

MORE THAN JUST AN ACCIDENT

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MORE THAN JUST AN ACCIDENT

Topic: Substance use and chronic pain

Abstract: Discerning the presence of a substance use disorder in the presence of chronic pain is difficult. This case presents the story of a 16-year-old boy who is medication dependent for management of chronic pain and is developing signs and symptoms that raise concern of a co-morbid substance-related disorder. Clinicians will discuss how to conduct an initial assessment and develop a brief treatment plan in the face of uncertain diagnoses.

Goal: To improve clinical skills in assessing and managing potential substance misuse by a patient who has chronic pain.

Objective: As a result of this session, learners will be able to

- Assess a patient with chronic pain requiring treatment with narcotic analgesics, who also has signs and symptoms of emerging drug abuse or dependence.
- Discuss the differences between physiological tolerance and withdrawal only, and the full presentation of drug dependence.
- Formulate an appropriate treatment plan for a patient who requires continued analgesia as well as management of possible substance abuse.
- Understand the importance of collaboration between pediatricians and child psychiatrists in managing substance use and chronic pain.

Themes: Adolescent Health/Chronic Illness, Adolescent Mental Health, Child Development and Behavior

Bright Futures Core Concepts: This case can be used to highlight communication, partnership, and advocacy.

Materials Provided:

- Facilitator Guide
- 3-part Case Narrative: Part I, Part II, Epilogue
- Handout #1: APA's DSM-IV diagnostic criteria for substance use disorders
- Handout #2: The CRAFFT screening test
- References

Facilitator Preparation: Facilitator should thoroughly review this guide and the other materials provided. At the end of the guide we have included a section entitled “Independent Learning/Prevention Exercises” that will further stimulate group and individual education on this topic. We anticipate that facilitators will modify implementation of the case session to best fit their educational setting and learners. For a summary of recommendations on leading discussions, please see Appendix #1 found in the Introduction to this manual.

MORE THAN JUST AN ACCIDENT: FACILITATOR GUIDE

Introduction

Substance use and abuse is prevalent among adolescents. There has been increasing emphasis in pediatric training programs on the screening and assessment of adolescents for substance use problems. However, some clinical situations are complicated and require modifications to the standardized evaluation. Patients with chronic pain and in need of opiate medication present a particular challenge.

When the condition of patients with chronic pain worsens, leading to increased doses of medication or refractoriness, a thorough re-evaluation is indicated. This may include coordinating care with other medical specialists or mental health clinicians. Close collaboration is essential during both the assessment and treatment phases. Some situations may be so complicated that the final diagnosis must be deferred. However, it is not necessary to have a final diagnosis to formulate and implement a treatment plan. Even asking the right questions in a caring and empathic manner can provide lifelong benefit to the patient.

OPEN THE DISCUSSION: INTRODUCE THE CASE TITLE AND THE SESSION GOAL. EXPLAIN THAT THIS WILL BE AN INTERACTIVE CASE DISCUSSION AND NOT A LECTURE. DISTRIBUTE PART I OF THE CASE AND ASK ONE OR MORE OF THE PARTICIPANTS TO READ IT ALOUD.

Part I: The Pediatrician's Office

Brian is a 16-year old boy whom you have followed in your pediatric practice since birth. He was a normal, healthy child with no medical problems until he was injured in a serious motor vehicle crash at age 10. He was an unrestrained passenger in the back seat of the family car during a one-vehicle accident on a rainy day. His mother, who was driving, suffered only minor injuries. Emergency department personnel suspected she had been drinking, but their suspicions were never confirmed. No one else was in the car or injured. As a result of the accident, Brian spent two weeks in the intensive care unit with a liver laceration, concussion, and multiple fractures. While he was hospitalized, Brian's mental status rapidly stabilized. He recovered without long-term neurologic sequelae. However, he has had major difficulties related to poorly healed pelvic fractures and subsequent orthopedic deformities. He has had multiple surgeries, and now has difficulty walking. He is in chronic severe pain necessitating opioid analgesia.

Yesterday his mother called the pediatrician's office to say that Brian had run out of pain medication again. The nurse told her that Brian would need to come to the office to get any prescriptions because his chart indicates that he's not yet due for refills.

Brian and his mother are waiting in the exam room. Dr. Jones, the pediatrician, asks how things have been. They both say, “Fine.”

