Religiously Unaffiliated 29%
  - Atheist 5%
  - Agnostic 6%
  - Nothing in Particular 19%
  - No Response 1%

- Of the Religiously unaffiliated:
  - Believe in Higher Power 70%
  - Spiritual 63%
  - None 19%
- Overall Belief in Higher Power 88%

Alcoholics Anonymous – 12 Step Program

-Alcoholics Anonymous is a fellowship of people who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

-The AA Grapevine, Inc.

The Doctor's Opinion – Wiliam D. Silkworth, M.D.

- The action of alcohol on these chronic alcoholics is a manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average temperate drinker.

- These allergic types can never safely drink alcohol in any form at all.

- They are restless, irritable and discontented, unless they can again experience the sense of ease of comfort which comes at once by taking a few drinks- drinks which others take with impunity.

Problem Statement - AA

The fact is that most alcoholics, for reasons yet obscure have lost the power of choice in drink. Our so-called will power becomes practically nonexistent. We are unable, at certain times , to bring into our consciousness with sufficient force the memory of the suffering and humiliation of the even a week or a month ago. We are without defense against the first drink.

Problem Statement – Spiritual

“To one who feels he is an atheist or agnostic such an experience seems impossible, but to continue as he is means disaster, especially if he is an alcoholic of the hopeless variety. To be doomed to an alcoholic death or to live life on a spiritual basis are not always easy alternatives to face”

Alcoholics Anonymous – 12 Steps – 4 Stages

- Steps 1 – 3 Trust in God or Higher Power
- Steps 4 – 7 Recognize Shortcomings
- Steps 8 – 10 Clean House of Past & Present Harms
- Steps 11 – 12 Help Others

Promises or Expected Outcomes - AA

- From: Incomprehensible demoralization
- To: **WE**
  - are going to know a new freedom and happiness
  - will not regret the past or shut the door on it
  - will comprehend the word serenity and know peace
  - no matter how far down the scale we have gone, we will see how our experience can benefit others
  - That feeling of uselessness and self-pity will disappear
  - Will lose interest in selfish things and gain interest in our fellows
  - Our whole attitude and outlook on life will change
  - Fear of economic insecurity will leave us.
  - Will intuitively know how to handle situations that used to baffle us
  - Will suddenly realize that God is doing for us what we could not do for ourselves

What is “Working the Program” ?

- Go to AA meetings – 90/90
- Read the Big Book and 12 & 12 (books available at desk)
- Get a sponsor and work the steps
- Help others – share experience, strength and hope
- Get involved in service work (Chair, coffee, greeter)
- Offer to sponsor others
- ACTION is the key – engage in the process

Subgroups Within AA

- BOAF

  Atheist/Agnostic

  Religious groups

  Men and women only

  LGBTQ+ groups

  English/non-English speaking

  Lawyers/Doctor/Actors/Police etc. etc.

Meetings / Accessibility - AA

- A**A World Wide**
  - 180 nations
  - 123,000 AA groups
  - Literature translated to over 100 languages
  - Membership estimated at over 2 million

- Websites / Apps
  - AA.org
  - AA meeting finder
  - Everything AA

Birds of a Feather

- **OUR SINGLENESS OF PURPOSE**

- Birds of a Feather was formed in response to the need for meeting places for pilots and cockpit crew members where the subject of addiction to alcohol might be discussed with impunity and anonymity. The cultural bias concerning this subject has prevented many in the past from seeking advice.

- Our concern is recovery from alcoholism. We have no loyalties to any company, government institution, medical facility, union, employee assistant program, treatment center or specific recovery program.

- BOAF has contributed immeasurably to our recovery and the spirit of passing this philosophy on to others who also might benefit is the reason for Birds of a Feather.

- Each nest is autonomous and determines its own membership requirements. Go to the NESTS AND CONTACTS page on the www.boaf.org website to determine the group conscience of a particular nest. (Statement approved at 2014 BOAF San Diego Convention)

Birds of a Feather

- The early meetings were criticized by other AA groups, accusing the Birds of violating the 3rd tradition (the only requirement for membership is a desire to stop drinking) by apparent discrimination against non-flight individuals. A member contacted the General Service Board in February of 1976, and they responded that "many special interest groups do meet together, and one of the ways this has been solved is by referring to it as a "meeting" rather than as a "group".

- Each Nest has its own rules concerning non-aviators

Al-Anon - 12 Step Support for Family Members

- The Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their, experience and hope in order to solve their common problem. We believe alcoholism is a family illness and that changed attitudes can aid recovery.
- 24,000 meetings worldwide, 133 countries
- AlaTeen, AlaTot

- HIMS program – Family support volunteers
- Birds of a Feather Al Anon https://boafalanon.org/
- Aviation Family Network https://aviationfamilynetwork.org/

What is SMART Recovery?

Self-Management and Recovery Training (SMART)

Smart Recovery is an evidenced-informed recovery method grounded in:

- Rational Emotive Behavioral Therapy (REBT)
- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing (MI)

SMART Recovery
Life beyond addiction

Smart Recovery

- Non-judgmental and stigma free mutual support meetings (in-person and on-line)
- Practical toolbox and other helpful resources
- Participants design and implement their own recovery plan
- The goal is to help participants build lives with new behaviors that transcend addiction

What is SMART Recovery- General

- 4-Point Program – Handbook and Mutual Support Meetings (4th edition – 2025)
- Founded in 1994
- Meeting 23+ countries, 2500+ groups
- Website, blogs, videos and message board

Problem Statement – What is it used for?

- For those experiencing problems with substances like alcohol, opiates, tobacco, meth and other drugs

- Activities that may become addictive like sexual activity, gaming, gambling, shopping and eating

Problem Statement – What are Addictive Behaviors?

- You might choose to describe your behaviors as addictive when:
  - Become a habitual pattern
  - Become stronger each time you do them
  - Involve short-term rewards or immediate satisfaction, but lead to longer term costs, like damaged relationships or financial problems
  - Start to crowd out other sources of satisfaction
  - Lead you to violate your values

Problem Statement – Is Addiction a Disease?

"There's a debate among medical and behavioral health professional around whether addiction is accurately described as a disease. Thankfully, it doesn't really matter in SMART. Our approach can help you regardless of whether you believe addiction is a disease or not."

