The ASAM Placement Criteria (2013)

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The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions: Safety-Sensitive Occupations (p. 340-349)

SAFETY-SENSITIVE OCCUPATIONS

Safety-sensitive workers can come from many different occupations, including:

- **Police officers**
- **Health care professionals**
- **Airline pilots**
- **Attorneys**

Here, you will see the four qualities that lead to the distinct needs for this special population.

Safety-sensitive workers with substance use disorders have four special qualities that lead to important and distinct treatment needs:

1. All safety-sensitive workers, by definition, have a responsibility to the public. The extent of the effect comes from two factors:
    a. The size of the population safety-sensitive workers effect and the depth of the effect from potential impairment, and
    b. The amount of public trust that is implied in that worker's occupation.

    Both these factors place a burden on treatment, its efficacy, and the importance of that patient's recovery for overall public welfare. These two factors color decisions that are made regarding the type, intensity, and setting of treatment provided to this special population.

    It is important to note that aggressive treatment and continued monitoring does more than assure the safety of the public at large. The consistent and sustained care of one individual helps his or her entire cohort. For example, if a police officer suffers an addiction relapse that has the slightest possibility of an adverse effect on public safety, his peers, the leadership of the police force, officials in the government jurisdiction served by the police force, and public opinion may reactively punish subsequent officers who develop a substance use disorder. "Guilt by association" is not an altogether appropriate term for such realities. In contrast, the compulsory and consistent management of a given individual's recovery status "pays forward" to others in his or her cohort; success of treatment and recovery for the one can have a positive "halo effect" for the many in that individual's occupational or professional cohort.

2. Safety-sensitive workers do best when offered cohort-specific treatment, which facilitates adequate self-disclosure and the subsequent repair of the damage produced by past substance-related behaviors. Once they develop a substance use disorder, many safety-sensitive workers compromise their job efficacy and (although less often than sensationalist journalism might suggest) at create public harm. When it happens to someone in the general public, harm from substance misuse or addiction has a limited size-effect. In the safety-sensitive worker, however, the depth and breadth of the potential damage to the public and the environment can be much larger. Addiction in a nuclear plant manager has an effect size that is greater than in a retail worker, for example. Most individuals in safety-sensitive positions take their oath of duty to heart; the breach of this commitment engenders shame. Safety-sensitive workers need to disclose, accept responsibility, normalize, and learn to prevent any future breach without excessive self-castigation. Participation in group therapy and/or support groups by individuals who have similar work issues and who conduct themselves under the same professional codes for ethical behavior is essential for a return of a healthy self-concept, and for a decreased probability of relapse. Such needs often prolong the treatment encounter.

3. Some safety-sensitive workers have direct access to addicting substances. Health care workers (physicians, advanced practice registered nurses (APRNs), physician assistants, dentists and dental workers, veterinarians and animal workers, nurses, pharmacists, and drug manufacturers) commonly have ready access to addictive substances. Police officers, especially those in undercover drug operations, have easy access to gray and black-market drugs. Attorneys who represent drug traffickers may also find an unfettered access to highly addictive drugs. The treatment of such individuals should include management of drug access, drug refusal skills, work environment modification to decrease drug access, and other occupation-specific interventions geared to decrease relapse. This too may require additional time in treatment to allow the patient to learn the complex skills necessary to remain abstinent in an environment that is "hostile," or at least not "neutral," when it comes to providing support for abstinence and recovery.

4. Health care professionals commonly have difficulty adopting the role of the patient. The origins of this difficulty are beyond the scope of this document. However, one needs to become a patient before treatment can successfully commence; this is especially true for behavioral health care workers. The more responsibility an individual has in his or her day-to-day life, the more difficult it is to adopt the patient role—one that accepts suggestions and sets aside one's well-formed worldviews, which may have become distorted by substance use. For example, academic health care workers who serve as faculty in a health professionals' school, or who may be medical directors of hospital or other treatment facilities, have the most difficulty in this regard. They have such special expertise and depth of technical knowledge that they over rely on those assets. They may have difficulty maintaining the patient role and accepting the recommendations of their own treating physician or clinician.