“How has your pain been? What medications are you taking?” you ask.

“Well, Dr. Jones, he’s had more trouble lately,” reports Brian’s mother.

In addition to complaining of pain, Brian has been irritable and sleeping more, his mother says. She adds that currently Brian is taking gabapentin (600 mg three times a day) and oxycodone (three 20 mg tablets every twelve hours). Brian then chimes in with “Yeah, and it’s not enough.” Dr. Jones responds, “Hmm. I notice from your chart that we increased your oxycodone dose from 40 to 60 at your last visit. I’ve been giving you your prescriptions on a regular basis, right? So I’m a bit confused about why do you need refills today? My records show it’s not time yet.”

“Well I lost some pills, so I don’t have enough. And I really need them now.” Brian is looking down at the floor as he speaks, and appears quite sad. Dr. Jones asks about school, and Brian says he has been unable to attend any classes for the past 2 weeks because of his pain. He spends most of his time in bed or lying on a sofa watching television. His appetite has been unchanged, but he complains he is having trouble sleeping unless he takes “extra pain pills.”

Following this reading, ask all participants “So what do you think about this case? What would you like to focus on during our discussion today?” List agenda items on a blackboard or flipchart. Then use the questions below to guide the discussion. Remember that the key to successfully leading a small group is facilitation of the discussion rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions. Present material from the discussion guide only when needed to complement or redirect the group discussion.

GUIDING QUESTIONS FOR PART I DISCUSSION:

What aspects of Brian’s presentation are you concerned about?

Working with patients with chronic pain presents a significant challenge for primary care pediatricians. Knowing a patient and a family over time is certainly an advantage. However, at times patients will warrant re-evaluation. Brian’s presentation in this scenario affords a good opportunity to re-evaluate his pain and his use of medications. Brian has stated that he feels that his present medication is not sufficient to control his pain, although his dose is substantial. He also reports needing to take more than the prescribed amount of analgesic medication to sleep. This history warrants further exploration.

What is your differential diagnosis for his increased use of medication?

The group will likely have many questions for Brian at this point. It may be useful to make a differential diagnosis for increased drug use and think about how to use the history to narrow the differential. The facilitator may begin to organize the group's questions into a chart. Alternatively, the facilitator may ask the group to generate a differential diagnosis first and then fill in questions that would be useful in narrowing the differential. The following is a sample of a table that may be generated from a group discussion.

Acute medical problem

- When was the last time Brian's regimen was adjusted?
- Could he have outgrown his medications?
- Was there a sudden change in the pain?
- Any history of recent trauma?
- Are there surgical devices in place (such as pins) that could become dislodged?
- Has Brian had fever, redness, new swelling, or a change in the character of the pain that might suggest an infection such as osteomyelitis?

Psychiatric problem

- How has Brian been functioning in school and within the family?
- Has the family had any acute stressors?
- Is Brian showing signs of depression?

Substance use disorder

- Are any of Brian's medications addictive?
- Are they likely to be drugs of abuse?
- How much extra medication is Brian taking?
- Has Brian ever gotten prescriptions from another physician?
- Is Brian using substances other than his pain medications, such as alcohol, marijuana, or other drugs?

In addition to obtaining a more detailed history, the pediatrician should perform a thorough physical examination with particular attention to:

- His area of pain. Does he have point tenderness that would suggest a new orthopedic problem? Does he have changes in his range of motion, swelling or redness over the joint that might suggest an infectious process? If history and physical are suggestive of either of these processes, Brian might require further evaluation such as x-rays or blood cultures.
- Physical signs that would be consistent with recreational drug use:
 - Conjunctivitis
 - Pupil changes

Irritation of the nasal mucosa
Skin lesions such as needle marks

What would you do next?

History and physical examination can help to rule out medical causes of Brian's symptoms. However, questions remain about Brian's mental health and/or a substance use disorder. It may be useful to define common words in order to further the discussion regarding Brian.

DISTRIBUTE HANDOUT #1: DSM-IV CRITERIA FOR SUBSTANCE USE DISORDERS AND GLOSSARY OF TERMS. ALLOW THE PARTICIPANTS A FEW MINUTES TO REVIEW THE CONTENTS.

How do these terms apply to Brian? Many questions are likely to arise during this discussion. More information is needed to proceed.