Page 16 of Smart Recovery Handbook

What is SMART Recovery - Principles

- Self-Management – People can manage their own behaviors
- Evidence Led – All our programs are based on scientific- evidence and we encourage their on- going evaluation
- Mutual Support – There is great value in connecting with and learning from peers with similar experience
- Person Centered – People with lived experience are central in guiding what we do
- Choice – People choose their own goals, skills and tools

Problem Statement – What about Abstinence?

It's your choice to make

"In a self-empowering approach like SMART, you choose your own goals. You might have different goals for different substances or activities. You might abstain, moderate, or reduce risk. You can change your goals at any time…"

Page 20 of Smart Recovery Handbook

How Does SMART Recovery Work?

1. Build and maintain motivation
2. Cope with urges and cravings
3. Manage thoughts, feelings and behaviors
4. Live a balanced life

Celebrate Recovery

- Christian 12-step program designed to facilitate recovery from a variety of behaviors
- Uses AA's 12 steps, as well 8 sequential principles
- Encourages groups of "accountability partners"
- May not use any other resources besides the bible and celebrate recovery materials

Refuge Recovery / Recovery Dharma

Based on Buddhist Teachings

1. Renunciation – Abstinence substances/behaviors
2. Meditation – Daily Practice
3. Meetings – In person and Online
4. The Path = Four Noble Truths and Eightfold Path
5. Inquiry and Investigation
6. Sangha, Wise Friends, Mentors
7. Growth – Life-long Journey of growth and awakening

Other Alternative Secular Recovery Programs

- Women for Sobriety
- Secular Organizations for Sobriety (SOS)
- LifeRing Secular Recovery
- Various others including medical and holistic therapies
- AA Agnostica - "A Collection of Alternative 12 Steps"
  - Agnostic AA 12S, Neil's 12S, Humanist 12S, White Bison, Practical 12S
- Secular Recovery
  – "Staying Sober Without God" @ registration area "Practical 12 Steps"

- Comparison of 12-step Groups to Mutual Help Alternatives for AUD in a Large, National Study: Differences in Membership Characteristics and Group Participation, Cohesion, and Satisfaction

https://pmc.ncbi.nlm.nih.gov/articles/PMC5193234/

FAA Bottom Lines for Pilots in Recovery

- Abstinence Based
- Mutual Group Support meetings
- Non-professional led
- Several times weekly in early recovery
- In-person strongly preferred

- Not replaced by aftercare or individual counseling

Success of Relapse Prevention Strategies

- Triumphs of Experience – George Valliant MD pp 307-314
  - 1938 – 268 Harvard men + 3 generations, Glueck Study inner-city Boston men
  - Best predictor of long-term sobriety – AA attendance

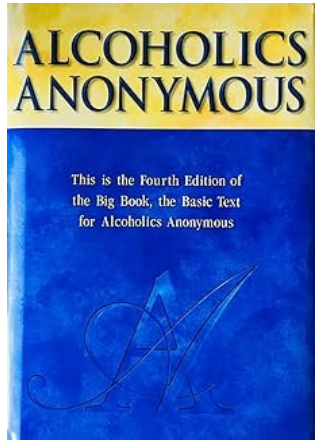
- NIDA – Nora's Blog https://nida.nih.gov/about-nida/noras-blog

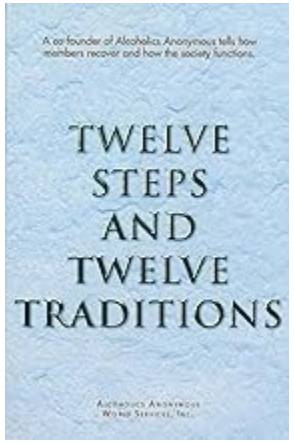
- Stillman MA, Sutcliff J. Predictors of relapse in alcohol use disorder: Identifying individuals most vulnerable to relapse. Addict Subst Abuse 2020. 1(1): 3-8.

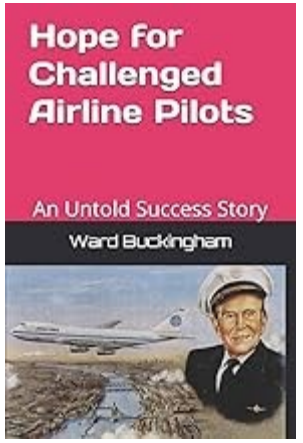
- Dr. Pakull and Dr. Modell in 1980's & 1990's

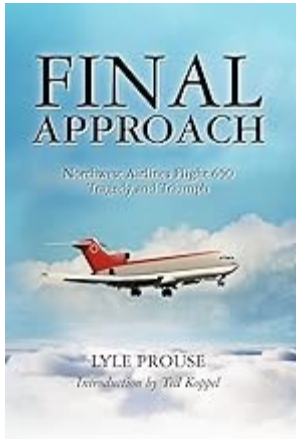
Books at Registration Desk

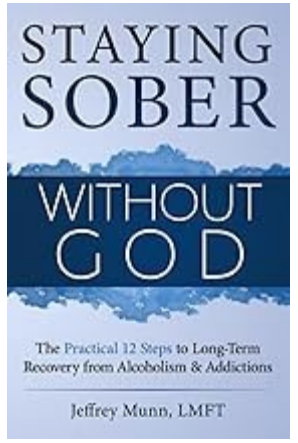
- Alcoholics Anonymous – The Big Book
- Twelve Steps and Twelve Traditions
- Hope for Challenged Airline Pilots
  – Dr. Ward Buckingham - The history of HIMS at individual airline and national level
- Final Approach – Capt. Lyle Prouse
- Staying Sober Without God – Jeffrey Munn











SEARCHING FOR SUBSTANCE ABUSE TREATMENT

Barbara D. Woods, LCSW, ACSW, SAP-Qualified

HIMS

2025 Basic Education Seminar

Sustaining Success – One Step at a Time

September 15-17, 2025
The Westin Hotel – Denver, CO

Helpful Resources

National Association of Addiction Treatment Providers www.naatp.org

Psychology Today
www.psychologytoday.com

Patient's Insurance Company (managed care)

Accreditation

The Joint Commission (www.jointcommission.org)

Credit: www.jointcommission.org

Commission on Accreditation of Rehabilitation Facilities (www.carf.org)

carf INTERNATIONAL

General Information

- Managed care vs self pay
- Medical necessity criteria
- ASAM (used by managed care) criteria vs FAR
- Age of Program—outcome studies
- 12 Step vs holistic vs scientific/medical model
- PPO vs HMO benefit– In vs Out of Network

Cost of Treatment

For profit vs nonprofit 501(c)(3)…What's the difference?