SAFETY-SENSITIVE WORKERS' KEY QUALITIES

1. **All safety-sensitive workers, by definition, have a responsibility to the public.**
2. **Safety-sensitive workers do best when offered cohort-specific treatment, which facilitates adequate self-disclosure and the subsequent repair of the damage produced by past substance-related behaviors.**
3. **Some safety-sensitive workers have direct access to addictive substances.**
4. **Health care professionals commonly have difficult adopting the role of a patient**

SETTING

During the initial diagnostic portion of the treatment experience, safety-sensitive workers should discontinue work. They should stay away from work until:

1. Public risk issues have been addressed and appropriately managed
2. All work regulations, licensure, and legal issues have been addressed and permit a return to the workplace
3. Work cues and triggers have been delineated, and a management plan is in effect.
4. The work environment has made appropriate alterations to maximally encourage sustained recovery. This is especially important for workers who have steady personal access to their previously addictive drugs.
5. Supervisory personnel have training to address profession-specific workplace issues for the recovering addicted worker.

Removing the worker from his or her work setting may involve Level 3 care, but, at the very least, the initial treatment setting should shield the patient, coworkers in the work environment, and members of the general public from the potential dangers created by addiction in the workplace. Specifically, when the patient in need of substance-related or co-occurring disorders is a health professional, that individual should not return to practice and those expose their own patient to the potential dangers posed by their own addiction. Abstinence and recovery should first be solidly established, and risks of relapse in the workplace should be fully identified with an initial management plan for those in place.

In addition, the setting of addiction treatment for safety-sensitive workers should reflect the reality that treatment is best executed for such persons in a milieu containing one's peers. This may necessitate travel to a specialized facility with expertise and a sufficient number of other patients with the same or similar professional training, licensure, and work environment as the safety-sensitive worker entering treatment. Once the patient (the worker with a substance use disorder) has accepted and internalized his or her need for addiction care, effective management of occupation-specific stressors is established, and triggers and recovery skills are addressed, safety-sensitive workers can usually continue their treatment in more generalized addiction care.

SUPPORT SYSTEMS

Safety-sensitive workers demonstrate similar medical and psychiatric comorbidities as the general population, except for a decrease in the probably of psychotic disorders (these tend to be screened out during the professional training). An efficient and well-integrated continuum of care is the most important component of the support system. Management of medical issues may be especially challenging with health care workers, as they are prone to critique their personal medical care due to "insider bias" and the misguided belief that they are their own best doctor, nurse, pharmacist, counselor, etc.

Many subgroups of safety-sensitive workers have profession-specific recovery monitoring programs that improve outcomes and increase public safety. Most states in the U.S. have Physician Health Programs, for example. Many nurses, dentists, pharmacists, airline pilots, and attorneys in the U.S. have comparable programs. Similar programs exist in many countries, with varied degrees of sophistication. Treatment providers must learn about each of these support networks, learn how to interface with such programs, and how to refer to and support the continued development of these programs. Indeed, these monitoring programs are critical for the long-term success of the safety-sensitive worker. Such programs are best visualized as an integral part of the continuum of chronic care for the chronic disease of addiction.

It is the job of initial treatment providers to seek out any available monitoring program for a patient under their care, and to help the safety-sensitive worker understand that these monitoring programs are an integral part of their care. Such programs are critical in maintaining a good outcome and are more than just an optional "support system." Monitoring programs that are independent of licensure and credentialing bodies provide a means of continuous support and advocacy for the patient whose career is a safety-sensitive occupation. Research has shown that such programs dramatically improve long-term prognoses as well. The combination of effective, manager initial treatment and long-term contingency contracting has been proposed as the gold standard for all addiction care in the United States.

Beyond formal monitoring and case management programs such as the Physician Health Programs (PHPs) and Lawyer Assistance Programs (LAPs), peer-led cohort-specific support groups may also be available. Physicians have "Caduceus" groups, pilots have "Birds of a Feather" groups, and attorneys have attorney-specific Alcoholics Anonymous groups, for example. Unlike monitoring programs, these support groups use volunteers and mutual help to ensure the recovery of each member. These mutual help groups are at times integrated into a monitoring program; in other places they are distinct. Treatment providers should locate peer-specific support groups for a patient under their care and integrate them into treatment whenever and wherever possible. For example, a treatment program may provide information to patients about International Doctors in Alcoholics Anonymous (IDAA), and help its patients register for and attend IDAA conferences.

Cohort-specific treatment of safety-sensitive workers may require travel to another part of the country, or even to another country. Such programs often have decades of experience with the subtleties of treatment in a particular cohort. Especially since the wars in the Middle East of the past quarter century, and since the events of September 11, 2001, the need for trauma-informed care for members of the armed forces, local first responders, and public safety officers has led to the development of specialized treatment programs or treatment tracks tailored to the needs of persons in safety-sensitive occupations outside of health care. Specialized treatment cohorts are available for police and fire fighters to go through treatment with others who have comparable workplace experiences.

