SUBSTANCE USE DISORDER PREAMBLE

Driving under the influence of marijuana, opioids and alcohol can have profound effects on driving. Almost 1 in 3 fatal motor vehicle accidents in Maine involved alcohol.[A] Use of illicit drugs or misuse of prescription drugs can make driving a car unsafe, just like driving after drinking alcohol. It's hard to measure how many crashes are caused by drugged driving, but estimates show that 43 percent of drivers tested in fatal car crashes were found positive for drugs and over half of those drivers were positive for two or more drugs.[B, C]

Many substances affect driving.[C] According to the National Academy of Sciences and the National Institutes of Health, there is evidence of an association between cannabis use and increased risk of motor vehicle crash.[D] Marijuana affects psychomotor skills and cognitive functions critical to driving including vigilance, drowsiness, time and distance perception, reaction time, divided attention, lane tracking, coordination, and balance. Opioids can cause drowsiness and can impair cognitive function. Alcohol can reduce coordination, concentration, ability to track moving objects and reduce response to emergency driving situations as well as difficulty steering and maintaining lane position. It can also cause drowsiness. The use of more than one drug or drugs combined with alcohol increase the effects on driver performance. The yearly prevalence of fatally injured drivers who tested positive for drugs increased significantly from 2007 to 2017. These findings highlight that drugged driving remains a public health priority.[E]

Clinicians are responsible to assess their patients for potential risks and advise them whether to drive or not based on their medications and medical conditions. Being alert to other medical or social history information that points to drug or alcohol abuse, such as gastrointestinal symptoms, falls or injuries, muscle or neurologic symptoms, infections, and social or work problems is part of that process. With this in mind, the clinician's role is to recognize high-risk individuals from a medical perspective and assess their physical and mental fitness to drive safely. Compliance with treatment and recovery is also a critical factor in determining whether a patient is stable and fit to return to safe driving. In addition, criteria for defining use versus abuse may be different in a community setting compared to use when in a treatment/recovery program where abstinence is a criterion. For specific details regarding abstinence and driving, refer to the FAP Table.

A diagnosis of Substance Use Disorder[F] can involve substance misuse or dependence and is diagnosed when a patient continues to use a substance or combination of substances at the expense of significant medical, social or legal consequences. *Please note that the descriptions of "Mild, "Moderate" or "Severe" in the Substance Use Disorder FAP Table,* ***do NOT*** *correspond to the similarly named categories in the DSM.*

In order to evaluate a patient for substance use-related fitness to drive safely, the clinician must take into account many factors. These include the substance/substances being used (e.g. alcohol, benzodiazepines, opiates/opioids, sedative-hypnotics, marijuana/cannabis, stimulants, heroin, cocaine, methamphetamine, and/or other street drugs), interactions between substances, including interactions with prescribed medications, the patient's insight into his/her misuse behaviors, his/her judgment about driving when intoxicated or impaired, the risk for polysubstance use and abuse, and the patient's ability or motivation to comply or participate in rehabilitation and recovery. In the context of alcohol or drug use this can be particularly challenging given the intermittent and/or relapsing nature of Substance Use Disorders.

Other medical risks or side effects related to Substance Use Disorder also need to be taken into account. For example, a person may have difficulty driving safely during periods of withdrawal from substances, especially alcohol and benzodiazepines where delirium and seizures are a risk. Withdrawal from opiates/opioids or heavy marijuana use can cause physical symptoms that would impair muscle control,

concentration and attention. Chronic heavy alcohol use[G] also puts a person at increasing risk for cognitive impairment and neuromuscular decline, both of which mean potentially unsafe motor vehicle operation. **Please note that a driver who suffers a convulsive seizure caused by abuse of or withdrawal from street drugs, prescription medications or alcohol is unfit to drive for a minimum of 6 months per NHTSA Driver Fitness Medical Guidelines.**[H] Clinicians also need to be aware of the risks to public safety from drivers that combine substances of abuse, and/or mix them with legitimately prescribed medications. Among the most significant substance mixtures are alcohol in combination with either marijuana or a stimulant such as cocaine; marijuana used along with either a stimulant, benzodiazepine or an opioid; and benzodiazepines combined with opioid. Methadone and benzodiazepines are an especially worrisome combination due to a greatly increased risk of sedation.