If self pay-know the cost prior to admission—including ancillary costs. No surprises.

"In network" vs "we accept insurance"

What is balance billing?

Levels of Care

- Detox (medical vs social detox)
- Inpatient Hospitalization
- Residential Treatment
- Partial Hospital (PHP) vs Boarded Partial
- Intensive Outpatient (IOP)

Professional Staff

Seasoned/experienced staff ie:

PhD/PsyD, Masters Level Counselors

Psychiatrist on staff-ability to treat co-occurring disorders

Virtual vs “In Person” evaluations/sessions

Willing to follow professional protocols (can involve extra $)

Treating Professional Pilot

Important to understand nuances of treating a professional pilot:
(high bottom, fear, need for control, lack of trust).

FAR violation(14 CFR part 67) vs DSM Diagnosis

Familiar with disqualifying disorders-psychiatric/medical

Comprehensive Treatment

- Family program included—in person or virtual?
- Discharge planning…who does it…when is it done?
- Individualized treatment plans to address specific clinical needs
- Chart to the treatment plan

General Information

- How often does treatment team meet?
- Is the doctor included (psych)…nursing?
- Warmth of staff—demonstrate they CARE
- Weekly reports --- timely...informative
- AA attendance – step work- temp sponsor
- BOAF

SUMMARY-Ideal Program for professional pilot

- Accredited—JCAHO or CARF
- Knowledge of HIMS program
- Caring, trained and credentialed staff
- Psychiatrist-admit to discharge
- Detailed and appropriate documentation
- Communication during treatment
- Comprehensive discharge planning
- Timely record submission to AME

Contact Info

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972-467-7993

Family Role in Recovery

Barbara D. Woods, LCSW, ACSW, SAP-Qualified

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It’s a Family Disease

National Council on Alcohol and Drug Dependency (NCADD) states that addiction is a family disease. It impacts the family and loved ones mental and physical health.

Stress of living with active alcoholic/addict produces dysfunctional coping behavior.

In It Together

- Family members deserve the opportunity for treatment
- Recover together- healthier family
- First step for family member: Identify or come to terms with whether or not you are codependent and/or an enabler.

Codependency

One who lets another person’s behavior affect him/her to extent they become focused on controlling “or fixing” their loved one's behavior. (Melody Beattie, Codependent No More)

Codependent personalities tend to be attracted to alcoholics, addicts, people with lots of problems-drama drama-drama

Patient Treatment Experience

- Treatment setting offers safety and security
- Shame, anger, guilt, fear reduction
- Education about disease of addiction
- Recipe for recovery provided
- Encounter “others like me”…normalize my situation

Family Treatment

- Education on disease of addiction
- Learn how to care for self…i.e. how to recognize unhealthy boundaries and establish healthy ones
- Normalize situation—meet other like minded
- Get referral for individual therapist post discharge

Family Programs

- Weekly visits/sessions in person
- Telephonic/virtual sessions
- Onsite family program-2-4 days
- Weekend extended programs

Benefits of Family Treatment

- Positive personality changes-self care
- Alanon/self help support group participation
- No drugs/alcohol in the home
- Improved communication
- Stronger family unit-”in it together”

Relapse

- Treatment for identified victim without family involved is recipe for relapse.

- Relapse happens to people in recovery for 10 months—for 10 years….20 years…..

Relapse Risks

- Alcoholic stops attending meetings
- Codependent spouse at risk of relapse
- Codependent spouse stops meetings—
- Alcoholic at risk of relapse

Helpful Hints

- Upon admit to treatment/ROI to contact family member
- Establish contact-collect collateral information
- Invite to family program—stress importance
- Refer family to www.himsprogram.com/familysupport or Kimberly Schroeder, Family Support Chair -507-382-5447 Schroeder.kimberly@yahoo.com

