

STATEMENT OF THE HONORABLE RICHARD H. JONES, DEPUTY ADMINISTRATOR, FEDERAL AVIATION ADMINISTRATION, BEFORE THE SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION, CONCERNING SUBSTANCE ABUSE BY AIRLINE PILOTS. FEBRUARY 18, 1986.

Mr. Chairman and Members of the Committee:

I welcome the opportunity to appear before the Committee today to describe for you the approach we have successfully used within the FAA to deal with the potential of substance abuse by airline pilots.

As the Members of the Committee are aware, despite our best efforts to build fail safe systems and to provide redundant safety features in transport aircraft, the aviation environment is nevertheless one which can be unforgiving of mistakes. There are times when a pilot must react to an emergency situation immediately, precisely, and without error, to avoid tragedy. It is with this requirement for a high order of precise skill and judgment in mind that we have established a strict regulatory framework concerning the use of alcohol or other drugs by air carrier pilots.

In fact, as an outgrowth of the approach we have taken, cooperation and support within the aviation community, and a strong commitment to safety within the industry, there have been no accidents in United States scheduled passenger service that have been determined to be related to alcohol or other drug usage.

Nevertheless, as I will describe for you, we have continued to upgrade our regulatory requirements where improvements could be made, particularly with respect to alcohol use which has been traditionally a greater cause for concern. We intend, however, to continue to remain cognizant of possible drug use by the pilot population, in order that we may take such appropriate measures as may be indicated.

I would like to take a moment now to outline our basic regulatory requirements for you. FAA operating regulations prohibit the use of alcohol by a pilot (or crewmember) for 8 hours before serving as a crewmember. They also prohibit serving as a pilot (or crewmember) while under the influence of alcohol or while using any drug (whether an illicit drug or not) which affects the pilot's capabilities in any way contrary to safety. To complement these regulations, we adopted new regulations last April which specify that a blood alcohol level of .04 percent by weight is evidence that a pilot is under the influence of alcohol. We have recently promulgated another rule, to be effective this April 9, which will require air carrier crewmembers to submit to a blood alcohol test when requested to do so by a local law enforcement official.

We also have in place medical regulations which make an individual ineligible for the issuance of an FAA medical

certificate, necessary to serve as a pilot, if that individual has an established medical history or clinical diagnosis of drug dependence or alcoholism, unless there is satisfactory evidence of sustained total abstinence from alcohol for at least the preceding two years. Airline pilots are required to undergo medical certification every six months; copilots are required to undergo such certification annually.

As indicated, we have a comprehensive framework of regulations intended to promote safety through strict prohibitions against the use of substances which might adversely affect a pilot's performance. What we learned in the 1970's, however, was that an inflexible approach to applying these regulations was probably frustrating the receipt of safety information by the FAA. More specifically, we were getting few reports of alcohol abuse by air carrier pilots. This concerned us, and we concluded that it resulted from fear on the part of pilots and other crewmembers that either seeking help for themselves or reporting others for alcoholism would cause the FAA to revoke their certificates, and end their means of livelihood. This led to a different approach by the FAA, under which a pilot, with strict monitoring and rehabilitation, could return to air carrier pilot duties. That program has proven highly successful, as I will describe.

The approach, adopted by the FAA in the mid-1970's, was to permit the return of airline pilots to flight duties within

relatively short periods of time after release from an inpatient facility--perhaps as little as three months--but under strict surveillance and with intense rehabilitation efforts.

The process starts when a pilot is first identified as having an alcohol problem and acknowledges that to be the case. The pilot is then placed in a treatment program--typically a month long program on an in-patient basis. After receipt of this initial treatment, the pilot must apply to the FAA for approval to return to flight duties. We require that a responsible medical source (for example, an airline medical department or the medical representative of the pilots' union) sponsor the pilot's request for certification. Further, the pilot must be checked by experts identified by the FAA, who will screen not only for underlying medical problems which have resulted from the alcoholism but review the progress of rehabilitation as a source independent of the treatment facility. Moreover, these experts can develop a baseline for continued monitoring of the recovery process and assist in judgments concerning the degree to which surveillance can be relaxed. I should note, at this point, that the continued medical certification of the pilot is based upon total abstinence.

The pilot is then carefully monitored for at least two years by the medical sponsor, who is required to report each six months

to the FAA on the status of the pilot's rehabilitation. As part of the overall monitoring of the pilot, a peer representative of the pilot and the pilot's flight operations supervisor are responsible for monthly reports to the medical sponsor on the pilot's progress. In addition, the pilot must continue treatment on an outpatient basis which provides a further source of periodic reports to the medical sponsor as well.

So far, over 600 pilots have been returned to flight duties under this program. We have experienced a success rate slightly better than 91%, with success defined as no relapses over a 2-year period following the return of medical certification. Interestingly, recovered alcoholic airline pilots have become the strongest supporters of this rehabilitation program and the FAA's stringent monitoring requirements.

In closing, Mr. Chairman, I would reiterate that we have been concerned for many years about the need to avoid the potential adverse impacts of substance abuse on aviation safety, and have taken a number of measures to address this issue. As earlier noted, these efforts have proven worthwhile and have assisted the industry in compiling an outstanding record in this area. We continue to be concerned about the potential for such problems, however, and, if we identify areas needing improvement, we will not hesitate to take such additional

measures in the future as may be determined necessary to protect the flying public.

That completes my prepared statement, Mr. Chairman. I would be pleased to respond to questions you may have at this time.