Reducing Drugged Driving: An Idea Whose Time Has Come
Summary Report of a Meeting of Experts
February 2011

On February 7, 2011, the Institute for Behavior and Health, Inc. (IBH) presented the John P. McGovern Award for leadership in drug abuse prevention to R. Gil Kerlikowske, Director of the White House Office of National Drug Control Policy (ONDCP), for his distinguished leadership in drugged driving prevention and enforcement including recognizing drugged driving as a featured national priority in the 2010 National Drug Control Strategy. The meeting was a celebration of Director Kerlikowske's leadership and an expression of gratitude and respect from the impressive audience of 60 national leaders in highway safety and substance abuse prevention, treatment and research.

The keynote address was given by David L. Strickland, Administrator of the National Highway Traffic Safety Administration (NHTSA). Following his presentation, Megan Harrington, representing Senator Rob Portman (R-OH), expressed support for these efforts. While a member of the US House of Representatives, then-Congressman Portman sponsored drugged driving legislation that was incorporated into the 2005 Safe, Accountable, Flexible, Efficient, Transportation Equity Act – a Legacy for Users (SAFETEA-LU) which brought attention to the drugged driving problem for the first time in legislation. Nora Volkow, M.D., Director of the National Institute on Drug Abuse (NIDA), highlighted the role of research in efforts to understand and curtail drugged driving and expressed NIDA's commitment to support the 2010 National Strategy's ambitious target of reducing drugged driving in the US by 10% by 2015.

IBH President Robert L. DuPont, M.D. asked meeting participants to contribute their suggestions for the future direction of US efforts to reduce this significant threat to highway safety. There was universal support for the idea that efforts to reduce drugged driving should never be at the expense of the nation's century-old efforts to reduce drunk driving. Efforts to reduce drunk driving establish a foundation for drugged driving prevention and provide ample basis for optimism that effective prevention and law enforcement can produce substantial reductions in drugged driving. Further the hope was expressed that new efforts to reduce drugged driving will prove useful in extending the success of drunk driving prevention.

The theme of the discussion was set by Jeff Michael, Ph.D., Director of NHTSA's Office of Impaired Driving and Occupant Protection, when he described Director Kerlikowske's contribution as showing NHTSA – and the nation – the path forward on drugged driving. This is critical because the issue previously seemed overwhelmingly complex. The discussion that followed detailed the range of many often confusing issues that needed to be confronted to move forward on drugged driving. This report briefly summarizes the five issues discussed and offers the perspective of the IBH Drugged Driving Committee on ways forward on these challenges.

There are three goals of drugged driving prevention and enforcement: 1) improve highway safety, 2) reduce illegal drug use, and 3) provide a major new pathway to long-term recovery.

1. Implement *Per Se* Drug Laws

While the 0.08 g/mL Blood Alcohol Concentration (BAC) level is used to establish the *per se* limit for drunk driving, there is no equivalent for drugs. The 0.08 BAC level for alcohol obscures the fact that many drivers are significantly impaired at levels well below 0.08. Due to tolerance and consumption effects, alcohol users can also not show signs of impairment at 0.08BAC or higher.

The only practical standard for drugged driving is zero tolerance. This is because while we can measure the presence of a drug in the body at the time of the sample we cannot establish: 1) a drug concentration that is either always or never impairing, 2) that the concentration of drug that is measured was present at the time of driving and 3) that the behavior observed was due to the drug detected. In addition there are literally thousands of illegal drugs so the task of establishing tissue threshold levels for each is not just daunting, it is impossible. There is no standard relationship between blood levels of a drug or drug metabolites and impairment. Additional studies will not change this fact, and the same is true for alcohol.

Nonmedical use of prescription drugs is illegal. This bright line makes any level of use identified a *per se* violation. The challenge of addressing an impaired driver who has a valid prescription for an impairing drug can be dealt with using the two-prong approach used for alcohol: impairment and *per se*. Under the first prong, identification of driver impairment is a violation. Under the second prong, the identification of the presence of a potentially impairing drug in a driver is a *per se* violation if the use is illegal.

Any driver who has a valid prescription for a drug identified though a drug test has an absolute affirmative defense against the *per se* standard. However, that driver is not protected from the impairment prong. Drivers who are impaired by the use of their own prescribed medicines can be prosecuted for this impairment despite their using the medicines prescribed for them.

There are ample precedents for a zero tolerance approach for illegal drug use. These precedents include underage alcohol use, as well as illegal drug use among commercial drivers and other safety sensitive roles including the US military and law enforcement personnel. The

zero tolerance *per se* standard for illegal drugs is used in Australia and many countries in Western Europe.

2. Assess the Extent and Nature of Drugged Driving

A good baseline is needed for determining the prevalence of drugged driving. The Fatality Analysis Reporting System (FARS) data collection is an important part of drugged driving research. Improving the data collection for alcohol and drugs is necessary as is increasing the overall number of drug tests conducted.

In order to collect new data on drug prevalence among drivers, several trauma centers could be set up to systematically collect drug and alcohol test data on seriously injured drivers. Research based in trauma centers will also lead to the development of risk studies for drugged driving.

In a time of tight budgets, it will be important to adapt available resources to increase the data available on drugged driving, particularly annual survey data including the National Survey on Drug Use and Health (NSDUH) and Monitoring the Future (MTF) survey. These surveys collect general data on impaired driving and have the potential to collect more detailed data on drugged driving and drunk driving as well as related behaviors and attitudes toward these behaviors.