Currently, the legal environment surrounding marijuana/cannabis has seen several changes. Clinicians need to be aware of related safety risks. NHTSA's Fatality Analysis Reporting System (FARS) reported that drugs were present in nearly 43% of the fatally injured drivers with a known test result, more frequently than alcohol was present.[I] Over a 10-year study period, cannabis has been detected in the blood in an increasing number of drivers involved in fatal accidents (from 4.2% in 1999 to 12.2% in 2010 in one study of 23,591 fatal accidents).[J] The most recent NHTSA Roadside Survey[K] at the time of this writing, found drugs in 22% of drivers both on weekend nights and on weekday days.

Resources and Tools for Clinicians*:*
(These resources are not part of rules. They are provided for informational purposes only.)

- *Maine's Prescription Monitoring Program. As of April, 2015, the link to sign up as a PMP "data requester" is* http://www.maine.gov/pmp.
- *Screening tools for alcohol risk exist, such as CAGE[L] and AUDIT.[M]*
- *Laboratory assessment may give objective evidence for substance use or compliance with a recovery program. However, urine drug testing is fraught with pitfalls. Medical providers are strongly encouraged to educate themselves before interpreting drug test data (for example via the paper on rational urine drug testing cited here)[N]. Medical providers need to be aware of the parameters for detection of the laboratory they use.[O]*
- *Biomarkers for Alcohol[O]—Located in the Appendix*

FUNCTIONAL ABILITY PROFILE
Substance Use Disorder[1]

Profile Levels	**Degree of Impairment/ Potential for At Risk Driving**	**Condition Definition / Example**	**Interval for Review and Other Actions**
1.	No diagnosed condition	No known substance use disorder.	N/A
2.	Condition fully recovered	History of substance use disorder, in sustained recovery for 2 or more years, and *must not fit any* of the profile level descriptions below.	N/A
3.	Active impairment (Profile levels are intended to describe potential for at risk driving; they are NOT consistent with clinical definitions for mild, moderate or severe.)	Substance use at any point in the past two years that meets current DSM Criteria for a Substance Use Disorder; and	
	a. Mild risk	**No motor, judgment or intellectual impairment with NO history of consequences** such as, but not limited to, medical detox, drug or alcohol related seizure[2], adverse driving or legal consequences of substance use **for the past 12 months, & no more than 1 consequence in last 5 years.**	1 year Until criteria met for Profile Level 2.
	b. Moderate risk	**History of problematic substance use significant enough to cause motor, judgment, or intellectual impairment, and may include** drug or alcohol related events such as, but not limited to, motor vehicle crash, OUI or serious medical consequences. (E.g. medical detoxification or seizure[2] from use or withdrawal)	6 months (To resume driving after specified period of abstinence, driver must be medically cleared and pass a ROAD TEST.)

		Has been abstinent or has demonstrated overall compliance with treatment/recovery plan[3] for **at least 3 months** with *up to one* event in one year or *two events* in 5 years, ***EXCEPT*** *in case of convulsive seizure*[2] related to abuse of or withdrawal from alcohol or drugs. **Has at least 6 months of abstinence or compliance with treatment/recovery plan[3];** or **History of** *two or more* events in 1 year, *three or more* in 5 years, has been **abstinent or demonstrated overall compliance with treatment/recovery plan[3] for at least 1 year.**	
	c. Severe risk	**History of drug or alcohol related event(s)** including motor vehicle crash, OUI, or medical consequences (including medical detoxification or seizure[2] from use or withdrawal). **Driver has not been abstinent or has not been compliant with treatment/recovery plan long enough** to meet criteria for Profile Level 3.b.; **or** **Substance use significant enough** to cause permanent motor, judgment, or intellectual impairment. For dementia related to substance use, see footnote[4]	No driving

[1] For further discussion regarding SUBSTANCE USE DISORDER, please refer to Preamble at the beginning of this section.
[2] For other types of seizures, refer to Seizure /Epilepsy FAP.
[3] Patient demonstrates overall compliance with treatment or personal recovery plan. Patient must be abstinent or have only had minimal use that does not lead to actions that jeopardize public safety; no new driving incidents. Patient is stable and fit to return to safe driving.
[4] If patient has dementia related to substance use, use Dementia FAP.