DISTRIBUTE PART II OF THE CASE AND HAVE PARTICIPANT(S) READ IT ALOUD. TWO GROUP PARTICIPANTS MAY READ THIS PART AS A DIALOGUE.

Part II: The Psychiatrist's Consultation

Dr. Jones, the pediatrician, is concerned about the possibility of depression and emerging drug dependence. He decides to refer Brian to a child and adolescent psychiatrist, whom Brian sees the following week:

"Hello, Brian. It's nice to meet you. I'm Dr. Smith. Dr. Jones called me last week to say he was worried you might be depressed and said that your pain has been worse. What do you think?"

"I'm not depressed. I'm just in pain. You'd be depressed too if you had my troubles. I only came today because he won't give me my pain medicine until I talk to you. I don't know why he's giving me such a hard time."

"Hmm. I see. Dr. Jones did mention something about some lost medicine. Can you tell me a little more about that?"

Brian says he dropped some pills down the drain at his grandmother's house last week, and he also accidentally put his refill prescription through the laundry.

"Oh, that's too bad. I understand that your pain has been terrible lately. Has there been some recent change?"

"Well, you know, it was never good. I've always had pain."

“Right, I’ve heard that. Do you sometimes take more medication than Dr. Jones has prescribed?”

“Well...I guess so. But I have to; I keep telling him I need more medicine. I’ve even grown, and he hasn’t increased it. Sometimes the pain is so bad that I take an extra one of the small ones – you know, oxycodone. My Mom and Dad know, and they say I should if I need it. I’m not an addict or anything, although Dr. Jones seems to think I am.”

“Well, let’s talk about that. Do you ever take extra pain pills when you’re feeling upset or to relax?”

“Of course I’m not relaxed when I have pain! But I’m careful. I make sure I don’t do it too often.”

“I see. Well, let me ask you a few more questions. Have your parents ever wondered if you’re taking too much?”

“No.”

“Well, have you noticed any trouble with your memory or that you forget things when you’ve taken extra?”

“Oh, I don’t know. School’s been really busy lately, so it’s easy to forget some things. I can’t tell if it’s related to when I need more medication; but being in pain doesn’t help my memory.”

“Well, that may be, but the medications can also have an effect on your memory. Have you ever had trouble because of your pain medications?”

“You mean like being picked up by the police or something? No. The only trouble I have had is with Dr. Jones.”

“Have you had any problems at school, with your parents, or with your friends?”

“My parents almost always know when I’m taking extra; they trust me to take it only when I need it. My friends have nothing to do with this.”

“Brian, have you ever driven after taking extra medication?”

“Oh no, Dr. Smith, I’m very careful about that.”

“One more question about this, Brian, have you noticed that you need more medication to get the same result than you used to need?”

“Well, maybe. But I’m sure that’s because I’ve grown.”

Dr. Smith also screens Brian for mood and anxiety symptoms. Brian has no neurovegetative signs of depression, has never had any suicidal ideation and is actually quite hopeful about the future, despite his medical problems. He denies any significant anxiety symptoms as well, but does worry about his health.

GUIDING QUESTIONS FOR PART II DISCUSSION:

What do you think of Brian's situation now? Do you have other questions for him?

The group may notice that the stated referral question is related to possible depression, yet the psychiatrist doesn't start with that assessment. This is a very complicated case and both the pain and possible inappropriate use of medication must be explored early on. Both of these can adversely affect mood. However, they also can contribute to a presentation that resembles a primary depressive disorder and yet is not. Both Brian's pattern of pain and his medication/substance use must be investigated. In addition, the idea of being an "addict" is clearly on Brian's mind and must be addressed.

Distribute Handout #2 and review the contents.

The CRAFFT test is a brief screening device for substance abuse that can help the clinician identify serious alcohol and drug problems.

C "Have you ever ridden in a car driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?"

R "Do you ever use alcohol or drugs to relax, feel better about yourself or fit in?"

A "Do you ever use alcohol or drugs while you are by yourself, alone?"

F "Do you ever forget things you did while using alcohol or drugs?"

F "Do your family or friends ever tell you that you should cut down on your drinking or drug use?"

T "Have you ever gotten into trouble while you were using alcohol or drugs?"

Two or more "yes" answers on the CRAFFT suggest a serious substance-related problem or disorder and a score of four suggests a diagnosis of alcohol or drug dependence.

