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SLIPPING THROUGH THE CRACKS: WHY CAN'T WE STOP DRUGGED DRIVING?

TINA WESCOTT CAFARO*

If you think about the dangerous people you share the roadways with when you get behind the wheel of your car and drive, you will likely consider the inattentive driver, the unskilled driver, the reckless driver, the cell-phone-talking-and-texting driver, and the drunk driver. But, how often do you contemplate a scenario where the driver of the vehicle next to you is under the influence of drugs? Many would argue not often enough.¹ Little is heard of the dangerous crime of operating a motor vehicle while under the influence of drugs (OUI drugs), also called drugged driving. This lack of awareness is attributable, at least in part, to the focus on curtailing alcohol-impaired driving over the last twenty years.²

Efforts to stop alcohol-impaired driving include numerous public-awareness campaigns,³ the expenditure of millions of dollars

* Clinical Professor of Law, Western New England College School of Law. I would like to express my deep appreciation to Lauren Carasik for reading earlier drafts of this article and offering advice. I also wish to thank Martha Santoro, Renee Rastorfer, and Kaitlin Pinette for their research assistance.

1. Melanie Marciano, *Drug-Influenced Driving a Growing Hazard*, UPI PERSPECTIVES, Dec. 2, 2004 (“There is a great deal of ignorance about drug impaired driving.” (quoting the Director of the Office of National Drug Control Policy (ONDCP), John Walters)); see also INST. OF BEHAVIOR & HEALTH, INC., IBH PUBLIC POLICY STATEMENT REGARDING DRUGGED DRIVERS, <http://www.druggeddriving.org/pdfs/IBHPublicPolicyonDruggedDriving715.pdf> (last visited Apr. 8, 2010) [hereinafter IBH PUBLIC POLICY STATEMENT].

2. See R.K. JONES ET AL., NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., STATE OF KNOWLEDGE OF DRUG-IMPAIRED DRIVING 9-10 (2003), available at <http://www.nhtsa.dot.gov/people/injury/research/StateofKnwlegeDrugs/StateofKnwlegeDrugs/pages/3Detection.html> [hereinafter STATE OF KNOWLEDGE OF DRUG-IMPAIRED DRIVING].

3. See WORKING GROUP ON ILLEGAL DRUGS & DRIVING, INT’L COUNCIL ON ALCOHOL, DRUGS & TRAFFIC SAFETY, WORKING GROUP REPORT—“ILLEGAL DRUGS AND DRIVING” 56-64 (2000), <http://www.icadts.org/reports/Drugs-FinalReport.pdf> [hereinafter WORKING GROUP REPORT]. Organizations such as MADD and SADD have long been working publicly to prevent the occurrence of this crime. See Mothers Against Drunk Driving, Mission Statement, <http://www.madd.org/About-us/About-us/Mission-Statement.aspx> (last visited Apr. 8, 2010); Students Against Destructive Decisions, SADD History, <http://www.sadd.org/history.htm> (last visited Apr. 8, 2010). National campaigns promoted by the National Highway Traffic Safety Administration

by both the government and private organizations,⁴ the demand for strict new legislation, and nation-wide implementation of uniform laws. While this has by no means eradicated the crime of alcohol-impaired driving, it has reduced the number of deaths on the highways.⁵ Unfortunately, the same focus has not been placed on stopping individuals from using drugs and driving a car. Typically, drugs are used for medicinal purposes, but some are also used for recreational purposes, mostly because of their psychoactive properties.

(NHTSA) and the Presidential Commission on Drunk Driving remind motorists that “Friends Don’t Let Friends Drive Drunk” and “You Drink & Drive. You Lose.” See WORKING GROUP REPORT, *supra*, at 57; Ad Council, Drunk Driving Prevention (1983-Present), www.adcouncil.org/default.aspx?id=137 (last visited Apr. 8, 2010).

The goal of You Drink & Drive. You Lose. [was] to enhance national awareness about the deadly toll drinking and driving exacts on America’s communities and to generate a greater national urgency to stop the senseless killing and injury on our nation’s highways, in support of the national goal to reduce alcohol-related traffic fatalities to no more than 11,000 by [sic] the year 2005.

WORKING GROUP REPORT, *supra*, at 57; see also Mothers Against Drunk Driving, Media Center, <http://www.madd.org/Media-Center/Media-Center/Media-Library/PSAs.aspx> (last visited Apr. 8, 2010) (providing examples of television, radio, and print ads).

4. See T.J. ZWICKER ET AL., NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., CONNECTICUT’S 2003 IMPAIRED-DRIVING HIGH-VISIBILITY ENFORCEMENT CAMPAIGN, at iv (2007) (stating that in 2003 “Congress appropriated \$11 million for paid media”). In 2005, the budget proposal for impaired driving was \$9.9 million. *National Highway Traffic Safety Administration’s Budget Request for Fiscal Year 2005: Hearings Before the Subcomm. on Transportation, Treasury, and Independent Agencies of the H. Comm. on Appropriations*, 105th Cong. 7 (2004) (statement of Jeffrey W. Runge, Adm’r, Nat’l Highway Traffic Safety Admin.), available at <http://www.nhtsa.dot.gov/nhtsa/announce/testimony/2005BudgetRequestTestimony.pdf>. For information on MADD’s finances, see MOTHERS AGAINST DRUNK DRIVING, ANNUAL REPORT FISCAL YEAR 2007-2008, at 7 (2009), <http://www.madd.org/getattachment/719560b1-b2c2-4bac-a35e-baf7568080fa/2007-2008-Annual-Report—PDF.aspx>; MOTHERS AGAINST DRUNK DRIVING, FINANCIAL STATEMENTS AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS 2-6 (2008), <http://www.madd.org/getdoc/1e18ffdb-2a36-44f2-8fa6-dc62056b0894/FSA---MADD---2008.aspx>.

5. See Mothers Against Drunk Driving, Campaign to Eliminate Drunk Driving—Statistics, <http://www.madd.org/Drunk-Driving/Drunk-Driving/Statistics.aspx> (last visited Apr. 8, 2010). “Since 1980 (the year Mothers Against Drunk Driving was founded), alcohol-related traffic fatalities have decreased nearly 50 percent, from over 30,000 to fewer than 15,500 . . .” *Id.* “In 2008, an estimated 11,773 people died in drunk driving related crashes—a decline of 9.8 percent from the 13,041 drunk driving related fatalities of 2007.” *Id.*; see also NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., 2006 TRAFFIC SAFETY ANNUAL ASSESSMENT—ALCOHOL-RELATED FATALITIES 1 (2007), <http://www-nrd.nhtsa.dot.gov/Pubs/810821.PDF> (stating that in 2006, “17,602 people were killed in the United States in alcohol-related motor vehicle traffic crashes”). For an analysis and suggested explanations of this decline, see generally NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., STATISTICAL ANALYSIS OF ALCOHOL-RELATED DRIVING TRENDS, 1982-2005 (2008), <http://www-nrd.nhtsa.dot.gov/Pubs/810942.PDF>.

Whether used for medicinal or recreational purposes, many drugs can impair a person's ability to drive. Millions of people in the United States and worldwide continue to take drugs, both licit and illicit, before driving a car.⁶ A report released by The Substance Abuse and Mental Health Services Administration (SAMSHA) stated that in the United States, "nearly 10 million people drove under the influence of drugs during the preceding year, roughly 1/3 of the number who reported driving under the influence of alcohol during the same time frame."⁷ The Institute for Behavior and Health (IBH) provides the following estimate: "[Twenty percent] of crashes are caused by drugged driving. That translates into 8,600 deaths, 580,000 injuries, and \$33 billion in property damage each year in the United States."⁸ These drug-impaired drivers are causing accidents and deaths on the roadways in increasing numbers, and the statistics are hard to ignore.⁹ "Without exception, all illicit drugs have the potential to impair the cognitive and behavioral skills that allow a person to engage in normal daily activities, such as driving and working."¹⁰ Additionally, the "[u]se of [prescription] drugs such as benzodiazepines and tricyclic antidepressants has been shown to more than double the risk of involvement in injuri-

6. In 2006, the National Survey on Drug Use and Health documented that 10.2 million people age twelve and older reported driving under the influence of illicit drugs during the year prior to being surveyed. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2006 NATIONAL SURVEY ON DRUG USE AND HEALTH, NATIONAL FINDINGS 2 (2007), <http://oas.samhsa.gov/nsduh/2k6nsduh/2k6results.pdf>.

In a large study of almost 3,400 fatally injured drivers from three Australian states (Victoria, New South Wales, and Western Australia) between 1990 and 1999, drugs other than alcohol were present in 26.7 percent of the cases. These included cannabis (13.5 percent), opioids (4.9 percent), stimulants (4.1 percent), benzodiazepines (4.1 percent), and other psychotropic drugs (2.7 percent). Almost 10 percent of the cases involved both alcohol and drugs.

NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., DRUGGED DRIVING 2-3 (2008), <http://www.drugabuse.gov/PDF/Infofacts/driving08.pdf> [hereinafter DRUGGED DRIVING] (footnote omitted).

7. IBH PUBLIC POLICY STATEMENT, *supra* note 1, at 1 (citing SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2007 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS (2008), <http://oas.samhsa.gov/nsduh/2k7nsduh/2k7results.pdf>).

8. *Id.*

9. See Centers for Disease Control & Prevention, Impaired Driving, http://www.cdc.gov/MotorVehicleSafety/Impaired_Driving/impaired-drv_factsheet.html (last visited Apr. 8, 2010) ("Drugs other than alcohol (e.g., marijuana and cocaine) are involved in about 18% of motor vehicle driver deaths. These other drugs are generally used in combination with alcohol.").

10. MARCELLINE BURNS, MEDICAL-LEGAL ASPECTS OF DRUGS 153 (2003).

ous falls and traffic accidents.”¹¹ While it is undisputed that the act of using drugs has an effect on one’s ability to operate a motor vehicle safely,¹² “the United States has invested little effort into combating drug impaired driving.”¹³

Unfortunately, the fight against drugged driving must overcome many obstacles. One of the biggest problems is the lack of uniformity regarding what exactly constitutes the crime of drugged driving. Legislative inadequacies in drafting uniform OUI drug statutes and articulating clear guidelines that identify the applicable legal standards make it difficult to prove cases of drugged driving. In addition, members of the public are often unaware that operating a motor vehicle while under the influence of a licit drug that affects their ability to operate safely is a crime.¹⁴ This lack of awareness is compounded by the insufficiency of police expertise in detecting the crime, inadequate prosecutorial experience in prosecuting the crime, and the minimal amount of resources expended for combating OUI drugs. It becomes obvious that without meaningful change, lives will increasingly be lost to drug-impaired drivers.

Part I of this Article briefly explains the history of impaired driving laws, with respect to both alcohol and drugs. It then sets

11. *Id.* at 170.