Barbara D. Woods, LCSW, ACSW, SAP-Qualified

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Writing Monitor Letters

Captain Billy Petersen
Jetblue Airways, Airbus JFK
ALPA Natl HIMS ViceChair

HIMS

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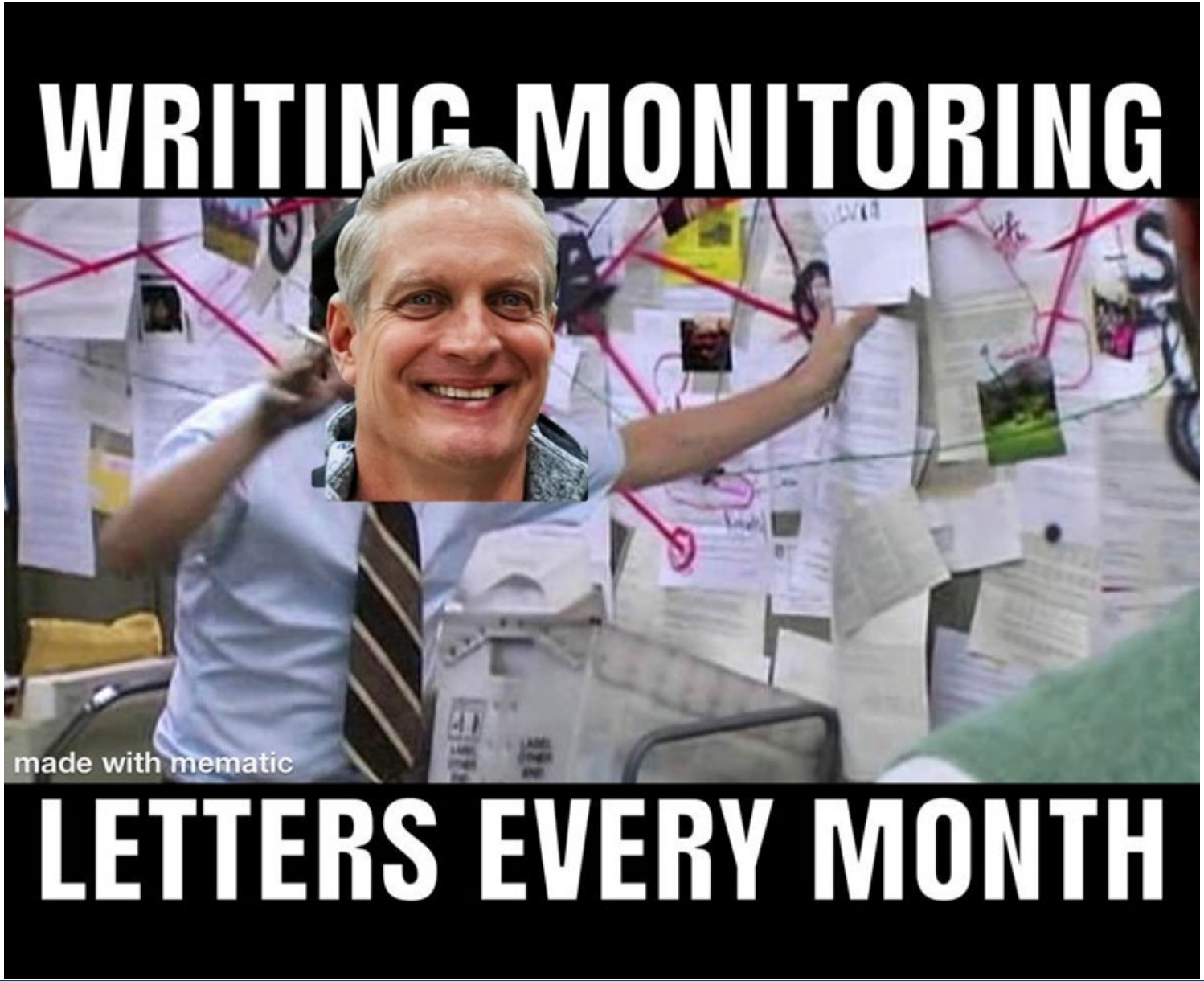
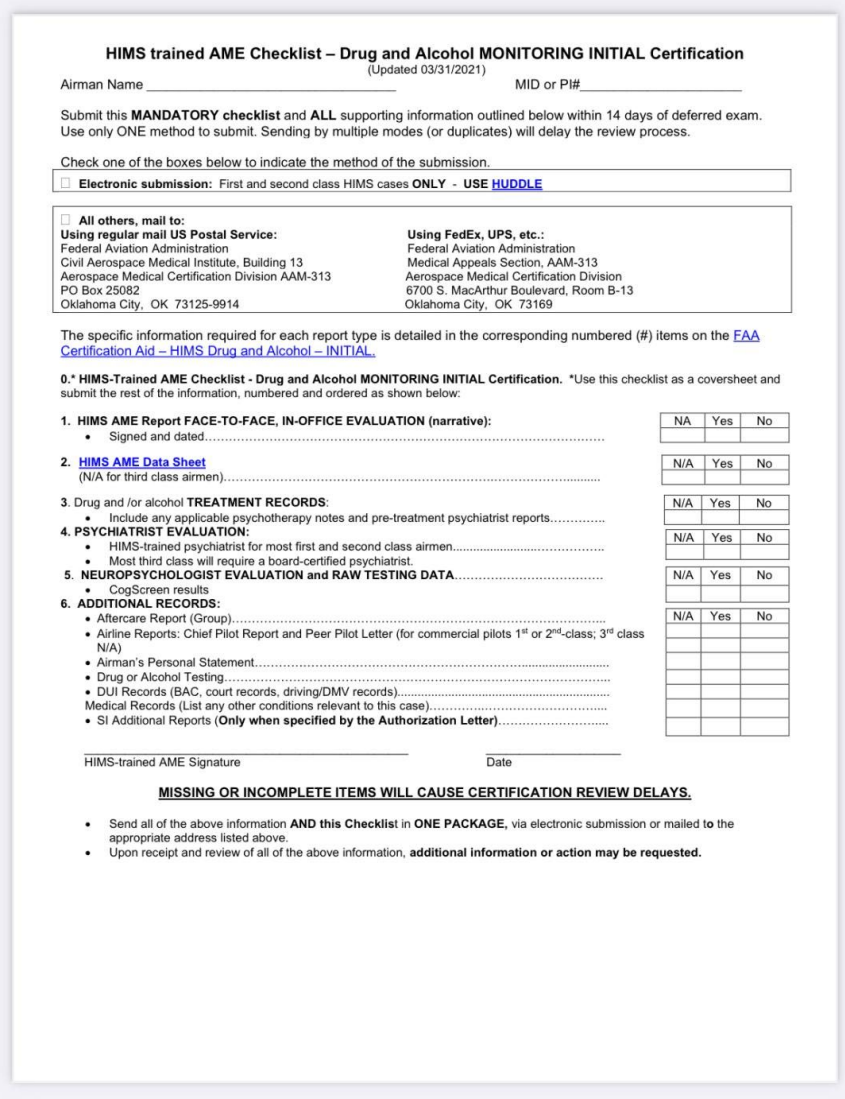

WRITING MONITORING
made with mematic
LETTERS EVERY MONTH

HIMS Requirements for Initial Certification

1. Inpatient Records
2. Aftercare Reports
3. Drug/Alcohol Test Results
4. **Monitoring Letters**
    1. **Peer Pilot**
    2. **Management Pilot**
5. Psychiatrist Report
6. Psychologist Results
7. HIMS AME Report and Checklist
8. Others Items as Necessary



HIMS trained AME Checklist – Drug and Alcohol MONITORING INITIAL Certification
(Updated 03/31/2021)

Airman Name _____ MID or PI#_____

Submit this **MANDATORY checklist** and **ALL** supporting information outlined below within 14 days of deferred exam. Use only ONE method to submit. Sending by multiple modes (or duplicates) will delay the review process.

Check one of the boxes below to indicate the method of the submission.

☐ **Electronic submission:** First and second class HIMS cases **ONLY** - **USE HUDDLE**

☐ **All others, mail to:**

Using regular mail US Postal Service:
Federal Aviation Administration
Civil Aerospace Medical Institute, Building 13
Aerospace Medical Certification Division AAM-313
PO Box 25082
Oklahoma City, OK 73125-9914

Using FedEx, UPS, etc.:
Federal Aviation Administration
Medical Appeals Section, AAM-313
Aerospace Medical Certification Division
6700 S. MacArthur Boulevard, Room B-13
Oklahoma City, OK 73169

The specific information required for each report type is detailed in the corresponding numbered (#) items on the FAA Certification Aid – HIMS Drug and Alcohol – INITIAL.