Ask the group how they think Brian would score on the CRAFFT .

Also note that the CRAFFT questions were modified to be relevant to Brian's situation. When asking the "R", relax, question, Dr. Smith used Brian's language referencing his use of an "extra one of the small ones." Using medication to "relax" rather than strictly for pain control, is a red flag for substance abuse. In this instance, it appears that the answer to the question isn't clear. However, a notable aspect of Brian's response to this question, and others, is his need to control his use. Whenever someone has the sense of needing to "control" his substance use behaviors, it is likely that he is struggling and may have a substance use disorder. The modifications Dr. Smith uses for the Car, Forget, Family or Friends and Trouble questions are fairly straight forward, even if the responses are less so.

Dr. Smith did not ask Brian whether he uses extra medication when Alone. Since Brian's use of the pertinent substance ostensibly begins with his pain, it would not be surprising for it to occur when he is alone. Generally, however, the Alone question is an important component of the CRAFFT screening. Most people will refer to its being "social" when talking about substance use; this is true for people at different stages of use. When someone has begun to use a substance when alone, the meaning of the use becomes quite different. It is then much more likely to be an activity that the person needs to do and may even feel ashamed or guilty about, and therefore it is indicative of a substance use disorder.

The group may still have trouble deciding whether or not Brian is abusing his medications after screening with the CRAFFT questions. Patients who are prescribed opioid therapy for chronic pain may range over a spectrum from complete adherence to drug dependence. Brian's pattern of use is somewhere between therapeutic use and abuse. He has been taking more pills than prescribed, yet it seems that most of his extra doses are to help with pain. Still, there are some hints (such as his need for control and his use of medications to relax) that he may be moving from strictly therapeutic use towards abuse. One may also wonder whether Brian has developed tolerance; however, this is also difficult to discern in the context of chronic pain in a growing adolescent. The group may debate whether they want to make a diagnosis. An important take-home message is that a diagnostic label is not critical here. Brian's presentation has raised concerns. A plan for intervention and monitoring can be made even without a formal diagnosis.

Dr. Smith's continued assessment of Brian—screening for mood and anxiety symptoms—is also very important and directly affects treatment planning. However, detailed discussion of this is beyond the scope of this case. The group is encouraged to read "The Transplant that Almost Failed," a case about depression in the context of chronic physical illness, for additional information on this topic.

What would you do next? How can Brian's pediatrician and psychiatrist work together to optimally manage his complex problem?

The Epilogue will provide a model for a treatment plan for Brian. Now that there has been a psychiatry consultation, group discussion of continued planning should focus on their current impressions and the need for collaboration between the two providers. Encourage the group to consider how the two clinicians might collaborate together and work with the patient to optimize care.

**DISTRIBUTE THE BIBLIOGRAPHY PAGE AND EPILOGUE.
ASK SOMEONE TO READ THIS EPILOGUE ALOUD.**

Part III: Epilogue

The next day Dr. Jones, Brian's pediatrician, and Dr. Smith, his psychiatrist, talk on the phone. Dr. Jones is reassured to hear that Brian does not have a mood disorder. However, he is quite concerned that Brian runs out of his medication before he should and that he always offers a different excuse for needing an early refill. Dr. Smith concurs that this is troubling, but she is not now convinced that Brian has a substance use disorder, especially in the context of Brian's chronic pain. She is convinced that Brian is at high risk, however. They work together to develop the following management plan:

- Dr. Jones will prepare a written contract for additional narcotic analgesic (i.e. "PRN dose") when needed to control Brian's increased pain, with specific limits: no more than one extra 20 mg. tablet of oxycodone per day. This will provide Brian with a greater sense of control over his treatment while limiting the potential for misuse
- Brian will not use extra medication or additional medications, other than that agreed to in the contract. One physician, Dr. Jones, will write all of Brian's prescriptions, and all of Brian's doctors will have open communication and knowledge of the plan.
- Brian will meet with an addiction counselor to receive education about substance abuse. He will also attend several Alateen or AA meetings.
- Dr. Smith will meet with Brian to discuss non-pharmacological coping strategies for pain management

Brian follows up with Dr. Jones a few days later to discuss the plan. He initially refuses to meet with Dr. Smith again or to see an addiction counselor. He does, however, agree to attend an Alateen meeting. In addition to the plan above, you counsel Brian to avoid the use of alcohol and illicit drugs, and to never drive after taking his extra medication.