12. “Drugs act on the brain and can alter perception, cognition, attention, balance, coordination, reaction time, and other faculties required for safe driving.” DRUGGED DRIVING, *supra* note 6, at 3; see also Cameron Mostaghim, *Roadside Seizures of Medical Marijuana: Public Safety and Public Policy as Limitations Upon Transporting and the Return of Lawfully Seized Medical Marijuana*, 36 W. ST. U. L. REV. 89, 98 (2008) (“[R]esearch has produced increasing evidence of significant impairment of the driving ability of persons under the influence of cannabis. Distortion of time perception, impairment of psychomotor function, and increased selectivity in attentiveness to surroundings apparently can combine to lower driver ability.” (alteration in original) (quoting *Ravin v. State*, 537 P.2d 494, 510 (Alaska 1975)) (internal quotation marks omitted)).

13. Aaron J. Marcus, *Are the Roads a Safer Place Because Drug Offenders Aren’t on Them?: An Analysis of Punishing Drug Offenders with License Suspension*, 13 KAN. J.L. & PUB. POL’Y 557, 574 (2004).

14. See PAUL A. MACLENNAN, AAA FOUNDATION FOR TRAFFIC SAFETY, *OLDER ADULTS’ KNOWLEDGE ABOUT MEDICATIONS THAT CAN IMPACT DRIVING* 3-4 (2009), <http://www.aaafoundation.org/pdf/KnowledgeAboutMedicationsAndDrivingReport.pdf> (discussing senior citizens as people who are following doctor’s orders with respect to dosage and usage but ignoring the advisory to avoid operating a motor vehicle). Others may follow instructions for particular prescriptions but ignore the effects of combining medications or combining medications with alcohol. See KATHY H. LOCOCO & LOREN STAPLIN, NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., *IDENTIFYING STRATEGIES TO COLLECT DRUG USAGE AND DRIVING FUNCTIONING AMONG OLDER DRIVERS* 8-9 (2006), http://www.nhtsa.dot.gov/people/injury/olddrive/DrugUse_OlderDriver/images/Job%202859%20Polypharmacy_New.pdf.

forth the various frameworks currently in place to establish that an individual is OUI drugs and evaluates the effectiveness of each standard. Part II discusses the impediments to detecting and prosecuting OUI drug cases. This section details the difficulties associated with the science behind drugged driving, including determining the effect a drug may have on an individual as well as the validity of tests used to determine if one has a drug in their system. Part II highlights the issues pertaining to laws that regulate OUI licit (prescription or over-the-counter) drugs. This section also discusses the impact that lack of funding and inadequate training for law enforcement officers and prosecutors has on combating this crime. Finally, Part III recognizes that targeting drugged driving is more complicated than fighting OUI alcohol and suggests what is needed to combat this problem.

I. HISTORICAL BACKGROUND OF IMPAIRED DRIVING LAWS

For over 100 years, the act of consuming alcohol has been recognized as having a negative effect on one's ability to operate a motor vehicle.¹⁵ The first laws criminalizing OUI alcohol were enacted soon after the invention of the motor vehicle.¹⁶ In the early 1900s, OUI alcohol laws typically punished the impaired driver with a fine or short jail sentence.¹⁷ Subtle changes were made to these

15. See Eric J. Gouvin, *Drunk Driving and the Alcoholic Offender: A New Approach to an Old Problem*, 12 AM. J.L. & MED. 99, 100 (1986) ("Inebriates and moderate drinkers are the most incapable of all persons to drive motor wagons. The general palsy and diminished power of control of both the reason and senses are certain to invite disaster in every attempt to guide such wagons." (quoting a 1904 editorial from the *Quarterly Journal of Inebriety*) (internal quotation marks omitted)).

16. See JAMES JACOBS, *DRUNK DRIVING: AN AMERICAN DILEMMA* 57 (1989); see also Jeffrey Robert Connolly, *Maas v. Department of Commerce and Regulation: Why Can't South Dakota Curb Repeat Offenses of Driving Under the Influence?*, 50 S.D. L. REV. 352, 357 (2005) ("Drinking and driving has been regulated in South Dakota nearly as long as driving itself. South Dakota's first drunk driving law, passed in 1913, simply prohibited driving while 'under the influence of liquor.'"). "[A]pproved on March 3, 1913, [the law] stated, 'It shall be unlawful for any person to operate or attempt to operate any automobile or other motor vehicle in this state while such person is under the influence of liquor.'" *Id.* at 357 n.48.

17. See, e.g., An Act Relative to Automobiles and Motor Cycles, ch. 412, § 4, 1906 Mass. Acts 419, 422.

Whoever operates an automobile or motor cycle on any public way or private way laid out under authority of law recklessly or while under the influence of intoxicating liquor, or so as to endanger the lives or safety of the public, shall be punished by a fine not exceeding one hundred dollars or by imprisonment for a term not exceeding six months. A conviction of a violation of this section shall forthwith be reported by the court or trial justice to the commission which shall immediately revoke the license of the person so

laws over the ensuing years, with the most drastic changes starting in the 1980s. As a result of pressure exerted by the National Highway Traffic Safety Administration (NHTSA) and the federal government, in the 1980s, almost every state in the United States passed stricter OUI laws.¹⁸ Alarmed by the impact of alcohol-impaired driving, the federal government employed its spending powers to facilitate state action regarding the creation of these stricter OUI laws.¹⁹ These laws included: mandatory minimum sentences for repeat OUI drivers, suspension or revocation of an individual's license to operate a motor vehicle upon conviction for a first OUI offense,²⁰ confiscation of the vehicle's license

convicted. If it appears by the records of said commission that the person so convicted is the owner of an automobile or motor cycle, or has exclusive control of any automobiles or motor cycles as a manufacturer or dealer, said commission shall thereupon revoke the certificate of registration of all automobiles or motor cycles so exclusively owned or controlled. No new license or certificate shall be issued by said commission to such person until after sixty days from the date of such conviction, nor thereafter except in the discretion of said commission.

Id.

18. See 2 ENCYCLOPEDIA OF CRIME AND PUNISHMENT 548-49 (David Levinson ed., 2002).

Forty-one states created commissions or task forces in 1981 to 1982 to examine the problem of drinking and driving, and the recommendations that they issued led to the legislative enactment of tough laws that dramatically increased criminal and civil penalties for DUI offenses. . . . By 1985, state legislatures had enacted more than 1,000 DUI statutes. . . . Between 1980 and 1990, no area of the law received more attention or more nationwide legislative activity than did laws governing intoxicated drivers.

Id. at 549.

19. For example, in 1984, Congress successfully demanded, under The National Minimum Drinking Age Act, that each state require all purchasers of alcohol to be at least twenty-one years old. See 23 U.S.C. § 158 (2006). If a state did not enact this legislation by 1986, the state would not be eligible to receive federal highway construction funds. *Id.*; see, e.g., Act of October 1, 1986, Act 207, 1992 Haw. Sess. Laws 549 (making permanent a 1986 amendment that had temporarily raised the minimum drinking age to twenty-one); see also 23 U.S.C. § 163 (enacted to encourage states to lower the legal BAC level from 0.10 to 0.08).

The law, passed under the [government's] spending power, allow[ed] the government to withhold 2 percent from federal highway funds, starting in 2004, if states [did] not comply with the federal mandate. Each subsequent year, until 2007, an additional 2 percent [would] be withheld from states that [were] not in compliance. Therefore, any state that [did] not pass legislation to lower the BAC to 0.08 [would] have 8 percent of their state's federal funding withheld in 2007, and each subsequent fiscal year thereafter.

Christopher O'Neill, *Legislating Under the Influence: Are Federal Highway Incentives Enough to Induce State Legislatures to Pass a 0.08 Blood Alcohol Concentration Standard?*, 28 SETON HALL LEGIS. J. 415, 416 (2004).

20. NATIONAL SURVEY OF STATE LAWS 129 (Richard A. Leiter ed., 4th ed. 2003); see also MARGARET C. JASPER, DRUNK DRIVING LAW 33 (1999); OFFICE OF THE SEC'Y,

plates,²¹ requiring ignition interlock devices,²² and vehicle forfeiture.²³ It is clear that the legislature has, at a minimum, made some effort to make OUI alcohol legislation effective. Unfortunately, the existing legislation has failed to be effective in combating the crime of OUI.²⁴ This is particularly true in terms of OUI drugs.

While recognizing that drugged driving is a grave problem that must be researched and addressed,²⁵ the federal government has not been proactive in passing legislation regarding OUI drugs. The first piece of legislation that contemplated the issue of drug-impaired driving was the Federal-Aid Highway Act of 1973.²⁶ This Act authorized the Secretary

to carry out safety research of the following: (1) [t]he relationship between the consumption and use of drugs and their effect upon highway safety and drivers of motor vehicles; and (2) [d]river behavior research, including the characteristics of driver performance, the relationships of mental and physical abilities or disabilities to the driving task, and the relationship of frequency of driver accident involvement to highway safety.²⁷

In 1988, Congress passed implied-consent legislation mandating that motorists who operate a motor vehicle in the special maritime and territorial jurisdiction of the United States and refuse to give consent to chemical testing to determine if they are under the influence of drugs or alcohol “shall be denied the privilege of operating a motor vehicle upon the special maritime and territorial juris-

U.S. DEP’T OF TRANSP., PRESIDENTIAL INITIATIVE FOR MAKING .08 BAC THE NATIONAL LEGAL LIMIT: RECOMMENDATIONS FROM THE SECRETARY OF TRANSPORTATION 20 (1998), <http://purl.access.gpo.gov/GPO/LPS2320>.

21. See JASPER, *supra* note 20, at 36 (listing fourteen states that have laws authorizing confiscation of license plates).

22. *Id.* at 37 (explaining that an ignition interlock is a device that has a breath tester that drivers blow into to measure their blood alcohol level, and which, if alcohol is detected, prevents the vehicle from starting). Thirty-seven states have such laws. *Id.*

23. *Id.* (listing twenty-one states that have vehicle forfeiture laws).

24. See Tina Wescott Cafaro, *Fixing the Fatal Flaws in OUI Implied Consent Laws*, 34 J. LEGIS. 99 (2008) [hereinafter Cafaro, *Fatal Flaws*]; Tina Wescott Cafaro, *You Drink, You Drive, You Lose: Or Do You?*, 42 GONZ. L. REV. 1 (2006).

25. See 131 CONG. REC. S6323-04 (daily ed. May 16, 1985) (statement of Sen. Chafee). Every year since 1981, the federal government has recognized a “National Drunk & Drugged Driving (3D) Prevention Month.” NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., HOLIDAY MINI-PLANNER (FRIENDS) TALKING POINTS & FACT SHEET 1 (2004), <http://www.stopimpaireddriving.org/HolidayPlanner/downloads/HolidaysFriendsFactSheet.pdf>.

26. See Federal-Aid Highway Act of 1973, Pub. L. No. 93-87, 87 Stat. 250 (codified as amended at 23 U.S.C. § 403(b) (2006)).