3. Increase Public Education

Not only is there is no clear message against drugged driving but alcohol related messages need to be improved. The current message against drunk driving that is widely used is “Don’t Drive Drunk” when it should be “Don’t Drink and Drive.” Similarly, the drugged driving prevention message must be “Don’t Use Drugs and Drive.”

In addition to the general public, there is an important opportunity to educate drivers convicted of impaired driving, older adults, and new drivers. Drugged driving messages must be built into all driver education programs along with drunk driving prevention. Educating communities on the drugged driving problem is essential, as will be educating them on drugged driving laws and enforcement procedures.

4. Implement Enforcement Procedures

Law enforcement officers need to know how to identify drivers to drug test, how to conduct the tests and the selection of drugs to test. Coordination of police with laboratories, courts, and probation will be needed in order to enforce drugged driving laws effectively.

Future enforcement actions taken to reduce drugged driving must be systematic and applied to all highway law enforcement in the same way uniformity is found in alcohol enforcement today. In particular, drug testing must be as widely used as alcohol testing is now. All 1.4 million drivers arrested for impaired driving each year should be tested for both alcohol

and drugs. Drug Recognition Experts (DRE) have excellent skills that should be utilized in a way to improve all enforcement, including training other law enforcement officers to recognize impairment and administer drug tests. However, because agencies can never have the time or resources to ensure DREs are available for every arrest, it is important that DRE evaluations not become the only screening for all drugged driving. Instead DREs must become a source of training and education for other law enforcement officers about drugged driving.

The combined strategy of having better trained officers stopping more drivers and performing more drug tests is needed to reduce drug related traffic fatalities and injuries, and to ensure that drugged driving criminal cases stand up in court. These officers can identify impairment whether from illicit or prescription drug use, and investigate misuse or abuse of prescription drugs by drivers. Together with dedicated coordinators, regular updates and training, and increased utilization, this approach will enhance the status of DRE programs and will greatly improve their contributions to public safety.

Testing all drivers who are identified as impaired for both alcohol and drugs, even if they test at or above the 0.08 BAC illegal limit, is an important part of combating the drugged driving problem. There must be incentive for law enforcement to conduct this added testing. New legislation making it an aggravated offense to drive with an illegal BAC and to test positive for drugs would incentivize drug testing and the prosecution of drugged drivers.

Testing panels should include the standard SAMHSA-6 developed by the Substance Abuse and Mental Health Services Administration amphetamine/methamphetamine, cocaine, cannabis (THC), phencyclidine (PCP), opiates, and MDMA at specific screening and confirmation levels. In addition, prescription drugs including methadone, oxycodone and benzodiazepines should be included as to this standard panel.

5. Manage Offenders

There is a new paradigm in substance abuse treatment and community corrections that is improving long-term outcomes among substance-using populations, including drivers convicted of impaired driving. This new approach sets the standard of no nonmedical use of drugs of abuse or alcohol while under supervision rather than the previous standard of merely not driving after alcohol or drug use. This new standard can be successfully monitored. In addition this approach features immediate -- but brief -- incarceration for any violation including missed tests as well as any positive tests for alcohol or other drugs of abuse. This is a fundamental change from the current management system. Changing the goal from “don’t drive after drinking and drugging” to “don’t drink or use drugs” while under community supervision has the potential to make impressive reductions in substance-using behaviors in this population.

South Dakota’s 24/7 Sobriety Project utilizes twice-daily alcohol breath tests for Driving While Intoxicated (DWI) offenders under community supervision and urine drug screens to detect recent drug use. Offenders who live at a distance from testing locations wear alcohol monitoring bracelets and drug sweat patches. Any detection of substance use results in a short-term stay in jail. The combination of alcohol and drug testing acts as a strong deterrent against

substance use and permits DWI offenders to maintain employment and driving privileges. Offenders who are unable to adhere to the drug-free standard though undergo treatment with alcohol and drug use monitoring.

Since February 2005, 16,824 people have been placed in the 24/7 Sobriety program. During this time 3.42 million twice-daily alcohol breath tests were administered with a 99.3% pass rate. Participants remain in the program for an average of 111 days. From January 2005 – May 2009, 66.6% of participants never failed an alcohol breath test, 17.1% failed only one test and 9.7% failed only twice. From November 2006 – May 2009, 1,383 participants wore alcohol monitoring bracelets; 74.9% of completed participants had no violation. From July 2007 – May 2009, 1,261 participants were administered drug urinalyses; 97.5% of all screens were negative. During this same time 45 participants wore drug patches with 93.5% of tests were passed.

The zero tolerance approach of 24/7 Sobriety has yielded impressive results. Contrary to many expectations, this program did not fill the jails with offenders. This approach to community supervision decreases recidivism and incarceration while reducing alcohol and drug use. The success of this zero tolerance approach can also be seen in HOPE Probation in Hawaii and in the state Physician Health Programs (PHP), both of which validate this new paradigm.

Conclusions

The study of drugged driving is more than four decades old. The evidence that drugged driving is a major public health and safety problem is unmistakable, as is the evidence that current efforts to combat it are inadequate. Now is the time to consolidate what is known about drugged driving and build effective policies, laws and programs based on that knowledge and experience base. The U.S. needs to extend the impact of drugged driving research into the development of a new generation of evidence-based drugged driving prevention and educational efforts as well as effective, affordable and practical laws enforcement practices. The primary goal of these efforts is to improve highway safety for all Americans. In addition drugged driving efforts hold the promise of creating significant improvements in drug abuse prevention and treatment.

For more information visit:

Institute for Behavior and Health, Inc.
www.ibhinc.org
www.StopDruggedDriving.org

Office of National Drug Control Policy
www.whitehousedrugpolicy.gov/druggeddriving/index.html