However, addiction is a chronic disease requiring chronic care. Therefore, the specialty programs located away from a patient's home should seek out practitioners in the worker's home locale that have demonstrated expertise in step-down care of safety-sensitive workers. Conversely, the local practitioner who focuses on a specific cohort should learn about the step-up facilities that have demonstrated expertise in their target population and be willing to refer his or her patients to such facilities. These offer the patient a cohort of peers with whom they can relate regarding workplace, licensure, and return-to-work issues.

STAFF

Treatment staff that work with safety-sensitive workers need a variety of therapeutic skills. Every staff member in a multidisciplinary setting need not have all skills, but all of the following skills should be at hand to ensure a positive outcome. These staff skills are as follows:

1. The staff should be trained in the specifics of their patient's work environment (eg, staff who work with pilots should know about aviation training, changing shifts from day to night, aviation-ingrained thinking patterns, and concerns over aero-medical and FAA rules and regulations).

2. The staff needs supervision to avoid reactive judgment and negative confrontive interpretations (e.g., "When you were working undercover, you arrested the same person who sold you drugs the previous day?"). Such insights are important in the process of discovery, shame, and commitment to recovery, but the staff must guide such insight, not demand it before the patient is ready.
3. The staff needs training to be able to manage the dynamic defenses of the particular cohort (e.g. learning how to circumvent argumentation with attorneys who are patients under their care).
4. The staff needs to manage intellectualization in highly educated safety-sensitive workers, and be sensitive, empathic, skilled, and firm when working with a patient whose occupation requires him or her to assume great responsibilities. Such individuals may be in the position of making decisions that affect many employees or subordinates, but their personal recovery requires them to be open to advice and even direction of their clinical caregivers.
5. The staff needs to understand the stresses and traumas that often accompany safety-sensitive positions. Staff with direct experience are helpful, even mandatory. One example might be having on staff a former fire fighter who has experienced the horrors of managing a conflagration of several city blocks.
6. The staff needs to understand the political context of addiction care in the patient's particular cohort. This is critical when giving advice to a safety-sensitive worker regarding self-disclosure after treatment and how best to reintegrate into his or her work environment.
7. The staff needs to understand, interface with, and work within the established continuum of care that may be present for a specific cohort and know what will be expected at the next point of care, including reporting progress and raising concerns when appropriate.
8. The staff will have to know about specifics of drug testing in health care practitioners with substance use disorders, including the types of drugs typically used in that cohort and their effects on the brain and body.
9. The staff will have to develop confidence in addressing a patient's cognitive abilities, have access to neurocognitive testing, and understand when to take action to delay or prohibit a physically or cognitively impaired safety-sensitive worker from returning to work. This limit-setting skill is both intellectually challenging and emotionally difficult, particularly when the treating clinician identifies with the professional who is a patient under his or her care.

THERAPIES

Profession-specific Group Therapy

Therapy skills of safety-sensitive workers vary according to their cohort. Put another way, not every patient who is a safety-sensitive worker has the same "psychological-mindedness" or is equally adept at being a constructive member of a therapy group of a therapeutic milieu. Many health professionals who are in treatment, for instance, slip into role of "junior therapist" in groups or within the patient community. These tendencies need to be managed skillfully, without having patients feel ashamed when they realize how they have been conducting themselves.

All types of safety-sensitive workers should have a setting where they talk openly with peers and staff about their responsibility to the public, and how this was potentially or actually breached in the course of their addiction. This type of therapy is best performed in a group setting. A specific reparative sequence occurs, where the patient discloses fully, and subsequently takes responsibility for his or her past actions. The group then normalizes such events without minimizing them, and the patient learns to prevent any future breach without falling into nihilistic self-blame. Safety-sensitive workers who intellectualize (of course, this means virtually all of them early in treatment) tend to move from the disclosure to a false normalization stage of intellectual acceptance without proper emotions and dynamic internalization.