27. *Id.* § 208.

diction of the United States.”²⁸ In 1991, the Alcohol-Impaired Driving Countermeasures Act provided a financial incentive to states to implement programs to help curtail impaired driving.²⁹ The Act provided that if a state implemented five or more enumerated programs, then that state would qualify for federal program funding.³⁰ One such program was a drugged-driving-prevention program. In 2004, legislators were unsuccessful in their attempts to pass two bills mandating that all fifty states enact certain OUI drug laws.³¹ In 2005, federal legislation regarding OUI drugs was enacted with the purpose of facilitating the creation of a cohesive strategy to address OUI drugs.³² The federal government recognized the growing concerns regarding this crime, the implications of doing nothing to combat impaired driving, and the difficulties in designing an effective strategy to fight it. The problem is that, on a federal level, little has been done to combat the crime. As a result, the task of addressing OUI drugs falls to the states.

28. 18 U.S.C. § 3118(b). The statute also states,

Whoever operates a motor vehicle in the special maritime and territorial jurisdiction of the United States consents thereby to a chemical test or tests of such person’s blood, breath, or urine, if arrested for any offense arising from such person’s driving while under the influence of a drug or alcohol in such jurisdiction. The test or tests shall be administered upon the request of a police officer having reasonable grounds to believe the person arrested to have been driving a motor vehicle upon the special maritime and territorial jurisdiction of the United States while under the influence of drugs or alcohol in violation of the laws of a State, territory, possession, or district.

Id. § 3118(a).

29. 23 U.S.C. § 410.

30. *Id.*

31. House Bill 3907, introduced on March 4, 2004, sought to employ the federal government’s spending power to withhold funds from states that did not have mandatory minimum penalties for those convicted of OUI drugs. H.R. 3907, 108th Cong. (2004). House Bill 3922, The Drug Impaired Driving Enforcement Act of 2004, introduced on March 9, 2004, sought to mandate the sanctioning of any motorist operating a motor vehicle with any detectable amount of a controlled substance present in the person’s body. H.R. 3922, 108th Cong. (2004).

32. 23 U.S.C. § 403(b).

In addition to the research authorized by subsection (a), the Secretary, in consultation with other Government and private agencies as may be necessary, is authorized to carry out safety research on the following: (1) The relationship between the consumption and use of drugs and their effect upon highway safety and drivers of motor vehicles. (2) Driver behavior research, including the characteristics of driver performance, the relationships of mental and physical abilities or disabilities to the driving task, and the relationship of frequency of driver crash involvement to highway safety. (3) Measures that may deter drugged driving. (4) Programs to train law enforcement officers on motor vehicle pursuits conducted by the officers.

Id.

In some states, statutes prohibiting a motorist from driving a motor vehicle while under the influence of drugs have existed for almost as long as those prohibiting OUI alcohol.³³ A look at these early statutes shows that from the inception of OUI drug laws, states have differed in drafting the most basic aspects of these laws. In New York, the first statute prohibiting OUI alcohol was passed in 1910, but it was one of the last states to enact an OUI drug statute in 1966.³⁴ In California, one could not drive a vehicle if they were “a habitual user of narcotic drugs” regardless of whether or not they had consumed any drug prior to driving at a particular time.³⁵ In West Virginia, the applicable standard generically forbade driving while intoxicated or under the influence of liquor, drugs, or narcotics.³⁶ In Kansas, the statute made it “unlawful for any person under the influence of intoxicating liquor or any exhilarating or stupefying drug to drive, operate or have charge of the

33. See *Helmer v. Superior Court*, 191 P. 1001, 1003 (Cal. Dist. Ct. App. 1920) (citing the Motor Vehicle Act of 1915, section 17, one of the earliest references to a state giving consideration to the dangers of OUI drugs); *Black v. State*, 130 S.E. 591, 592 (Ga. Ct. App. 1925) (“[I]t is . . . an indictable offense for any person, ‘while under the influence of intoxicating liquors or drugs,’ to operate any motor vehicle upon any highway of this state, regardless of the rate of speed.” (quoting The Act of 1921, 1921 Ga. Laws 255)); *Newbauer v. State*, 161 N.E. 826, 827 (Ind. 1928) (“Any person who shall drive or operate a motor vehicle or motor bicycle on any highway of this state while under the influence of intoxicating liquor or narcotic drugs shall be deemed guilty of a misdemeanor” (quoting Acts of 1925, ch. 213, § 40) (internal quotation marks omitted)); *State v. Ketter*, 247 P. 430, 430 (Kan. 1926) (referring to state statute); *State ex rel. Burkett v. Robinson*, 123 S.E. 575, 576-77 (W. Va. 1924) (referring to section 88 of chapter 43 of the state code, which went into effect on April 22, 1921).

34. See *People v. Litto*, 822 N.Y.S.2d 130, 130-31 (App. Div. 2006) (“[I]n 1966, the [New York] Legislature added Vehicle and Traffic Law § 1192(4), making it a misdemeanor to operate a motor vehicle while impaired by the use of a drug.” (internal quotation marks omitted)). In a letter to the Governor, the bill’s sponsor, Senator Norman F. Lent, wrote, “[A]s presently written [the provision prohibiting driving while intoxicated] pertains to the operation of a motor vehicle while under the influence of alcohol,” and that “New York is one of the few remaining major states without a law against operating a motor vehicle while one’s ability is impaired by the use of drugs or narcotics.” *People v. Grinberg*, 781 N.Y.S.2d 584, 588 (Crim. Ct. 2004) (citation and internal quotation marks omitted).

35. See *Helmer*, 191 P. at 1003. In *Helmer*, the court cited the Motor Vehicle Act of 1915: “No person who is under the influence of intoxicating liquor and no person who is an [sic] habitual user of narcotic drugs shall operate or drive a motor or other vehicle on any public highway within this state.” *Id.* (internal quotation marks omitted). This statute appears to refer to an operator of a motor vehicle who is a habitual user, rather than exclusively referring to one who is operating under the influence of drugs. See *id.*

36. See *Burkett*, 123 S.E. at 577 (“No person shall drive or operate any vehicle, motor driven or otherwise, upon any public road or street in this state, when intoxicated or under the influence of liquor, drugs or narcotics” (citation and internal quotation marks omitted)).

power or guidance of any automobile.”³⁷ In New Jersey, the statute forbade operating a motor vehicle while under the influence of intoxicating liquor, narcotics, or habit-producing drugs.³⁸ Statutes even differed on the definition of the terms “intoxicants” and “intoxication.” In Oklahoma, the statute’s use of the terms “intoxicant” and “intoxication” was held to refer to liquor only, and not drugs.³⁹ In New York, the term “intoxication” was specifically held to refer to both liquor and other intoxicating agents.⁴⁰

As more became known about the effects of narcotics on an individual’s ability to operate a motor vehicle, some states enacted statutes that broadened the scope of what constituted an intoxicant. In Massachusetts, the first OUI drug law forbade the operation of a motor vehicle while under the influence of narcotics as defined by the state’s drug laws.⁴¹ Through the years, the definition of a narcotic for purposes of the OUI law has become more explicit and the statute has enumerated more substances, including marijuana, barbiturates, amphetamines, other hypnotic or somnifacient drugs, vapors of glue, carbon tetrachloride, acetone, ethylene, dichloride, toluene, chloroform, xylene, or any combination thereof.⁴² How-

37. See *Ketter*, 247 P. at 430.

38. *State v. McCarty*, 125 A. 138, 138 (N.J. 1923) (“No person shall operate a motor vehicle while under the influence of intoxicating liquor or any narcotic or habit-producing drugs, or permit any person who may be under the influence of intoxicating liquor or narcotic or habit-producing drugs to operate any motor vehicle owned by him or in his custody or control” (citations and internal quotation marks omitted)).

39. *Sudderth v. State*, 282 P. 1109, 1110 (Okla. Crim. App. 1929) (“True, *intoxicants* might have a broader meaning than intoxicating liquors. It might include certain narcotic *drugs* that would produce intoxication, but that is not the ordinary sense in which the term “*intoxicants*” is now generally used. If one is spoken of as *intoxicated*, it will immediately be understood that such a one is under the influence of *intoxicating* liquors and not doped as is commonly used of narcotics.” (emphases added)).

40. *People v. Koch*, 294 N.Y.S. 987, 989 (App. Div. 1937). Appellant was convicted of a “violation of the Vehicle and Traffic Law, section 70, subdivision 5, as added by Laws 1933, c. 290, in that he operated a motor vehicle upon a public highway while in an intoxicated condition.” *Id.* at 988. While Koch was held not to have violated the statute because he accidentally overdosed on medication that was properly prescribed, the court noted that “[t]he statute contemplates only voluntary intoxication resulting from imbibing alcoholic liquors or the voluntary taking into the system of other intoxicating agents The term ‘intoxication’ includes also the condition produced by excessive use of agencies other than alcoholic liquor, when they are taken voluntarily.” *Id.* at 989-90.

41. An Act Imposing a Penalty for Operating a Motor Vehicle While Under the Influence of Narcotic Drugs, ch. 422, § 2, 1961 Mass. Acts 240, 241.

42. See MASS. GEN. LAWS ANN. ch. 90, § 24 (West 2008). The history of additions to this statute includes the following:

St.1961, c. 422, § 2, approved May 3, 1961, inserted “or narcotic drugs, as defined in section one hundred and ninety-seven of chapter ninety-four” in the

ever, the Massachusetts OUI drug statute only allows for the prosecution of OUI drugs when a motorist operates a motor vehicle on a public way while under the influence of a *scheduled* drug as defined in chapter 94C, section 1 of the General Laws of Massachusetts.⁴³ Therefore, if an individual decides to drive on a public way while inhaling nitrous oxide, this would not constitute the crime of OUI drugs because nitrous oxide is not a scheduled drug, even though nitrous oxide, also referred to as laughing gas, “impairs psychomotor and cognitive functioning.”⁴⁴ While the legislature in Massachusetts has broadened the scope of what constitutes a drug for purposes of the state’s OUI drug statute, it struggles with the application of this law. The same is true in many other states.

Nationwide, three different standards have been drafted in legislation defining what constitutes OUI drugs: two “effect-based” laws and one “per se” law.⁴⁵ The first effect-based law requires that an OUI drug motorist be rendered incapable of driving due to drug use.⁴⁶ The second effect-based law requires a demonstration that an OUI drug motorist’s ability to operate a motor vehicle is impaired or that the motorist is under the influence or affected by an intoxicating drug while driving.⁴⁷ Some per se laws set a limit on the amount of drug or drug metabolite in the driver’s system at the

first sentence of par. (a) of subd. (1). St.1962, c. 394, § 2, approved May 1, 1962, inserted “or under the influence of barbiturates, amphetamines, or other hypnotic or somnifacient drugs” in the first sentence of par. (a) of subd. (1). St.1963, c. 369, § 2, approved May 6, 1963, inserted “or under the influence of the vapors of glue, carbon tetrachloride, acetone, ethylene, dichloride, toluene, chloroform, xylene or any combination thereof” in the first sentence of par. (a) of subd. (1).