0.* HIMS-Trained AME Checklist - Drug and Alcohol MONITORING INITIAL Certification. *Use this checklist as a coversheet and submit the rest of the information, numbered and ordered as shown below:

	NA	Yes	No
1. HIMS AME Report FACE-TO-FACE, IN-OFFICE EVALUATION (narrative): • Signed and dated			
2. HIMS AME Data Sheet (N/A for third class airmen)	N/A	Yes	No
3. Drug and /or alcohol **TREATMENT RECORDS**: • Include any applicable psychotherapy notes and pre-treatment psychiatrist reports	N/A	Yes	No
4. PSYCHIATRIST EVALUATION: • HIMS-trained psychiatrist for most first and second class airmen • Most third class will require a board-certified psychiatrist.	N/A	Yes	No
5. NEUROPSYCHOLOGIST EVALUATION and RAW TESTING DATA • CogScreen results	N/A	Yes	No
6. ADDITIONAL RECORDS:	N/A	Yes	No
• Aftercare Report (Group)			
• Airline Reports: Chief Pilot Report and Peer Pilot Letter (for commercial pilots 1st or 2nd-class; 3rd class N/A)			
• Airman's Personal Statement			
• Drug or Alcohol Testing			
• DUI Records (BAC, court records, driving/DMV records)			
Medical Records (List any other conditions relevant to this case)			
• SI Additional Reports (**Only when specified by the Authorization Letter**)			

_____ _____
HIMS-trained AME Signature Date

MISSING OR INCOMPLETE ITEMS WILL CAUSE CERTIFICATION REVIEW DELAYS.

- Send all of the above information **AND this Checklist** in **ONE PACKAGE,** via electronic submission or mailed to the appropriate address listed above.
- Upon receipt and review of all of the above information, **additional information or action may be requested.**

What is Monitoring?

- To observe and check the progress or quality of something over a period of time

- To listen to and report on
  - (oxford Languages, Google.com)

The 2 Types Of Monitors

- **1- HIMS Peer Pilot**
- **Union volunteer, fellow BOAF member, etc.**

- **2- HIMS Management Pilot**
- **Chief pilot, DO, company designee, etc.**
- **More difficult for GA, luckily, there are resources**

What is a HIMS Peer Pilot?

- A Credible, Vetted, HIMS Trained Volunteer* $
- The Pilots HIMS Program Resource
- The FAA's "eyes and ears"
- NOT a Sponsor, But Someone Who Listens
- Often in recovery themselves

What is a HIMS Management Pilot

Chief Pilot Office Representative

HIMS Trained (preferably)*

Company's observer for "Compliance"

NOT A Sponsor

The Peer Pilot's Role

- **Communicate With The Pilot Being Monitored**

-Be a Resource – Guide Them Through the Program

-*Pilot advocate (when necessary & appropriate)

-Set Boundaries/Requirements consistent with HIMS policy*

-Talk weekly? Meet Monthly?

-We Can Only Write What We Know!!

-Hold Pilot Accountable

-Write Monthly Letters to the AME

The Management Pilot's Role

- **Monitor the pilot's monthly requirements**

Know enough to be familiar with pilot's case history

Set boundaries/requirements consistent with HIMS Policy

Be Cautionary of the "fly by"

Writes Letters to AME

Guarded Relationships

-This is for anyone working with HIMS pilots

-New HIMS pilots are emotionally vulnerable

-It is easy to cross the line in a relationship

-This is especially true when working with a pilot of the opposite sex

-Firm Boundaries must be set and followed

Monthly Report

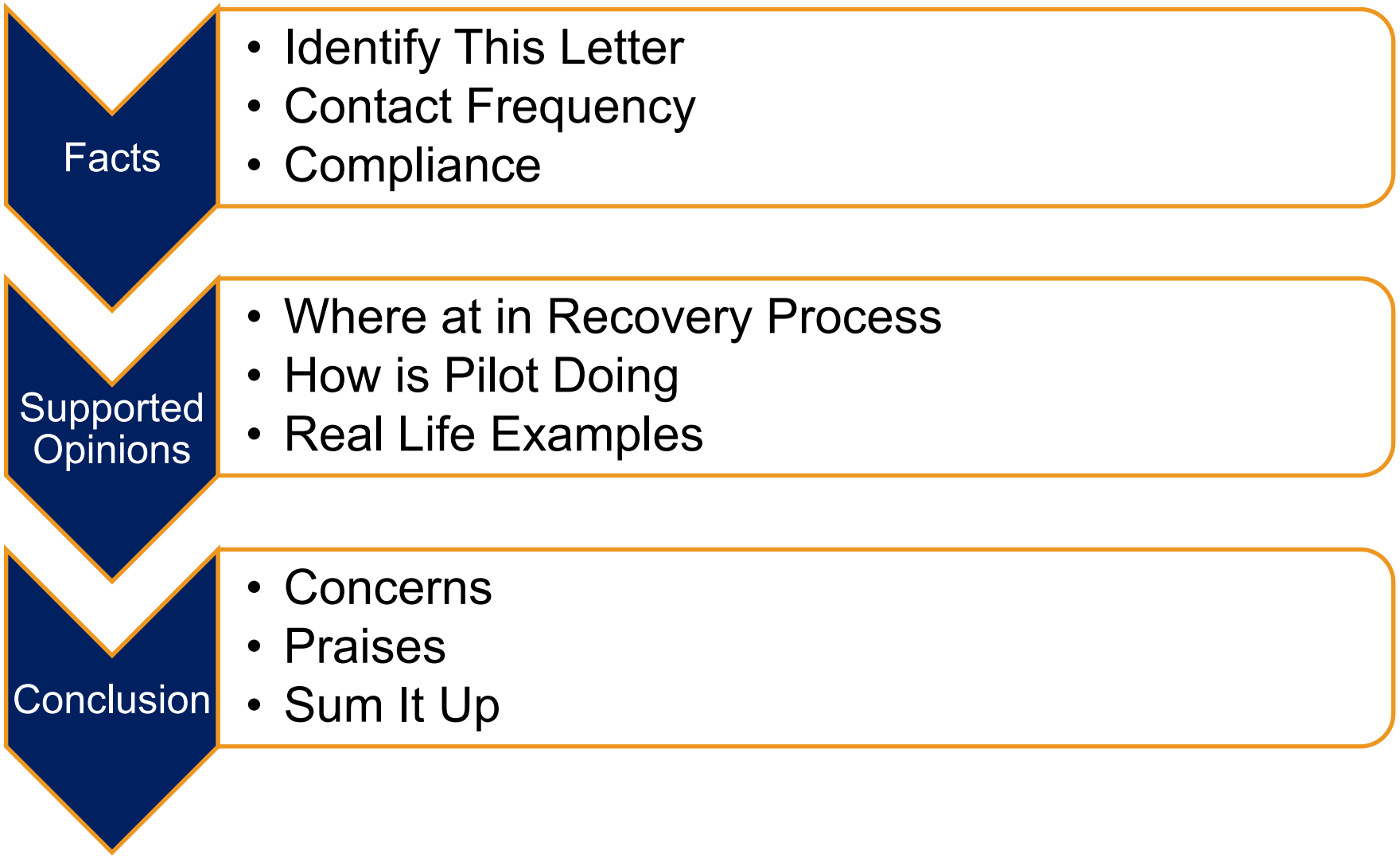
- **FAA is asking <u>your opinion</u> of the pilot's recovery not an expert evaluation**
  - ***Report the facts and observations only!***