Profession-specific Support Groups

Profession-specific support groups are distinctly different from (and often confused with) profession-specific group therapy. Support groups may be in the format of 12-Step groups or a more informal discussion group. They may be led by a professional facilitator but are more often organized and led by volunteers from the same cohort. The purpose of such support groups is to provide understanding about the substance use disorders in that profession and normalize past behaviors (normalizing is different from absolving blame or responsibility). Members of the group who are further along in recovery provide mentorship, sponsorship, and hope for patients who have just entered the support group. The group addresses the nuts and bolts of how to work in a safety-sensitive occupation with a history of a substance use disorder, and how to interact with coworkers, supervisors, and those who rely on the patient's future integrity.

Job and Career Issues

Proper treatment of a substance use disorder in a safety-sensitive worker should address the pragmatic, logistical, and emotional problems that the worker will face in recovery. Such information and its processing may occur in profession-specific group therapy (discussed earlier), but commonly needs to be addressed in individual sessions as well. The therapist assigned to occupational reentry should understand the profession of the patient. The therapist often works with a supervisor, credentialing body, licensing board, and workplace peers to structure work reentry. Reentry should be staged and timed to ensure the best possible prognosis for the safety-sensitive worker, lest public opinion be swayed against the profession or, more dramatically, a member of the public is placed in harm's way.

Drug Safety and Drug Refusal Skills

Safety-sensitive workers who are in many health care fields may be required to handle, on a daily basis, the same drugs to which they are addicted (e.g., an opioid-addicted anesthesiologist who handles her drug of choice every day during the course of a routine work day). Much of the success of their clinical recovery and reintegration into work comes from proper environmental controls (e.g., ensuring narcotics accountability systems are in place in a veterinary practice) combined with drug refusal skills. Health care professionals need a very different set of skills than the alcohol-addicted person who goes to dinner in an environment where alcohol is served. Cue exposure, role-playing, workbook activities, and experiential therapist should all be used in combination to ensure that the health care worker is prepared for returning to a high-risk environment.

Medication Management

Pharmacotherapies for addiction (such as the prescribing of an opioid receptor antagonist) may be useful components of a treatment plan and return-to-work agreement. Programs and physicians who treat commercial airline pilots must be especially cautious about prescribing medications for addiction or co-occurring conditions, carefully balancing the pilot's need for medication with the grave consequences to his or her career should a non-approved medication be prescribed. Physicians who treat commercial pilots should be familiar with Federal Aviation Regulations (FARs) 61.53, 67.113, 67.313, and 91.17.

ASSESSMENT/TREATMENT PLAN REVIEW

The Assessment and treatment planning process in the treatment of safety-sensitive workers is complicated by two factors:

1. The difficult line between an individual's privacy needs and the imperative for public safety. This is covered in the documentation section.
2. The need for more extensive cognitive testing in safety-sensitive workers.

The assessment process should, naturally, involve family members and peers at work as collateral sources of historical data. Often, formerly high-functioning individuals will show a more intense deterioration at home while they try (and are successful for a time) to hold their career together. Those conducting the assessment should have the knowledge and experience to realize that the workplace is usually the last domain of a health professional's life to manifest signs of impairment, and that just because there have been no "workplace incidents" does not mean that the patient's addiction is not serious or even advanced.

A careful balance between the patient's need for privacy and the work environment's involvement exists here too. The work environment must be involved because the breadth and depth of the breach in public safety (if any) must be assessed. This often conflicts with the patient's need for privacy. A multidisciplinary team should work on this balance for each patient they assess.

Neurocognitive testing should be performed in almost every case. Such testing requires a seasoned neuropsychologist who can determine how the results of a substance use disorder impact the safety-sensitive worker's work. Neurocognitive testing should be covered by third party payers.

Assessment of comorbid psychiatric and medical disorders is crucial, as with any patient who suffers from a substance use disorder.

Treatment planning and its review for the safety-sensitive worker should include the following elements:

1. A commitment to a long-term, de-escalating treatment process with checks and balances that ensure the public's safety.
2. Structured, long-term schedules for body fluid or tissue analysis (collection of samples of urine, saliva, hair, etc., for drug testing), which ensure the best treatment prognosis and thus public safety.
3. Involvement of the patient's work environment, which provides input into treatment issues, managed and scaled work reentry, work environment safety (to prevent relapse), and management of certification and licensure issues.
4. Contingency planning that would come into effect should the individual discontinue treatment without a viable alternative (to prevent a surreptitious and premature reentry into the workforce).
5. The involvement of profession-specific group therapy (if available) and profession-specific support groups.
6. Neurocognitive testing and repeat neurocognitive testing, if indicated.
7. Other therapist noted in the therapies section.