Id.; see also *Commonwealth v. Green*, 543 N.E.2d 424, 425-26 (Mass. App. Ct. 1989) (explaining the history behind the OUI drug statute prior to its amendment and chronicling its incorporation of the “Uniform Controlled Substances Act, 9 Uniform Laws Annot. § 101(o) (Master ed. 1988), including its definition of ‘narcotic drug’”).

43. MASS. GEN. LAWS ch. 90, § 24 (1)(a)(1).

44. BURNS, *supra* note 10, at 148. This example of driving while at the same time inhaling nitrous oxide is born from a real case that was unsuccessfully prosecuted in the Springfield District Court, Hampden County, Massachusetts.

45. See STATE OF KNOWLEDGE OF DRUG-IMPAIRED DRIVING, *supra* note 2, at 88.

46. *Id.* States with this type of law include Alabama, Arkansas, Kansas, Maryland, New Mexico, North Dakota, Oklahoma, South Dakota, Vermont, and Wyoming. See ALA. CODE § 32-5A-191(a)(3) (LexisNexis Supp. 2009); ARK. CODE ANN. § 5-65-102(2) (2005); KAN. STAT. ANN. § 8-1567(a)(4) (2001); MD. CODE ANN., TRANSP. § 21-902(c)(1) (LexisNexis 2009); N.M. STAT. ANN. § 66-8-102 (West Supp. 2008); N.D. CENT. CODE § 39-08-01 (Supp. 2009); OKLA. STAT. ANN. tit. 47, § 11-902 (A)(3) (West Supp. 2010); S.D. CODIFIED LAWS § 32-23-1(3) (Supp. 2009); VT. STAT. ANN. tit. 23, § 1201(a)(3) (Supp. 2009); WYO. STAT. ANN. § 31-5-233 (a)(ii)(B) (2009).

47. States with this type of law include Florida, Hawaii, Kentucky, Montana, and Massachusetts. See FLA. STAT. ANN. § 316.193 (West Supp. 2010); HAW. REV. STAT.

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time of the arrest.⁴⁸ However, there was a lack of consensus as to the particular levels. As a result, states with per se laws now employ a “zero tolerance” per se law.⁴⁹ This zero tolerance per se law prohibits motorists from operating a motor vehicle if there is any detectable level of illicit drug or drug metabolite in their body, regardless of whether the motorist operated the motor vehicle in an impaired manner.

While all fifty states have laws that include sanctions for OUI drugs, these laws differ dramatically both in substance and application.⁵⁰ The majority of states have effect-based or “under the influence” statutes.⁵¹ Yet, as mentioned above, within this classification of effect-based laws, two different standards exist. The first standard requires that the motorist be “incapacitated” by the drug, and the second requires that the motorist be “impaired” by the drug.⁵² In order to prove that one is incapacitated, it must be demonstrated that the “influence of the drug ‘renders the driver incapable of safely driving’ . . . and the prosecutor must show a connection between the drug ingestion and the incapacity of the driver.”⁵³ The requirement of proof in impairment cases is less stringent than the standard that a driver must be rendered incapable of safely driving, but proof must still exist that the driver’s impairment is directly related to the use of the drug.⁵⁴

Proving impairment or incapacity in OUI drug cases is often very challenging because it is difficult to establish “a nexus between the observed impairment and a drug as required by most state stat-

§ 291E-3 (LexisNexis Supp. 2009); KY. REV. STAT. ANN. § 189A.010 (LexisNexis Supp. 2009); MASS. GEN. LAWS ch. 90, § 24; MONT. CODE ANN. § 61-8-406 (2009).

48. See, e.g., NEV. REV. STAT. ANN. § 484.379 (LexisNexis Supp. 2007). This statute originally provided a detailed list of prohibited substances and set forth the amount (in either urine nanograms per milliliter or blood nanograms per milliliter) of a prohibited substance that constitutes a per se violation.

49. See, e.g., ARIZ. REV. STAT. ANN. § 28-1381(A)(3) (Supp. 2009); DEL. CODE ANN. tit. 21, § 4177(a)(6) (Supp. 2008); GA. CODE ANN. § 40-6-391(a)(2) (Supp. 2009); 625 ILL. COMP. STAT. ANN. 5/11-501(a)(6) (West Supp. 2009); R.I. GEN. LAWS § 31-27-2 (Supp. 2009); UTAH CODE ANN. § 41-6a-517 (2005); WIS. STAT. ANN. § 346.63 (West 2005); The Governors Highway Safety Association, Drug Impaired Driving Laws (Apr. 2000), http://www.ghsa.org/html/stateinfo/laws/dre_perse_laws.html.

50. STATE OF KNOWLEDGE OF DRUG-IMPAIRED DRIVING, *supra* note 3, at 88.

51. *Id.*

52. *Id.*

53. *Id.*

54. See *id.*

utes.”⁵⁵ Effect-based laws require law enforcement officers to employ a “driving under the influence of alcohol” approach, where officers evaluate a motorist suspected of driving under the influence of a drug in the same manner as they do an OUI alcohol suspect. This includes making observations of the motorist’s driving, appearance, behavior, and coordination, and typically involves evidence regarding the defendant’s performance on standardized field sobriety tests. The officer will then be asked to give an opinion as to the motorist’s state of sobriety. Under these statutes, the prosecution must typically produce evidence that identifies the specific drug used by the suspect. With this comes a plethora of issues regarding opinion, expert, and scientific testimony. As will be discussed in Part II, such testimony will likely require the use of Drug Recognition Experts (DREs).

A *per se* law that sets specific limits of concentrations of drugs that are permissible in a person’s system, similar to the .08% blood alcohol content (BAC) limit in OUI alcohol cases, is easier to establish than an effect-based standard. As discussed in Part II of this Article, several factors make setting *per se* levels difficult: the sheer number of different drugs that need to be tested to determine specific concentration limits; the science behind the correlation between the effects of drugs and blood plasma levels; individual sensitivities and tolerance levels; individual differences in absorption, distribution, and metabolism; acute versus chronic administration of the drugs; the effect of accumulation; and the effect of combining drugs, both illicit and licit.⁵⁶

A zero tolerance law is the easiest standard to prove, as this law makes it a criminal act to operate a motor vehicle while any proscribed substance is in one’s blood or system, regardless of the impact the drug has on one’s ability to drive. Under zero tolerance laws, motorists only need to have a detectable amount of drug in their system to be guilty of OUI drugs. Opponents of the zero tolerance law argue that the law is unjust because an individual would be guilty of OUI drugs if they have even a miniscule amount of

55. THE WALSH GROUP, THE FEASIBILITY OF *PER SE* DRUGGED DRIVING LEGISLATION: CONSENSUS REPORT 5 (2002), available at <http://www.walshgroup.org/FINAL%20CONSENSUS%20with%20inside%20cover%20text.pdf>.

56. RICHARD COMPTON & AMY BERNING, NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS: RESULTS OF THE 2007 NATIONAL ROADSIDE SURVEY OF ALCOHOL AND DRUG USE BY DRIVERS 3-4 (2009) [hereinafter *ROADSIDE SURVEY*], available at <http://www.nhtsa.dot.gov/staticfiles/DOT/NHTSA/Traffic%20Injury%20Control/Articles/Associated%20Files/811175.pdf>.

drugs in their system regardless of the issue of impairment. The example most often used is marijuana. Marijuana's primary active chemical is THC (delta-9-tetrahydrocannabinol), which is found in all forms of marijuana that are psychoactive.⁵⁷ Because THC is absorbed and stored in fatty body tissue, including the brain, and due to the varying concentrations of THC, it is difficult to know the exact length of time traces are detectable in the body.⁵⁸ However, full elimination of THC from the body can take several weeks while the peak effects of the drug appear after thirty to sixty minutes and typically last for two to four hours.⁵⁹ For that reason, a motorist tested one week after using marijuana may still test positive although the effects have long worn off.⁶⁰

Proponents of the zero tolerance law argue, "[T]he premise for the law is that the use of the drug is illegal, not that a specific concentration equates to impairment."⁶¹ Consequently, by virtue of using an illegal substance, an individual has already broken the law and by driving after using this illegal substance, the charge of OUI drugs is warranted.⁶² Proponents also assert that a zero tolerance law puts drivers on notice that they must abstain from any illegal drug use prior to driving or face arrest. Zero tolerance laws also take away the need for expert testimony regarding the levels and effects of illicit drugs. In addition, these laws make getting a conviction in an OUI drug case a more certain outcome, which, in turn, has a deterring effect that will promote public safety.

57. BURNS, *supra* note 10, at 140.

58. *Id.*

59. *Id.*

60. *Id.*

61. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., PRIORITIES AND STRATEGIES FOR IMPROVING THE INVESTIGATION, USE OF TOXICOLOGY RESULTS, AND PROSECUTION OF DRUG-IMPAIRED DRIVING CASES: FINDINGS AND RECOMMENDATIONS 12 (2004) [hereinafter PRIORITIES AND STRATEGIES], available at <http://www.decip.org/pdfs/ImprovingDUICasesNHTSARreport.pdf>.

62. See Donna Leinwand, *Growing Danger: Drugged Driving*, USA TODAY, Oct. 21, 2004, available at http://www.usatoday.com/news/nation/2004-10-21-cover-drugged-driving_x.htm (reporting that John Walters, the past Director of the White House Office of National Drug Control Policy, argued that "authorities have to draw the line somewhere, and that a simple clear guideline—like that used to determine alcohol intoxication—is needed to combat drugged driving" and that "drugs such as cocaine and marijuana are illegal so a driver who tests positive likely has broken the law").

II. IMPEDIMENTS TO DETECTING AND PROSECUTING OUI DRUG CASES

A. The Need to Establish Scientific Standards for Drug Impairment

OUI drug cases prove to be an extremely difficult area of the law to govern and prosecute.⁶³ One of the primary reasons for this is that the nature of impairment in drug cases is not consistent. "There are three main categories of drugs based on their effects on the body: stimulants, hallucinogens and depressants . . . [and] each have different effects on driving ability."⁶⁴ Given the number of potentially impairing drugs, and because "[m]ost psychoactive drugs are chemically complex molecules, whose absorption, action, and elimination from the body are difficult to predict, and considerable differences exist between individuals with regard to the rates with which these processes occur,"⁶⁵ determining which drugs and dosage levels impair driving-related skills is an overwhelming undertaking.⁶⁶ In OUI alcohol cases, the predictability associated with the side effects and the levels of impairment due to the consumption of alcohol⁶⁷ fostered the passing, by all fifty states, of a per se law providing that someone is guilty of operating under the

63. EDWARD L. FIANDACH, HANDLING DRUNK DRIVING CASES 2-2 (2d ed. 1995).

If it can be said that there is a single area of the law of operating offenses which is incapable of a single rational standard, it is operating under the influence of drugs. The vast onslaught of drug usage in America has created a problem of virtually insurmountable proportions.

By and large, this has been due to the dominant trend, if not the unavoidable need, of defining drug influenced operating offenses within the context of the traditional boundaries of alcohol and the inability to impose any rational per se standards.

Id.