The FAA is looking for positive change in the life of the HIMS pilot – This should be demonstrated through good recovery – Find a way to express this positive change in your reports

- Is pilot Compliant or Noncompliant?
- Observe Verbal and Nonverbal communication
- Share situations where recovery was utilized*
- How is their appearance? Excessive use of sick time?
- Any calls about them to pro standards?

- ***Write it as if you will need to defend it in court! No suspicions or suggestions**

Monitor Letter Format



Dr. xxxx, 09/2025

This letter will serve as my monthly monitoring report for Craig for September 2025. I had phone contact with Craig 4 times this month and met with him once in person for about an hour over coffee. He tells me he has frequent contact with his sponsor and attends at least 3 AA meetings per week. Craig is in compliance with the terms of his aftercare contract and the terms of his Special issuance from the FAA.

He has been very open with me concerning his recovery and is currently working on step 9 amends. Craig told me about a time this past week where he used new recovery tools to handle a situation at home differently than he would have in the past. I feel Craig is dealing well with the stress of getting back to work, while still making the requirements of his aftercare a priority. When I saw Craig, he seemed relaxed and looked great.

I have no concerns about Craigs's sobriety. I feel he is working the recovery program he chose and is using all available tools of recovery. This is demonstrated to me not just by what he says, but by how he acts in and out of our meetings.

Please let me know if you have any questions or require any more information.

Sincerely,

CA Bill

What to do with a Sick Pilot?
Put it in the letter!

Monitor Letter Format

Facts

- Identify This Letter
- Contact Frequency
- Compliance

Supported Opinions

- Where at in Recovery Process
- How is Pilot Doing
- Real Life Examples

Conclusion

- Concerns
- Praises
- Sum It Up

Dr. xxx

This letter will serve as my monthly monitoring report for Rick for September 2025. I had phone contact with Rick 1 time this month and he was unable to meet with me in person due to his schedule constantly changing. He tells me he has frequent contact with his sponsor and attends AA meetings “all the time”, however when I asked him his sponsors name and homegroup, he didn’t seem too sure of his answer. Ricks’s lack of contact with me is not in compliance with the terms of his aftercare contract or the terms of his Special issuance from the FAA.

Rick has been very guarded with me concerning his recovery and always has an excuse for why he can not meet with me or call me as required. I feel that since Rick has returned to work, he has no longer made the requirements of his aftercare a priority. Ive told him numerous times that it is up to him to call me, and that I can only put what I know in his letter, and he seems unfazed by this.

My main concern with Rick is his lack of contact. This has made it very difficult for me to access how his recovery is truly going.

Please let me know if you have any questions.

Sincerely,

CA Bill

In Conclusion

- -It is the pilots program, and it is your job to convey that message to them and their AME.
- -When the pilot is doing great, let them know that.
- -If they can do better, let them know that as well, but give them a chance. Especially in early recovery.*
- ***-Its our job to be there for them, this is what we signed up for.***

What Not to Put in a Letter

Dr xxxx, Sept 2025

This letter will serve as Danas monitoring letter for September 2025. Where do I even start? This guy is a disaster!

Dana has a terrible attitude. He claims he was forced into the program even though he had multiple alcohol issues in the past and frequently tells stories about doing hard drugs. Hes always late to our monthly meetings, is always asking people for money, and is consistently hostile. No one in the group likes him.

Dana somehow manages to pass his drug tests, but Im not convinced. I think hes on something else, possibly those pills they sell at gas stations, or kratom or something like that. I think you should really test him more, and test for other substances as well. In addition, I wouldn't be opposed to grounding him for a while to make him reconsider his actions.

Questions/Comments/Concerns/Complaints?

www.HimsProgram.com

What Does Relapse Look Like?