DOCUMENTATION

Documentation in the treatment of safety-sensitive workers necessitates a balance between the needs of the patient and the needs of the public. Strict confidentiality with regard to the patient's record will engender trust. On the other hand, many safety-sensitive workers require letters of other forms of communication that attest to their overall condition. This type of reporting is commonly an ongoing process for a number of years and may include updates as to the patient's status to licensing boards, superior officers, a state bar association, commanding officers, or regulatory bodies.

At times, these agencies demand more specific information than a simple Safe/Unsafe to work assertion. Disclosure of limited information in the medical record may be required before that individual is cleared to work. Thus, the medical record in facilities that care for safety-sensitive workers must be clearly delineated into "potential release information" and "strict privacy" sections. All treatment providers must be aware on a daily basis that their chart entries may result in a complete loss of their patient's professional career if careful attention is not paid to detail.

Every evaluation performed on the safety-sensitive worker patient must be carefully conducted with such information in mind. Some evaluators split their evaluations into two parts, one focused on the patient's ability to work and a second focused on internal treatment needs. Many consider such a process to constitute best practice in the medical records management of this population.

DIAGNOSTIC ADMISSION CRITERIA

The diagnostic admission criteria for the safety-sensitive workers who have a substance use disorder do not differ in form from diagnostic admission criteria for patients from the general public. The final treatment placement, however, may need to be distinctly different for reasons described in this section.

One notable exception to the diagnostic admission criteria exists. In an effort to ensure all professional pilots are not underdiagnosed, and to ensure public safety, pilots in the United States are subject to 14 CFR 67.107. In this section of the U.S. Code of Federal Regulations, both the DSM-IV diagnoses of substance abuse and substance dependence are treated in a similar fashion. Pilots who meet DSM-IV criteria for substance abuse are to be treated in a fashion similar to those diagnosed with substance dependence. This issue will change in a yet to be determined manner after the implementation of the DSM-5, which no longer distinguishes between "substance abuse" and "substance dependence."

Careful assessment is important with safety-sensitive workers, as they may derive intense secondary gain from underreporting symptoms of any substance abuse disorder. The final treatment disposition of a safety-sensitive worker with a substance use disorder should commence only after a thorough assessment is complete, including interviews with (usually more than one) a collateral source of information, such as a workplace superior, a coworker, and/or a spouse.

PERSONS IN SAFETY-SENSITIVE OCCUPATIONS: DIMENSIONAL ADMISSION CRITERIA

Dimension 1: Acute Intoxication and/or Withdrawal Potential

In Dimension 1, withdrawal management can be provided at any level that is medically appropriate, provided that the individual is kept from his or her work if there are known or suspected concerns for public safety.

Dimension 2: Biomedical Conditions and Complications

In Dimension 2, biomedical problems may prove especially vexing in health care professionals who "know too much for their own good" and attempt to direct their personal care without input from their real medical team. Experience has shown that health care providers can develop a rigid but incorrect analysis of their own medical illnesses, often to their own detriment. Data shows that physicians with a substance use disorder often have no personal physician, and have not received the usual, periodic physical examinations or preventative health care procedures. A firm hand combined with differential diagnosis acumen should be applied to all such patients.

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

The emotional and behavioral needs of safety-sensitive workers are similar to those of the general public. Physicians, for instance, have rates of depression that are comparable to rates among the general public (though their rates of suicide are higher). As previously described, the safety-sensitive worker must have a more comprehensive assessment, and a more measured approach to intellectual deficits caused by substance use disorders, whether acute of chronic. The older adult patient may attempt to cover up cognitive slippage in an attempt to return to a demanding job that is central to his or her life meaning.

Dimension 4: Readiness to Change

This dimension is important in the care of safety sensitive workers. Workers are often motivated and ready for action in order to keep their job more than they are interested in recovery and wellness. It is usual for them to be quite ambivalent about whether they have an addiction or not. Safety-sensitive workers may be very intelligent, have years of post-secondary education, and may learn the language of recovery quickly. They can repeat it back to the staff and combine their words with whatever sincerity they perceive will maximize their chances of quickly returning to their work or profession. As summarized in "walking the talk," assessment of a patient's stable progress in stages of change involved tracking outcomes in behavior, attitude, application of skills, and reports of improvement from collateral sources, not just what a patient says.