64. See BURNS, supra note 10, for a detailed discussion of the many effects drugs have on an individual.

65. See ROADSIDE SURVEY, supra note 56; see also GOV'T OF W. AUSTR., DRUG DRIVING BOOKLET (2007) [hereinafter DRUG DRIVING BOOKLET], available at http://www.officeofroadsafety.wa.gov.au/documents/DrugDrivingBooklet2007.pdf (detailing a list of stimulants (ecstasy, cocaine, and amphetamines), depressants (heroin, marijuana, alcohol, and tranquilizers) and hallucinogens (LSD) and the duration and effects of these drugs on individuals and their ability to drive).

66. The NHTSA began research to identify methods for assessing impairment. It states, "[L]aboratory research [is being] conducted . . . to measure the effect of drug dosage on driving-related skills." ROADSIDE SURVEY, supra note 56, at 3.

67. Id. ("A strong relationship between BAC [blood alcohol content] level and impairment has been established, as has the correlation between BAC level and crash risk.").

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influence of alcohol if their BAC is at a level of .08 or above.⁶⁸ However, the science behind the effects of drugs and the duration of these effects makes it difficult to adopt a blanket per se “under the influence” amount in OUI drug cases. Establishing scientific standards is especially challenging with respect to illegal drug use, as researchers cannot ethically administer the doses of drugs typically taken by regular users. Judge Roderick Kennedy of the New Mexico Court of Appeals described the differences between OUI alcohol and OUI drugs as follows:

Alcohol is a substance which affects the brain in a broad, non-specific fashion. That is, alcohol acts on the entire brain when it is present, in a pretty much uniform, predictable fashion. Drugs often (if not usually) don't act as broadly. Drugs act on specific areas, functions or receptors in the brain, and often with different results in different persons. Poly-drug abuse only increases the possibilities. In a ‘normal’ drug case like possession or sale the problem pertaining to a drug is *what it is*. In DUI/DRUG cases, the issue is *what the drug does* Both cases can deal with amount of a drug, but in the first instance, the problem is purely quantitative (how many units?), where the latter blends quantitative considerations with qualitative—is the amount of drug enough to impair this person at the time the person is driving? . . . Quantifying driving behavior, quantifying drug doses which are sufficient to cause decreased ability to drive a car, and then relating them all is challenging, to say the least. Add to this the differing statutory schemes nationwide (worldwide) concerning driving while under the influence of drugs and the universal facts become merely that drivers ingest drugs that impair driving abilities, and drug-impaired drivers cause accidents. How these things are handled is not universal.⁶⁹

Added to the already difficult job of determining how a specific drug impacts an individual is the fact that many people use more than one type of drug at a time. Polysubstance use occurs when substances such as illicit drugs, prescription drugs, and over-the-counter drugs are mixed at the same time, so that more than one substance is active in the body. This also includes combining

68. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS: IMPAIRED MOTORCYCLE OPERATORS INVOLVED IN FATAL CRASHES 1 (2005), available at <http://www-nrd.nhtsa.dot.gov/Pubs/809939.PDF>. As of August 2008, “[a]ll 50 States, the District of Columbia, and Puerto Rico have by law created a threshold making it illegal [per se] to drive with a BAC of .08 g/dL or higher.” *Id.*

69. THE WALSH GROUP, *supra* note 55, at 4 (omissions in original) (quoting Judge Kennedy) (internal quotation marks omitted).

any of these drugs with alcohol, as small doses of a drug coupled with alcohol use may cause a greater level of impairment.⁷⁰ Generally, combinations of drugs act together in four ways. First, the combination can create an “additive effect” that produces an enhanced result.⁷¹ “Stimulants when combined with other stimulants greatly increase the associated side effects causing a greater false sense of confidence and risk-taking behavior. When a depressant is combined with another depressant, it dangerously increases the associated side effects, drastically slowing reaction time and distorting the driver’s perception.”⁷² Second, the combination can produce “[a]ntagonistic [e]ffects” where the two drugs have exactly opposite effects.⁷³ Third, the combination can produce “[o]verlapping [e]ffects” where each drug may affect the suspect in some distinct ways.⁷⁴ Fourth, the combination can produce “[n]ull [e]ffects” where none of the drugs have a visible effect.⁷⁵ There is also a possibility that the combination of drugs will act in a totally unexpected manner. For example, “[h]allucinogens when combined with any drug can be very unpredictable and dangerous. This is because they can cause visual distortion, including perceptions of speed and dis-

70. See LAWRENCE TAYLOR & STEVEN OBERMAN, DRUNK DRIVING DEFENSE § 1.06, at 45 (6th ed. 2006) (“[T]he cumulative impairment [of small doses of alcohol and another drug] will probably be greater than expected. This is a case of one plus one equaling three.”); Lawrence R. Sutton, *The Effects of Alcohol, Marijuana and Their Combination on Driving Ability*, 44 J. STUD. ON ALCOHOL 438, 442-43 (1983).

71. MASS. CONTINUING LEGAL EDUC., 2 TRYING OUI CASES IN MASSACHUSETTS, at A.V-12 (Hon. Kenneth J. Cote, Jr., ed. 2004) [hereinafter TRYING OUI CASES IN MASSACHUSETTS] (“For example, both CNS Stimulants and Hallucinogens dilate the pupils. A person who has combined a stimulant with a hallucinogen will exhibit dilated pupils.”).

72. DRUG DRIVING BOOKLET, *supra* note 65, at 13.

73. TRYING OUI CASES IN MASSACHUSETTS, *supra* note 71, at A.V-12.

In combination, it can be difficult to predict which drug will exert the stronger effect. It is even possible that the opposing effects will mask each other for a time.

For example, CNS stimulants usually cause pupil dilation, while narcotic analgesics usually cause pupil constriction. A person under the combined influence of a stimulant and a narcotic may have pupils that are nearly normal in size. And, it is possible that their pupils may be dilated at one time, and then become constricted, as the effects of one drug diminish or the effects of the other increase.

Id.

74. *Id.* at A.V-12 to -13 (“In combination, both effect[s] may be observed. For example, PCP enhances nystagmus, Narcotic Analgesics do not cause nystagmus. A person under the influence of both drugs will exhibit nystagmus.”).

75. *Id.* at A.V-13 (“For example, neither CNS Stimulants or Narcotic Analgesics enhance nystagmus. A person under the influence of these drugs would not exhibit nystagmus.”).

tance and greatly limit the accuracy of actions when driving.”⁷⁶ Additionally, combining a stimulant with a depressant produces a “dangerous masking effect”: if someone takes a drug like speed and combines it with alcohol, he or she may not feel intoxicated; however, his or her ability to drive will be affected.⁷⁷

B. *Use of Roadside Devices to Determine Impairment*

Given the magnitude of the number of combinations of different types of drugs and alcohol, it is easy to see why it is complicated to make a determination that an individual is under the influence of drugs. Even absent polysubstance use, it is difficult for a law enforcement officer to make a determination that a motorist is under the influence of drugs. Often times, the officer at first believes a motorist is under the influence of alcohol. It is not until the motorist takes a breathalyzer test resulting in a BAC indicating the absence of alcohol or a small amount of alcohol that the officer realizes that another substance may be in play. It is at this point in the investigation that a roadside device to test for the presence of drugs would be useful.

Unfortunately, a traditional breathalyzer test will not establish that one is under the influence of drugs. In order to establish that drugs are present in one’s system, other tests such as blood, saliva, urine, sweat, and hair must be used. Theoretically, a law enforcement officer at the roadside can ask for any one of these samples of a suspected OUI drug motorist. Realistically, the easiest samples to collect and test are sweat, saliva, and, if proper facilities are available, urine. Developing devices, called roadside testing devices or point-of-contact-testing devices, that screen suspects for drug use and immediately provide drug test results has long been touted as one of the most important advances necessary to combat OUI drugs.⁷⁸ Such testing devices do exist, and researchers continue to develop saliva and urine tests that will facilitate roadside testing for

76. DRUG DRIVING BOOKLET, *supra* note 65, at 13.

77. *Id.*

78. STATE OF KNOWLEDGE OF DRUG-IMPAIRED DRIVING, *supra* note 2, at 16 (“For more than twenty years, medical and traffic safety researchers have been aware that the prevalence of illegal drug use among impaired drivers, especially those in motor vehicle crashes, is not negligible. However, the lack of forensic resources and technology to routinely and rapidly test for drugs has limited efforts to accurately document the scope of the problem or enforce DUID laws. There have been significant technological advances in drug testing technology during the last five years, but generally this new technology has not been integrated into DUID enforcement or crash investigations.” (citation omitted)); *see also* Marcus, *supra* note 13, at 574 (“The object is to develop low

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drugs.⁷⁹ However, the question remains as to exactly what type of drugs these tests should screen for. Presently, most devices only screen for illicit narcotics, but as will be discussed later in this section, many prescription and some over-the-counter drugs can also impair an individual's ability to operate a motor vehicle.

Many other countries currently use "drugalyzers" to identify motorists who are driving with drugs in their system, and Great Britain is currently test piloting the use of such devices.⁸⁰ In Great Britain, if a roadside "drugalyzer" produces a positive reading, the motorist is taken to the police station where a doctor will draw blood to confirm the presence of drugs. The blood test results will then be used as evidence at trial.⁸¹ Similarly, in August 2008, the French government began a road testing program where over 50,000 drug screening kits were distributed across France to be used by police to test motorists for OUI drugs. A motorist is required to deposit a saliva sample on a stick, "which is then dipped in a chemical substance to test for the presence of marijuana, ecstasy, cocaine, heroin, or amphetamines."⁸² Such noninvasive tests detect the presence of drugs in approximately five minutes.⁸³ In Australia, saliva testing is deemed an accurate and reliable method for detecting the recent consumption of marijuana, speed, and ecstasy, and it is

sensitivity roadside testing kits that detect drug metabolites at rates only exceeding pre-determined threshold values.").

79. Laura June, *Philips to Unveil Saliva-Based Roadside Drug Test Later This Year*, ENGADGET, Aug. 6, 2009, <http://www.engadget.com/2009/08/06/philips-to-unveil-saliva-based-roadside-drug-test-later-this-yea/>.

In the vein of the breathalyzer, Philips has developed an on-the-go drug test, that can be used by the side of the road to test suspected imbibers for cocaine, heroin, cannabis, amphetamines and methamphetamine. Unlike the standard alcohol testing equipment, this one is used by having the suspect spit into a small receptacle, which is then inserted into the measurement chamber which contains magnetic nanoparticles coated with ligands that bind to one of five different drug groups, delivering color coded test results in about 90 seconds. Philips, which has been developing the device since 2001, built it as an optical device that would be easy to mass produce for law enforcement.

Id.; see also PETER WIERENGA, PHILIPS: RESEARCH FOR VALUE CREATION 18 (2007), http://www.philips.com/shared/assets/Downloadablefile/9_Peter_Wierenga_280907.pdf.

80. For example, Romania, Australia, and Italy all employ roadside testing. David Millward, *Motorists Face Roadside Drug Tests Under Government Plans*, TELEGRAPH.CO.UK, May 10, 2009, <http://www.telegraph.co.uk/motoring/5303341/Motorists-face-roadside-drug-tests-under-Government-plans.html#>.