Dr. Katie McQueen
First Officer Rick Mahoney

HIMS

2025 Basic Education Seminar

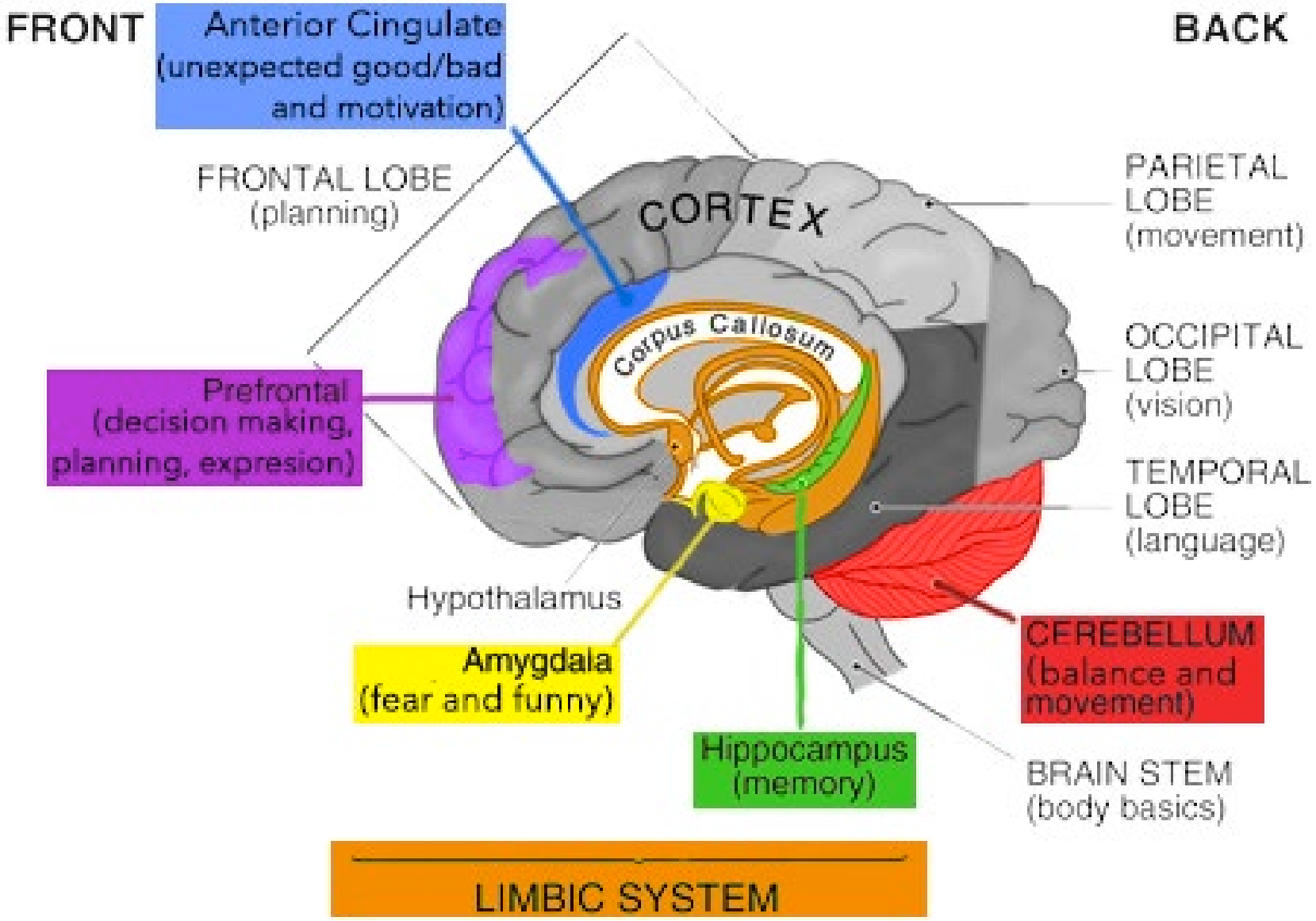
Sustaining Success – One Step at a Time

September 15-17, 2025
The Westin Hotel DIA, Denver, CO

Objectives

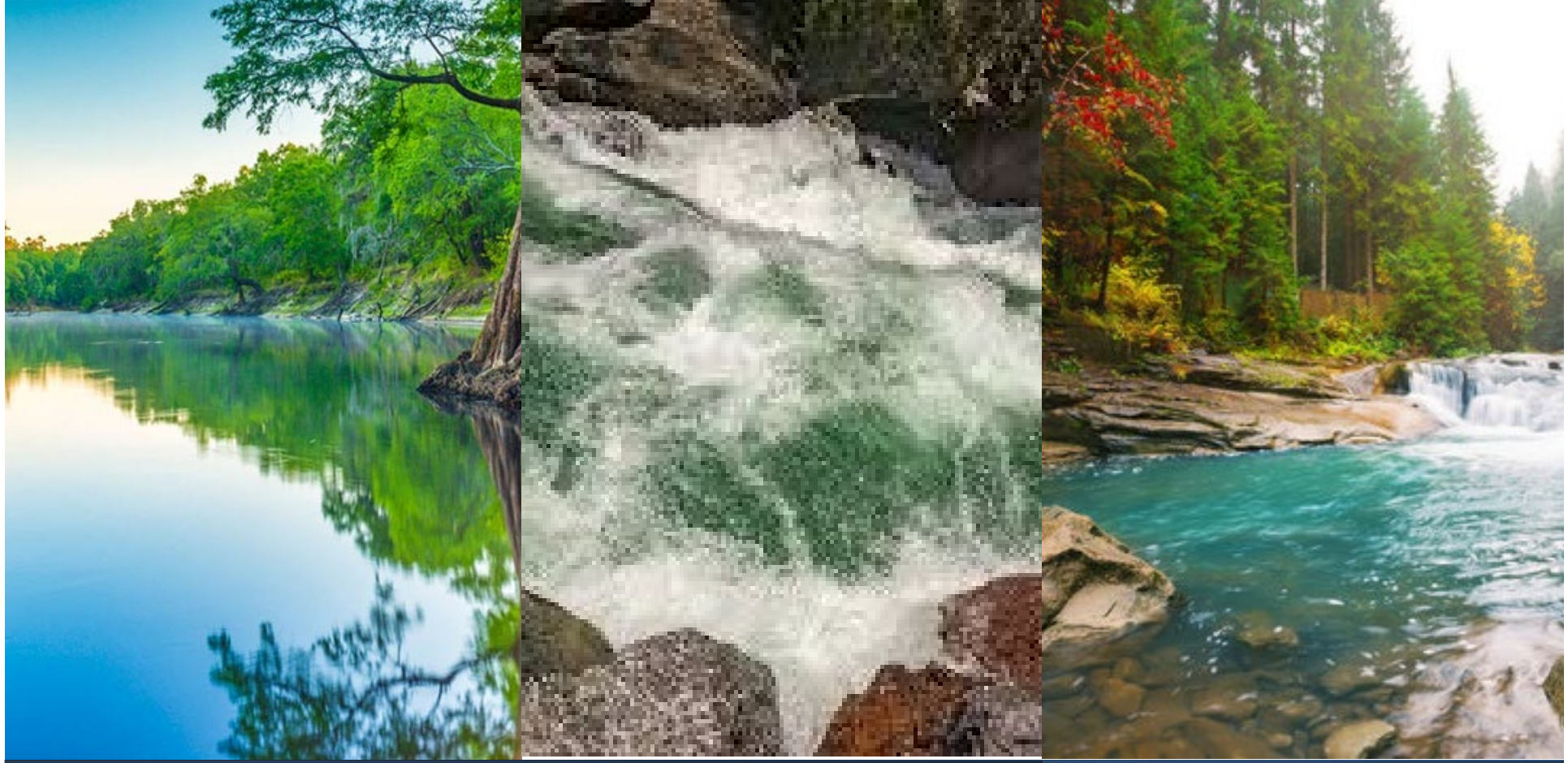
- Understand the physiology of addiction and Relapse.
- Understand relapse in context of a chronic medical illness model.
- Recognize common predictors of relapse.
- Use information to understand relapse prevention.