For patients in non-safety-sensitive occupations, progress in the other five dimensions may be such that one would normally return the patient to a work setting. However, for patients in safety-sensitive occupations, the treatment team may need to hold ambivalent individuals away from the risky portions of their work, or keep them from their work completely, until Dimension 4 issues mend. Because risks to the public are so high, skilled individual and group therapists assess for measurable improvement in readiness to change to be sure that recovery is well underway before returning the worker to full work activity.

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

The most important issue in Dimension 5 comes from what is termed "relapse tolerance." Substance use disorders, including other addictive disorders are, by nature, potentially relapsing disorders. The normal course of care is to work with a patient over time, often through repeated recurrences of signs and symptoms, until the patient fully and consistently understands the total impact of the negative consequences of his or her continued substance use, and the mounting life problems associated with such use. Even after the illness is internalized, the patient may lapse into alcohol or other drug use from time to time. With safety-sensitive workers, there is not the luxury for the treating clinician to stand back and sagely watch while a series of lapses and relapses helps the patient internalize full acceptance of his or her addiction. For many safety-sensitive workers, there can be little or no tolerance for relapse. This intolerance comes from two places: (1) the potential for real public harm, and (2) the reprisal from licensing agencies, legal action, professional organizations, or command structures.

Careful attention must be paid to relapse prevention. All types of relapse prevention skills should be taught and effectively displayed back to the treatment team by the patient. Traditional lecture formats are of limited benefit in learning these skills. Skills in cognitive-behavioral therapy, de-escalation of harmful thoughts and emotions, drug refusal skills, and moving away from high-risk stimuli should be practiced prior to a return to work. All safety-sensitive workers should have a confidential individual, sponsor, or therapist ready at their fingertips when triggered to relapse, so that urges do not become drug use behaviors.

All safety-sensitive workers should participate in random, observed drug-screening program of sufficient sophistication to detect surreptitious substance use or other addictive drug/alcohol use which was not identified in the original assessment. Such drug screening of body fluids and hair provides reassurance to the workplace system at risk were to individual to relapse to use. It also provides a comfort to the patient who has a substance use disorders. Treatment providers often hear: "I had a craving and began thinking about using, and then thoughts about those drug tests popped in my head. I realized that if I used, the test would show it, and that I couldn't hide it. I felt disappointed and safe at the same time."

Dimension 6: Recovery Environment

All patients who develop substance use disorders need to address their environment. In the case of many safety-sensitive workers who have drug exposure in their workplace, the work environment should be modified to accommodate the patient returning from treatment for a substance use disorder. Early in recovery, when their recovery is fragile, it may be necessary to limit drug exposure in this subgroup. All safety-sensitive workers should also have decreased exposure to alcohol.

Safety-sensitive workers are no different from others with substance use disorders in needing to address their living environment. Returning home to a using spouse, or to a spouse ignorant of or even hostile to recovery, is not a safe path to ongoing recovery. Moving from a highly structured treatment environment to living alone, in isolation, is never recommended. Some sort of extended residential care in a halfway house or sober house, especially one designed for professionals in safety-sensitive occupations, is preferable to living alone, especially during early recovery.

Levels of Care

With concerns for public safety in mind, treatment should be aggressive and definitive. Many safety-sensitive workers are given only one change to attain recovery by licensing boards, professional organizations, command hierarchies, and civil agencies. With this in mind, the initial level of care that provides the best possible prognosis should be selected. Referral to the "least restrictive environment for care" is generally the norm for members in the general public who seek addiction treatment. But for those living under a "one strike and you're out" professional environment, where there is "zero-tolerance" of any lapse or relapse, the driving force behind the level of care chosen is the level that has the best chance of establishing stable recovery.

Containing the alcohol or other drug use and sequestering the patient away from work may mandate a more intensive level of initial care than with the general public. "Fail first" requirements for admission to a more intensive level of care are formulae for disaster when designing treatment plans for this special population of individuals with substance-related and co-occurring disorders. Many workers in the health professionals treatment field have seen suicides. Such experienced clinicians have also seen cases of the public being placed at risk by a safety-sensitive worker who was sent to a less intensive level of care because of misplaced notions based upon application of the ASAM criteria without taking into account the dangers attendant to the patient's occupation.

Transfer to a less intensive level of care should occur only if that level of care has exhibited past expertise in managing the multiple patient-and environment-related issues for the patient's professional cohort. The lack of expertise at a less intensive level of care may necessitate treatment away from the patient's geographical home or remaining in a more intensive level of care for a longer period of time.

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