81. *Id.*

82. *Europe: French Police Start Saliva-Testing Drivers for Drugs*, DRUG WAR CHRON., Aug. 15, 2008, available at http://stopthedrugwar.org/chronicle/547/france-drugged_driving_saliva_test.

83. MOTOR ACCIDENT COMM'N, THE LOW DOWN ON DRIVING HIGH, available at <http://www.mac.sa.gov.au/file.php?f=i66xRW.VHXjPX.91> (last accessed Mar. 8, 2010).

routinely given during roadside stops of suspected drugged drivers.⁸⁴

In the United States, roadside devices that test a motorist's urine, sweat, or saliva are neither widely available nor widely used. Because of the lack of availability and use of these roadside devices, the scientific reliability of these devices has yet to be vetted by the courts. Indeed, differences of opinion still exist among toxicologists regarding which specimen, other than blood, is the most appropriate to test.⁸⁵ In all European nations, "blood is considered the best fluid for confirmation analysis, because the presence of drugs in blood corresponds best with recent use and impairment."⁸⁶ However, after comparing the results of reference analysis in blood, urine, oral fluid, and sweat, it has been determined that use of urine and saliva also produces accurate results.⁸⁷

The European Union, with cooperation from four individual states of the United States, conducted a study from 2003 until 2005 to evaluate the usability and analytical reliability of roadside saliva drug-testing devices.⁸⁸ The study evaluated nine different brands of

84. *Id.*

85. PRIORITIES AND STRATEGIES, *supra* note 61, at 7.

86. U.N. INT'L DRUG CONTROL PROGRAMME, RAPID ON-SITE SCREENING OF DRUGS OF ABUSE 19 (2001) [hereinafter RAPID ON-SITE SCREENING OF DRUGS OF ABUSE], available at http://www.unodc.org/pdf/scitec18_final1.pdf.

87. *Id.* at 19-20.

On the basis of the comparison between the results of reference analysis in blood, urine, oral fluid and sweat, the following fluids seem suitable for on-site analysis (i.e. there is a good agreement between the results in this fluid and in blood).

Amphetamines: excellent agreement between urine, oral fluid and blood; for sweat, the low numbers of samples do not allow a conclusion;

Benzodiazepines: urine gives moderately good results, for oral fluid, the sensitivity needs to be improved and sweat was not tested;

Cannabinoids: better agreement with oral fluid than with urine. Urine has a better sensitivity, but not a good specificity. Oral fluid has a sensitivity and specificity of approximately 90%;

Cocaine: excellent for urine and oral fluid; for sweat, the low numbers of samples do not allow a conclusion;

Opiates: slightly better agreement with oral fluid than with urine. Urine has a better sensitivity (97%), but a lower specificity (85%). Oral fluid has a sensitivity and specificity of approximately 90%.

Id.

88. ROSITA—2 PROJECT, FINAL REPORT 4 (Alan G. Verstraete & Elke Raes eds., 2006), available at <http://www.rosita.org/> (click link for "Executive Summary").

The study was carried out by National Institute for Criminalistics and Criminology in Brussels, Belgium, the National Public Health Institute in Helsinki, Finland, the Institute for Legal Medicine in Strasbourg, France, the Institute for Legal Medicine in Homburg/Saar, Germany, the Division of

devices administered to 2,046 subjects.⁸⁹ Throughout the course of the study, 2,605 device evaluations were performed.⁹⁰ All of the devices tested for the presence of the following illicit drugs: amphetamines, methamphetamine, marijuana, cocaine, and opiates, while three devices also had a test for prescription benzodiazepines.⁹¹ The study found that saliva was a good screening fluid for the presence or absence of amphetamines, marijuana, cocaine, and opiates in the body.⁹² However, the study exposed a number of impediments to the use of the devices: the failure rate of the devices, the sometimes too lengthy and complicated testing procedures, and the problems associated with the use of these devices during cold and rainy weather.⁹³ “At the [conclusion] of the study, no device was considered to be reliable enough in order to be recommended for roadside screening of [motorists].”⁹⁴ While research appears promising that saliva and other bodily fluid roadside testing can be accurate and indicative of drug use, further technological development and validation is needed before this testing will be generally accepted.

When these devices do become available, law enforcement will be confronted with the issue of how to implement testing. In addition to the practical issues that arise from administering roadside urine tests without proper facilities, several states refuse, on constitutional grounds, to allow the compulsion of any tests. Even

Forensic Toxicology and Drug Abuse, Norwegian Institute of Public Health, Oslo, Norway and Institute of Legal Medicine, University of Santiago de Compostela, Spain. It was coordinated by Ghent University, Ghent, Belgium.

The study was performed in cooperation with the [United] States, where it is funded by The National Institute on Drug Abuse (NIDA), National Institutes of Health, US Department of Health and Human Services, the National Highway Traffic Safety Administration (NHTSA), US Department of Transportation and the Office of National Drug Control Policy Executive Office of the President. The US part is coordinated by The Walsh Group (Bethesda, Maryland). The study is carried out in the following states: Florida (Hillsborough County Sheriff's Office, Florida Department of Law Enforcement, Manatee County Sheriff's Office), Washington (Washington State Police, Washington State Toxicology Lab), Utah (Salt Lake City Police Department, Center for Human Toxicology) and Wisconsin (12 Police Jurisdictions, Wisconsin State Lab of Hygiene).

Id.

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.* at 6.

94. *Id.*

though the Supreme Court, in *Schmerber v. California*,⁹⁵ allowed states to compel a motorist suspected of OUI alcohol to submit to a blood test as long as probable cause existed and the manner employed was reasonable under the circumstances, many states do not allow law enforcement to take this type of evidence by force.⁹⁶ In fact, in some states a motorist cannot be compelled to provide a less-intrusive breath sample, and a refusal is met with little consequence because the motorist's refusal to take such a test is inadmissible at trial.⁹⁷ Given the state of the law in OUI alcohol cases and BAC tests, it seems unlikely that these states would compel an individual to take a roadside drug test.

C. *Should OUI Drugs Include both Illicit and Licit Drugs?*

Prescription and over-the-counter drug use clearly contributes to the number of deaths and accidents caused by OUI drugs.⁹⁸ In some instances, licit drug use more than doubles the risk of involve-

95. 384 U.S. 757, 758, 770-72 (1966).

96. See, e.g., 75 PA. CONS. STAT. ANN. § 1547 (b) (1) (West 2006) ("If any person placed under arrest for a violation of section 3802 is requested to submit to chemical testing and refuses to do so, the testing shall not be conducted . . ."); S.C. CODE 1976 § 56-5-2950 (2006) ("No tests may be administered or samples obtained unless the person has been informed in writing that: (1) he does not have to take the test or give the samples . . ."). *But see* United States v. Kincade, 379 F.3d 813, 849 n.6 (9th Cir. 2004) ("Some states have already passed legislation authorizing police to collect blood samples, with or without consent, from any driver reasonably suspected of drunk driving."); see also Joseph T. Hallinan, *In Fight to Stop Drunk Driving, Police Draw Blood*, WALL ST. J., Mar. 23, 2004, at A1 (noting eight states that have passed legislation permitting similar procedures).

97. See Jay M. Zitter, Annotation, *Admissibility in Criminal Case of Evidence that Accused Refused to Take Test of Intoxication*, 26 A.L.R. FED. 4th 1112 (1983) (providing a detailed study of the admissibility of BAC test refusals); see also MASS. GEN. LAWS ch. 90, § 24(e) (2008) ("Evidence that the defendant failed or refused to consent to such test or analysis shall not be admissible against him in a civil or criminal proceeding, but shall be admissible in any action by the registrar under paragraph (f) or in any proceedings provided for in section twenty-four N."); Opinion of the Justices to the Senate, 591 N.E.2d 1073, 1077-78 (Mass. 1992) (holding proposed legislation making admissible evidence of a refusal to take a breath test unconstitutional).

98. See NAT'L INST. ON DRUG ABUSE, NIDA, INFO FACTS: DRUGGED DRIVING 4 (2009), available at <http://www.drugabuse.gov/PDF/Infofacts/driving09.PDF>.

Prescription drugs: Many medications (e.g., benzodiazepines and opiate analgesics) act on systems in the brain that could impair driving ability. In fact, many prescription drugs come with warnings against the operation of machinery—including motor vehicles—for a specified period of time after use. When prescription drugs are taken without medical supervision (i.e., when abused), impaired driving and other harmful reactions can also result.

Id.; see also J Kaplan et al., *Alcohol and Other Drug Use Among Victims of Motor-Vehicle Crashes—West Virginia, 2004-2005*, 55 MORBIDITY & MORTALITY WEEKLY REP. 1293, 1295 (2006), available at <http://www.cdc.gov/mmwr/PDF/wk/mm5548.pdf>.

ment in motor vehicle accidents.⁹⁹ As a result of the increase in drug-impaired driving, the NHTSA convened a panel of international experts “to review developments in the field of drugs and human performance[,] . . . to identify the specific effects that both illicit and prescription drugs have on driving[,] and to develop guidance for others when dealing with drug-impaired driving problems.”¹⁰⁰ The NHTSA’s Report on Drugs and Human Performance documented the conclusions of the panel and included the state of current scientific knowledge in the area of drugs and human performance for the sixteen drugs selected for evaluation.¹⁰¹ Five licit drugs were evaluated: over-the-counter diphenhydramine (found in antihistamines and sleep aids such as Benadryl® and Unisom®); over-the-counter dextromethorphan (found in cough syrups and cold remedies such as Robitussin®); prescription diazepam (commonly known as Valium®); prescription zolpidem (commonly known as Ambien®); and prescription carisoprodol and meprobamate (commonly known as Soma®).¹⁰² Of these five drugs, three were determined to significantly impair one’s ability to drive: diazepam, diphenhydramine, and zolpidem.¹⁰³ In fact, the report concluded that over-the-counter diphenhydramine “has repeatedly been shown to severely impair tracking and reaction time

The editors of *Morbidity & Mortality Weekly Report* described the prevalence of drugged driving in the West Virginia study:

The effects of drugs other than alcohol on drivers have been studied by laboratory testing of volunteers and epidemiologic studies comparing drug-positive and drug-negative drivers after crashes. Results vary by type of drug. . . .

. . . This report differs from previous reports in terms of the relatively high prevalence of drugs among drivers in West Virginia and the finding that prescription drugs (e.g., opioid analgesics and depressants) were more prevalent than illicit drugs. In certain demographic groups of decedents, drugs were more prevalent than alcohol.

Id.

99. BURNS, *supra* note 10, at 170 (“Use of medicinal drugs such as benzodiazepines and tricyclic antidepressants has been shown to more than double the risk of involvement in injurious falls and traffic accidents.” (citations omitted)).

100. NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., DRUGS AND HUMAN PERFORMANCE FACT SHEETS 2 (2004) [hereinafter DRUGS AND HUMAN PERFORMANCE], available at http://www.nhtsa.gov/people/injury/research/job185drugs/drugs_web.pdf.

101. *Id.* (“The selected drugs include[d] over-the-counter medications such as dextromethorphan and diphenhydramine; prescription medications such as carisoprodol, diazepam and zolpidem; and abused and/or illegal drugs such as cocaine, GHB, ketamine, LSD, marijuana, methadone, methamphetamine, MDMA, morphine, PCP and toluene.”).

102. *Id.* at 13, 25, 29, 35, 91.

103. *Id.* at 16, 27, 32, 37, 94.

performance in actual on-the-road driving tests. . . . [It also] compared the effects of a single oral dose of 50 mg diphenhydramine to the effects corresponding to a blood alcohol concentration of 0.1g/100mL,” which is over the legal limit of .08%.¹⁰⁴ In addition, all five of the licit drugs tested, when taken recreationally and not consistent with a doctor’s instructions, produced impairment.¹⁰⁵

Impairment from licit drugs can parallel the symptoms of illicit drugs, “include[ing] poor perception, impaired reaction time, . . . confusion, disorientation, [marked drowsiness], inattentiveness, slurred or thick speech, slow [verbal] responses, lack of balance and coordination, unsteadiness, and difficulty standing [and] walking.”¹⁰⁶ The increasing number of accidents associated with licit drug use and driving

might reflect recent nationwide growth in the volume of prescriptions for opioid analgesics and other potentially impairing medications. . . . These results might also reflect a recent increase in abuse of prescription drugs; the number of U.S. persons who started recreational use of opioid analgesics, sedatives, and tranquilizers in the previous year increased substantially from 1990 to 2003.¹⁰⁷

As both licit drug use and the number of people driving under the influence of these drugs increases, legislation must be enacted to adequately address this issue.

D. *Inconsistencies in the Treatment of Licit Drugs*

The current application of states’ OUI licit drug laws is inconsistent. As a result of the lack of uniformity, an unequal system is created wherein actions that would constitute an OUI offense in one state are legal in another. One difference is in determining

104. *Id.* at 37. “Overall driving performance was the poorest after taking diphenhydramine, and participants were most drowsy after taking diphenhydramine (before and after testing). The authors concluded that diphenhydramine clearly impairs driving performance, and may have an even greater impact than does alcohol on the complex task of operating a motor vehicle.” *Id.*

105. DRUGS AND HUMAN PERFORMANCE, *supra* note 100, at 16, 27, 32, 37, 94.

106. *Id.* at 16; *see also* DEP’T FOR TRANSP., ROAD SAFETY COMPLIANCE CONSULTATION § 5.4, at 51 (2008), available at <http://webarchive.nationalarchives.gov.uk/+http://www.dft.gov.uk/consultations/closed/compliance/roadsafetyconsultation.pdf> (“Impairment includes adverse effects on judgment and self-confidence, and after-effects—such as the extreme tiredness experienced in some cases—when the drug itself is no longer active. These impairing effects can be increased if any drug is misused and if drugs are used in combination with each other.”).

107. Kaplan et al., *supra* note 98, at 1295-96.

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what exactly constitutes a prohibited drug. As discussed in Part I, Massachusetts only allows for the prosecution of OUI drugs when a motorist operates a vehicle on a public way while under the influence of a *scheduled* drug as defined in chapter 94C, section 1 of the General Laws of Massachusetts.¹⁰⁸ If the drug used by the motorist is not a scheduled drug, then the OUI drug statute cannot be applied, regardless of how impaired the motorist was while driving, and, consequently, there is no “crime.”¹⁰⁹ In California, it is illegal to drive while under the influence of *any* drug if the drug “affect[s] the nervous system, the brain, or muscles [of the individual] as to impair to an appreciable degree *the ability to operate a vehicle* in a manner like that of an ordinarily prudent and cautious person in full possession of his faculties.”¹¹⁰ Under California’s statute, it need not be a scheduled drug; it can be any drug that causes impairment, including prescription and over-the-counter medicines or any substance with a mind- or body-altering effect that impairs driving ability.¹¹¹ California also makes it a crime for anyone addicted to a drug, other than controlled substances authorized for replacement narcotic therapy, to drive a vehicle.¹¹²

In OUI licit drug cases, a lack of uniformity also exists concerning what the prosecution must prove and what defenses are available to an individual arrested for OUI drugs. In Louisiana, in cases where over-the-counter and prescription drugs are at issue, the prosecutor must prove that “the influence is caused by the operator knowingly consuming quantities of the drug or drugs which substantially exceed the dosage prescribed by the physician or the dosage recommended by the manufacturer of the drug.”¹¹³ In Massachusetts, the quantity of the drugs taken is not an issue; however, the prosecution must establish that an individual knew or should have known that taking a prescribed substance would affect driving

108. MASS. GEN. LAWS ch. 90, § 24(1)(a)(1) (2008).

109. Commonwealth v. Ferola, 889 N.E.2d 436, 437 (Mass. App. Ct. 2008).

The crime, which is legislatively created, does not criminalize operation under the influence of all narcotics, stimulants, or depressants, but only those “defined in section one of chapter ninety-four C.” Absent proof that the defendant’s operation was impaired by a drug, depressant, or stimulant that is among those so defined, no statutory violation arises.

Id. (citations omitted).

110. People v. Torres, 93 Cal. Rptr. 3d 303, 307 (Ct. App. 2009) (alteration in original) (quoting People v. Canty, 90 P.3d 1168, 1174 (Cal. 2004) (internal quotation marks omitted)); see CAL. VEH. CODE § 23152 (a) (West 2000).

111. See Torres, 93 Cal. Rptr.3d at 307.

112. Cal. Veh. Code § 23152 (c).

113. State v. Kestle, 996 So. 2d 275, 278 (La. 2008) (citation omitted).

ability, because only voluntary intoxication is prohibited.¹¹⁴ The defendant may attempt to establish that his impairment was involuntary by “introducing evidence that he did not know of the possible effects of the medication on his driving ability, that he did not receive warnings as to [the medication’s] use, and that he had no reason to anticipate the effects which the drugs induced.”¹¹⁵ In Pennsylvania, the OUI drug statute sets forth a zero tolerance standard for driving with any amount of a Schedule I¹¹⁶ controlled substance in a person’s blood, but only applies a zero tolerance standard to prescription drugs (under Schedule II¹¹⁷ or III¹¹⁸) in a person’s blood if the drug was not prescribed to the individual.¹¹⁹ If an individual has a valid prescription for a particular Schedule II or Schedule III controlled substance, they can only be found guilty of OUI drugs if they are “under the influence . . . to a degree which impairs the individual’s ability to safely drive, operate or be in actual physical control of the movement of the vehicle.”¹²⁰ In North

114. *Commonwealth v. Reynolds*, 852 N.E.2d 1124, 1130 (Mass. App. Ct. 2006) (“[T]he Legislature did not intend to penalize a person . . . who drives after consuming a therapeutic dose of a prescription drug unaware of its possible effects. Yet, we have not ruled out the possibility of imposing criminal liability in circumstances where, as here, the defendant had reason to know of the drug’s possible effects . . .” (citations omitted)).

115. *Commonwealth v. Wallace*, 439 N.E.2d 848, 852-53 (Mass. App. Ct. 1982); KIMBERLY A. FOGARTY, MASS. DIST. ATTORNEYS ASS’N, *THE MASSACHUSETTS PROSECUTORS’ MANUAL: OPERATING UNDER THE INFLUENCE* (2008).

116. 35 PA. STAT. ANN. § 780-104 (West 2003) (describing that a Schedule I controlled substance has “a high potential for abuse, no currently accepted medical use in the United States, and a lack of accepted safety for use under medical supervision”).

117. *Id.* (describing that a Schedule II controlled substance has “a high potential for abuse, currently accepted medical use in the United States, or currently accepted medical use with severe restrictions, and abuse may lead to severe psychic or physical dependence”).

118. *Id.* (describing that a Schedule III controlled substance has “a potential for abuse less than the substances listed in Schedules I and II; well documented and currently accepted medical use in the United States; and abuse may lead to moderate or low physical dependence or high psychological dependence”).

119. 75 PA. CONS. STAT. ANN. § 3802 (West 2006).

120. *Id.* Georgia has a similar statutory scheme. *See* GA. CODE ANN. § 40-6-391 (West Supp. 2009). The statute states,

(a) A person shall not drive or be in actual physical control of any moving vehicle while:

....

(2) Under the influence of any drug to the extent that it is less safe for the person to drive;

....

(6) Subject to the provisions of subsection (b) of this Code section, there is any amount of marijuana or a controlled substance, as defined in Code Section 16-13-21, present in the person’s blood or urine, or both, including the

Dakota, it is a defense to OUI licit drugs if “a drug which predominately caused impairment was used only as directed or cautioned by a practitioner who legally prescribed or dispensed the drug to that person.”¹²¹

How the prosecution goes about proving that an individual is under the influence of a drug also differs between states. Some statutes require the prosecution to identify the intoxicant and require expert testimony regarding exactly how that drug affects the body. For example, in Pennsylvania, the prosecution must use expert testimony to establish that a prescription drug had an effect on an individual’s driving ability.¹²² However, other states are more lax and allow nonexpert testimony to establish that a motorist was under the influence of some intoxicant and that the intoxicant, whatever it may be, impaired diving ability. For example, in *State v. Kestle*, the Louisiana Supreme Court held that there is no rule that requires expert training in recognizing drug intoxication and no rule requiring the State to prove that a specific substance caused the intoxication.¹²³

Another variation in OUI laws concerns how states address polysubstance use. This has become a serious issue, as “drugs are at times taken in combination or with alcohol. In an average week, at least 25% of U.S. adults take five or more prescription or over-the-counter drugs, and 7% take five or more prescription drugs.”¹²⁴ Some OUI drug laws that require proof identifying the intoxicating drug fail to take into account that many times the impairment is

metabolites and derivatives of each or both without regard to whether or not any alcohol is present in the person’s breath or blood.

(b) The fact that any person charged with violating this Code section is or has been legally entitled to use a drug shall not constitute a defense against any charge of violating this Code section; provided, however, that such person shall not be in violation of this Code section unless such person is rendered incapable of driving safely as a result of using a drug other than alcohol which such person is legally entitled to use.

Id.

121. N.D. CENT. CODE § 39-08-01 (Supp. 2009); *see State v. Bitz*, 757 N.W.2d 565, 567 (N.D. 2008).

122. *Commonwealth v. Griffith*, No. 1315-MDA-2008, 2009 WL 1887535 (Pa. Super. Ct. July 2, 2009) (stating that the need for expert testimony is “necessitated by the inability of the trial court or any member of the jury to take notice of the effect of prescription medication on the human body, either alone or in combination with another controlled substance”).

123. *State v. Kestle*, 996 So. 2d 275, 282 (La. 2008).