Refer back to group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Independent Learning/Prevention Exercises: Facilitator may wish to assign "Independent Learning/Prevention Exercises" to the group, particularly if time constraints prevent the completion of the case. The following list includes suggestions to explore the available community resources that focus on adolescent substance abuse, as well as other avenues of pertinent interest that can be pursued during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Attend an open AA or Ala-non meeting

2. Invite a speaker from AA or Ala-non to speak at the session. If inviting a speaker, specify a young person in recovery.

**Meetings and possible speakers can be located by calling the AA or Ala-non central service number in the telephone directory.

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PART I: CASE NARRATIVE

The Pediatrician's Office

Brian is a 16-year old boy who you have followed in the same pediatric practice since birth. He was a normal, healthy child with no medical problems until he was injured in a serious motor vehicle crash at age 10, when he was an unrestrained passenger in the back seat of the family car during a one-vehicle accident on a rainy day. His mother, who was driving, suffered only minor injuries. Emergency department personnel suspected she had been drinking, but their suspicions were never confirmed. No one else was in the car or injured. As a result of the accident, Brian spent two weeks in the intensive care unit with a liver laceration, concussion, and multiple fractures. Brian's mental status rapidly stabilized while he was hospitalized. He recovered without long-term neurologic sequelae. However, he has had major difficulties related to poorly healed pelvic fractures and subsequent orthopedic deformities. He has had multiple surgeries, and now has difficulty walking and chronic severe pain necessitating opioid analgesia.

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"How has your pain been? What medications are you taking?"

"Well, Dr. Jones, he's had more trouble lately," reports Brian's mother.

In addition to complaints of pain, Brian's been irritable and sleeping more, his mother says. She states that currently Brian is taking gabapentin 600 mg three times daily, and three 20 mg. oxycodone tablets every twelve hours. Brian then chimes in with "Yeah, and it's not enough."

Dr. Jones responds, "Hmm. I notice from your chart that we increased your oxycodone dose from 40 to 60 at your last visit. I've been giving you your prescriptions on a regular basis, right? So I'm a bit confused about why do you need refills today? My records show it's not time yet."

"Well I lost some pills, so I don't have enough. And I really need them now."

Brian is looking down at the floor as he speaks, and appears quite sad. Dr Jones asks about school, and Brian says he has been unable to attend any classes for the past two weeks because of his pain. He spends most of his time in bed or lying down on a sofa watching television. His appetite has been unchanged, but he complains he is having trouble sleeping unless he takes "extra pain pills."

MORE THAN JUST AN ACCIDENT PART II: CASE NARRATIVE CONTINUED

The Psychiatrist's Consultation

Dr. Jones, the pediatrician, is concerned about the possibility of depression and emerging drug dependence. He decides to refer Brian to a child and adolescent psychiatrist, whom Brian sees the following week:

“Hello, Brian. It’s nice to meet you. I’m Dr. Smith. Dr. Jones called me last week to say he was worried you might be depressed and said that your pain has been worse. What do you think?”

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“Hmm. I see. Dr. Jones did mention something about some lost medicine. Can you tell me a little more about that?”

Brian says he dropped some pills down the drain at his grandmother’s house last week, and he also accidentally put his refill prescription through the laundry.

“Oh, that’s too bad. I understand that your pain has been terrible lately. Has there been some recent change?”

“Well, you know, it was never good. I’ve always had pain.”

“Right, I’ve heard that. Do you sometimes take more medication than Dr. Jones has prescribed?”

“Well...I guess so. But I have to; I keep telling him I need more medicine. I’ve even grown, and he hasn’t increased it. Sometimes the pain is so bad that I take an extra one of the small ones – you know, oxycodone. My Mom and Dad know, and they say I should if I need it. I’m not an addict or anything, although Dr. Jones seems to think I am.”

“Well, let’s talk about that. Do you ever take extra pain pills when you’re feeling upset or to relax?”

“Of course I’m not relaxed when I have pain! But I’m careful. I make sure I don’t do it too often.”

“I see. Well, let me ask you a few more questions. Have your parents ever wondered if you’re taking too much?”

“No.”

“Well, have you noticed any trouble with your memory or that you forget things when you’ve taken extra?”