Courtesy of Laurel Edgecomb, MFT



What is Relapse?

- Addiction is chronic medical condition characterized by relapses and remissions.
- Goal of treatment is to induce a sustained remission....
- But likelihood of relapse is real and often a part of the journey.
- And yet, responses to a relapse can often be unpredictable, confused, disproportionate, irrational and usually unhelpful.



Equilibrium ~ Homeostasis ~Allostasis

Relapse happens when my needs are not being met.

- Physiological
  - Breathing, food, water, shelter, clothing, sleep
- Safety
  - Health, employment, property, famkly
- Love/Belonging
  - connection to others
- Self-Esteem
  - I am enough
- Self-actualization
  - connection to self others & beyond

Resilience = Loadbearing

- Loadbearing capacity is the maximum ability of a structural member or material to take loading before failure occurs.

- What is a human's loadbearing capacity?
  - Static load versus Dynamic load
  - "the consequences of ignoring loadbearing capacity can be catastrophic"

Biological Levels of Defense

- Neurotransmitters (nervous system)
- Hormones (endocrine system)
- Cytokines (immune system)
- Interconnectedness (musculoskeletal system)
  - Threats to the system lead to activation of all four
  - Building resilience in one can contribute to resilience in all.

Resilience

- Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands.
  - The ways in which individuals view and engage with the world
  - The availability and quality of social resources
  - Specific coping strategies
    - *APA Dictionary of Psychology*
    - ***WHAT HAPPENED TO THE MUSCULOSKELETAL SYSTEM?***

What is a typical response to Relapse?

- Denial, minimization, projection, anger, blaming.
- Shame, guilt, learnt helplessness (the F--- its!).
- The Abstinence Violation Effect (AVE): The response to relapse when person incorrectly concludes that it signifies moral failure and confirmation that long term recovery is not possible. “Might as well get stoned!”
- Counter-therapeutic and sets obstacles to getting back to recovery.

What is a typical response to Relapse?

- Unrealistic expectations of perfection. “All or nothing at all!”
- Isolation, stigmatization.
- Punitive.
- Reinforces the AVE.
- Counter-therapeutic and sets obstacles to getting back to recovery.

Taking a page from another Chronic Medical

- 30 year old Male, newly diagnosed Non-Insulin Dependent Diabetes.

- How is the response and outcome different?

Relapse versus Re-Instatement?

- When is it a true relapse?
- Was there true recovery ever established? Or was it just a prolonged state of externally mandated abstinence?
- Relapse track versus being treated for the very first time (again)!
- Can a relapse be predicted? And Prevented?

Relapse Prevention – How Honest is Your Program?

- "…we covered low self-esteem by hiding behind phony images that we hoped would fool people. **The masks have to go."**

  NA Basic Text, p. 33

- A deep experience of and daily practice with Steps 1-3 in a pilot's 12-Step Recovery Program are hugely correlative to the pilot's risk of relapse, particularly in early recovery.
- Rigorous honesty required…

Relapse Prevention – Does Everyone Relapse?

- Relapse *can* be a part of someone's recovery path - but doesn't *have* to be.

- 3 simple things get/keep someone Sober. A lack of those three things lead down the path to relapse:
  - Sponsor
  - Steps
  - Community

Relapse Prevention – 3 Building Blocks

- The 3 Pillars to strong 12-Step recovery:
    1. Strong Sponsor Relationship
    2. 12-Step **<u>Work</u>**
    3. Community
        - AA Home Group
        - BOF
        - Airline HIMS Group

SLIP – Sobriety Lost Its Priority

Relapse Triggers – What do you look for?

- In-patient treatment sets the foundation, but it doesn't build the house.
- Post-discharge through Year 1 particularly vulnerable.
- Pilot returns to familiar surroundings, with different tools to engage with old challenges.
  - Relationship/Marital Issues
  - Family Conflict
  - Previous Trauma History
  - Workplace Issues

Relapse Prevention – Everyone's Role is Important

- Every aspect of the pilot's After-Care Team is a vital stakeholder to relapse prevention.
  - System-based approaches work best.
  - Peer and Chief Pilot Meetings are critical tools.
  - Regular training and strong communication networks are vital.
- Do you really know *where* the pilot's program is at? *How* do you know?
- Design and implement qualitative measures – box checking isn't going to get it done.
- The FAA asks for good **recovery**, *not* just abstinence.

The Pilot Relapsed – What Now?

- Respond with compassion, empathy, & be mindful of the stigma the pilot feels associated with the event.
- Stigma is a barrier to truth.
- Ensure support of the Program –the pilot's health, safety and welfare is *always* first.
- Remove from flight status via appropriate means.
- Notify the Pilot's HIMS AME.
- Enact HIMS Relapse Protocol for your respective airline.

How are Relapses Handled in Real Life? -- Case Study

- Senior Captain. Previous DWI history.
- Presented initially to HIMS for alcohol-use concerns by co-workers and management pilot.
- Pilot going through difficult divorce, admitted he had a drinking problem and was a self-referral into HIMS.
- Pilot had elevated ETG on two occasions. Negative PeTH. No concerns from peer, AA Sponsor, or Chief Pilot.
- Conferring with drug testing coordinator, had history of *multiple failed ETG and ETS' over the last 12 months.*

How are Relapses Handled in Real Life? – Case Study

Pilot went for secondary Substance-Use Disorder Evaluation at different facility from where they initially went to treatment. They found him to be in good recovery.

…but, then the labs/drug testing came back.

Pilot tested above the highest measurable lab value for Kratom.

Confronted, the Pilot got honest and succeeded in recovery after secondary treatment.

Moving to the front brain

- Joy, collected over time, fuels resilience – ensuring we'll have reservoirs of emotional strength when hard things do happen.

  - Brene Brown

Precipice Lake – High Sierra Trail 2021

Recovered

- “That is the miracle of it. We are not fighting it, neither are we avoiding temptation. We feel as though we have been placed in a position of neutrality – safe and protected. We have not even sworn off. Instead the problem has been removed. It does not exist for us. We are neither cocky nor are we afraid. That is our experience. That is how we react as long as we keep in **fit spiritual condition**.”

Where to find me

RECOVERY MEDICINE

830 201-0880

3300 Junction Hwy
Ingram, Texas
Virtual Appointments available

Sarah McDonald
Director of Strategic Partnerships
361 290-6580
smcdonald@lahacienda.com

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