“Oh, I don’t know. School’s been really busy lately, so it’s easy to forget some things. I can’t tell if it’s related to when I need more medication; but being in pain doesn’t help my memory.”

“Well, that may be, but the medications can also have an effect on your memory. Have you ever had trouble because of your pain medications?”

“You mean like being picked up by the police or something? No. The only trouble I have had is with Dr. Jones.”

“Have you had any problems at school, with your parents, or with your friends?”

“My parents almost always know when I’m taking extra; they trust me to take it only when I need it. My friends have nothing to do with this.”

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PART III: CASE NARRATIVE CONCLUSION

Epilogue

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- Brian will not use extra medication or additional medications, other than that agreed to in the contract. One physician, Dr. Jones, will write all of Brian's prescriptions, and all of Brian's doctors will have open communication and knowledge of the plan.
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- Dr. Smith will meet with Brian to discuss non-pharmacological coping strategies for pain management

Brian follows up with Dr. Jones a few days later to discuss the plan. He initially refuses to meet with Dr. Smith again or to see an addiction counselor. He does, however, agree to attend an Alateen meeting. In addition to the plan above, you counsel Brian to avoid the use of alcohol and illicit drugs, and to never drive after taking his extra medication.

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DSM-IV Criteria for Substance Use Disorders

Substance Abuse

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period.
 - a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
 - b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
 - c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
 - d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Dependence

1. A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period.
 - a. Tolerance, as defined by either of the following:
 - Need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - Markedly diminished effect with continued use of the same amount of the substance
 - b. Withdrawal, as manifested by either of the following:
 - The characteristic withdrawal syndrome for the substance taken
 - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
 - c. The substance is often taken in larger amounts or over a longer period than was intended
 - d. There is a persistent desire or unsuccessful efforts to cut down or control substance use
 - e. A great deal of time is spent in activities necessary to obtain the substance,

- use the substance, or recover from its effects
- f. Important social, occupational, or recreational activities are given up or reduced because of substance use
- g. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal

Without Physiological Dependence: no evidence of tolerance or withdrawal

Definitions

Tolerance refers to a need for increasing doses in order to maintain effect. Tolerance with prolonged use is a property of opioids, though clinical experience suggests that most patients do not require increasing doses of medication unless their pain is progressive.

Withdrawal refers to the occurrence of either physical (e.g., tachycardia, abdominal cramps, diarrhea) or psychological (e.g., restlessness, depressed mood) symptoms when a drug is stopped abruptly.

Physiological Dependence is manifested by tolerance, physical withdrawal symptoms, or both. (At times clinicians may use the phrase “physical dependence” instead of physiological dependence.) This can occur with several classes of drugs, including alcohol, sedatives, and opioids. Note that physiological dependence is distinguished from psychological dependence, which is also defined by DSM-IV criteria.

Abuse of a substance is a psychological diagnosis, made by criteria from the DSM-IV. Note that these criteria are related to the problems associated with drug use, not the amount of drug that is being used.

Psychological Dependence is also a psychological diagnosis made by criteria. This diagnosis is made when problems associated with substance use are more severe than abuse.

Addiction is a psychological and behavioral syndrome in which there is drug craving and compulsive use. This is not a formal diagnosis. The American Society of Addiction Medicine defines **Addiction** as being a disease characterized by continuous or periodically impaired control over the use of drugs of alcohol, preoccupation with drugs or alcohol, continued use of these chemicals despite adverse consequences related to their use, and distortions in thinking, most notably denial.

MORE THAN JUST AN ACCIDENT HANDOUT #2:

The CRAFFT Screening Test

This test is a brief screening device that can help the clinician identify serious alcohol and drug problems.

- C “Have you ever ridden in a **car** driven by someone (including yourself) who was ‘high’ or had been using alcohol or drugs?”
- R “Do you ever use alcohol or drugs to **relax**, feel better about yourself or fit in?”
- A “Do you ever use alcohol or drugs while you are by yourself, **alone**?”
- F “Do you ever **forget** things you did while using alcohol or drugs?”
- F “Do your family or **friends** ever tell you that you should cut down on your drinking or drug use?”
- T “Have you ever gotten into **trouble** while you were using alcohol or drugs?”

Two or more “yes” answers suggest a serious problem, or disorder, with alcohol or drugs. More recent data suggest that four or more “yes” answers are predictive of a diagnosis of substance dependence.

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