124. Kaplan et al., *supra* note 98, at 1296 (citing David W. Kaufman et al., *Recent Patterns of Medication Use in the Ambulatory Adult Population of the United States: The Slone Survey*, 287 JAMA 337 (2002)).

attributable to a mixture of substances. If a statute does not allow the prosecution of someone who is impaired due to using a combination of substances and any one substance alone did not cause the impairment, then the impaired motorist will not be held responsible. In North Dakota, the OUI statute expressly accounts for situations where there is a combination of drugs and alcohol.¹²⁵ In contrast, the Massachusetts statute does not.¹²⁶ In order to prosecute a motorist for driving under the influence of a combination of drugs and alcohol in Massachusetts, that person must be charged with OUI alcohol, and the prosecution must rely on the portion of the law that states that alcohol only needs to be “‘one contributing cause of the diminished ability.’ Alcohol need not be the sole cause of the defendant’s impaired ability.”¹²⁷

The difficulties associated with prosecuting OUI licit drugs go deeper than the inconsistent application of laws. The complexity of this crime is compounded by issues such as lack of roadside testing devices designed to detect licit drug use, lack of public awareness that certain licit drugs impair driving ability, and lack of public awareness that licit drug use can result in an arrest for OUI drugs. Further challenges include the large volume of prescription and over-the-counter drugs in existence, the number of people who take these drugs, and the lack of scientific testing regarding how each individual drug affects an individual. These challenges make it extremely difficult to develop a strategy to combat both OUI licit and illicit drugs without adequately funding research and adequately

125. See N.D. CENT. CODE § 39-08-01(1)(d).

(1) A person may not drive or be in actual physical control of any vehicle upon a highway or upon public or private areas to which the public has a right of access for vehicular use in this state if any of the following apply:

....

(d) That person is under the combined influence of alcohol and any other drugs or substances to a degree which renders that person incapable of safely driving.

Id.

126. See MASS. GEN. LAWS ch. 90, § 24 (2008). In Massachusetts, there is no separate charge of OUI combination drugs and alcohol. See *id.* In instances where there is evidence of some alcohol use, which appears to be compounded by drug use, the defendant is charged with OUI alcohol. See *id.*

127. Commonwealth v. Widmaier, No. 08-P-918, 2009 WL 1979967, at *1 (Mass. App. Ct. July 10, 2009) (citation omitted) (quoting Commonwealth v. Stathopoulos, 517 N.E.2d 450, 453 (Mass. 1988)). “It is enough if the defendant’s capacity to operate a motor vehicle is diminished because of alcohol, even though other, concurrent causes contribute to that diminished capacity.” *Id.* (quoting *Stathopoulos*, 517 N.E.2d at 453) (internal quotation marks omitted).

training law enforcement on how to investigate and prosecute these cases.

E. Obstacles Confronted by Law Enforcement and Prosecutors

Law enforcement officers are the frontline defense in the effort to combat OUI drugs. When a motorist is stopped due to erratic driving, it is up to the officer to make a determination that an individual is impaired. However, when drugs are involved, many officers are ill equipped to properly investigate the cause. As a result, impaired drivers are allowed to continue to drive. It was situations such as this that prompted the creation of the NHTSA's Drug Evaluation and Classification Program (DEC Program).¹²⁸ The DEC Program is modeled after a program that was started in the early 1970s by Los Angeles Police Officers.¹²⁹ Officers in the LAPD were frustrated that many drivers who were clearly impaired by drugs were going unpunished because the officers lacked the training and experience to support their suspicions that drugs caused the impairment.¹³⁰ As a result, members of the LAPD began to "collaborate[] with various medical doctors, research psychologists, and other medical professionals to develop a simple, standardized procedure for recognizing drug influence and impairment. Their efforts culminated in the development of a multi-step protocol and the first DRE [Drug Recognition Expert] program."¹³¹

The NHTSA soon took notice of this program and, along with the National Institute on Drug Abuse and various other agencies and research groups, began an examination of it.¹³² The overall conclusion of these studies was that DRE procedures provided trained police officers with the ability to accurately recognize the symptoms of many types of drugs used by drivers.¹³³ As a result of

128. The International Drug Evaluation & Classification Program, Drug Recognition Experts (DRE): History and Development, <http://www.decp.org/experts/> (last visited Mar. 26, 2010) [hereinafter IDECP].

129. *Id.*

130. *Id.*

131. *Id.* A DRE "is a police officer [who is] trained to recognize impairment in drivers [who are] under the influence of drugs other than, or in addition to, alcohol."
Id.

132. *Id.*

133. THOMAS E. PAGE, L.A. POLICE DEP'T DRUG RECOGNITION EXPERT UNIT, THE DRUG RECOGNITION EXPERT (DRE) RESPONSE TO THE DRUG IMPAIRED DRIVER: AN OVERVIEW OF THE DRE PROGRAM, OFFICER, AND PROCEDURES pt. 1, available at http://www.ndaa.org/apri/programs/traffic/thomas_page_article_facts.html (last visited Mar. 26, 2010). In 1996, the NHTSA reported to Congress that the DRE program "has been remarkably successful in producing meaningful results[,] . . . saving lives on our

these studies, in 1987, the NHTSA initiated pilot DEC Programs in four states¹³⁴ and the next year added three more states.¹³⁵ “[I]n 1989, [the International Association of Chiefs of Police (IACP)] and [the] NHTSA expanded the DEC Program across the country.”¹³⁶ Under the guidance of the IACP, as of November 2009, forty-six states, plus the District of Columbia, participate in the program in the United States.¹³⁷ Additionally, “three branches of the military, the Internal Revenue Service (IRS), and several countries around the world participate in the DEC Program.”¹³⁸

Becoming a DRE is a rigorous process.¹³⁹ The DEC Program enables a police officer who is certified as a DRE to employ a stan-

nation’s roads[.] . . . gaining court acceptance[.] . . . and showing a steady return on investment.” *Id.* (omissions in original) (internal quotation marks omitted).

134. IDECP, *supra* note 128 (Arizona, Colorado, New York, and Virginia).

135. *Id.* (Utah, California, and Indiana).

136. *Id.*

137. The International Drug Evaluation & Classification Program, Drug Recognition Experts (DRE): State and Countries with DREs, <http://www.decp.org/experts/statescountries.htm> (last visited Apr. 29, 2010). Those states include Alabama (recently added to program), Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming. *Id.* The four states currently not in the DEC Program are Connecticut, Michigan, Ohio, and West Virginia. *See id.*; Telephone Interview with Chuck Hayes, DRE Coordinator, Int’l Ass’n of Chiefs of Police (Nov. 3, 2009).

138. IDECP, *supra* note 128.

139. “A [DRE] must have successfully completed an approved course in the Standardized Field Sobriety Testing (SFSTs) before beginning the three-phase Drug Evaluation and Classification (DEC) Program” The International Drug Evaluation & Classification Program, Drug Recognition Experts (DRE): How Do I Become a DRE?, <http://www.decp.org/experts/howdoi.htm> (last visited Mar. 26, 2010). The first phase of the program consists of a “16-hour DRE Pre-school, which includes an overview of the DRE evaluation procedures, the seven drug categories, eye examinations and proficiency in conducting the SFSTs.” *Id.* The second phase consists of a

56-hour DRE School which includes an overview of the drug evaluation procedures, expanded sessions on each drug category, drug combinations, examination of vital signs, case preparation, courtroom testimony, and Curriculum Vitae (C.V.) preparation. At the conclusion of the 7-days of training, the officer must successfully complete a written examination before moving to the third and final phase of training.

Id. In the third phase,

the candidate DRE must complete a minimum of 12 drug evaluations under the supervision of a trained DRE instructor. Of those 12 evaluations, the officer must identify an individual under the influence of at least three of the seven drug categories and obtain a minimum 75% toxicological corroboration

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standardized twelve-step evaluation¹⁴⁰ “to determine whether a suspect is under the influence of alcohol and/or drugs and, if so, what category of drugs, by combining basic medical knowledge about drug pharmacodynamics with validated psychomotor tests.”¹⁴¹ A DRE must complete the entire twelve-step evaluation before reaching an opinion regarding what category or categories of drugs an individual has ingested. This rigorous system

is standardized in that all DREs, regardless of agency, utilize the same procedure, in the same order, on all suspects. It is systematic in that it logically proceeds from a BAC, through an assessment of signs of impairment, to toxicological analysis for the presence of drugs. This procedure is rooted in standard medical procedures that are used to reach a diagnosis of illness or injury.¹⁴²

The creation and nationwide implementation of the DRE program has alerted all officers, whether certified as DREs or not, that they need to be more aware of the warning signs of drugged driving. If an officer who is not DRE-certified suspects that a motorist is under the influence of drugs, protocol is to call in a DRE to investigate. Unfortunately, nationwide there are only 6,143 trained DREs.¹⁴³ In a nation with roughly 18,000 police departments and approximately 732,000 fulltime sworn officers, this number of DREs is extremely low.¹⁴⁴ In fact, most departments do not have

rate. The office [sic] must then pass a final knowledge examination and be approved by two DRE instructors before being certified as a certified DRE.

Id.

140. The International Drug Evaluation & Classification Program, Drug Recognition Experts (DRE): The DRE Protocol, <http://www.decp.org/experts/12steps.htm> (last visited Feb. 13, 2010). The twelve standardized evaluative steps utilized to assess a suspected OUI drug motorist are: (1) Breath Alcohol Test (a review of the Breath Alcohol Concentration to determine if alcohol is the cause of impairment, if not, then the DRE becomes involved); (2) Interview of the Arresting Officer; (3) Preliminary Examination (includes the first of three pulses); (4) Eye Examinations; (5) Divided Attention Tests; (6) Vital Signs Examinations (includes the second of three pulses); (7) Darkroom examinations of pupil size (includes an examination of the nasal and oral cavities); (8) Muscle Tone Examination; (9) Examination of Injection Sites (includes the third pulse); (10) Statements and Interrogation; (11) Evaluator Opinion; and (12) Toxicology Examination (obtaining a specimen and subsequent analysis). *Id.*

141. AM. PROSECUTORS RESEARCH INST., THE DRUG EVALUATION AND CLASSIFICATION (DEC) PROGRAM: TARGETING HARDCORE IMPAIRED DRIVERS 1 (2004), available at http://www.ndaa.org/pdf/drug_evaluation_classification_dec.pdf.

142. PAGE, *supra* note 133, at pt. 3.

143. Telephone Interview with Chuck Hayes, DRE Coordinator, Int'l Ass'n of Chiefs of Police (Nov. 3, 2009).

144. See BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, CENSUS OF STATE AND LOCAL LAW ENFORCEMENT AGENCIES 1 (2004), available at <http://>

any drug recognition experts at all. Because the vast majority of officers in the United States are not DREs and availability to call in a DRE is often very limited, evidence needed to prosecute an OUI drug suspect is often nonexistent.

The low number of DREs is likely attributable to both the expense and time necessary to send an officer to DRE training. In the state of Washington, the cost of this training is approximately \$3,000 per student.¹⁴⁵ Compounding this initial cost is the burden of maintaining the program, which is typically “not adequately supported with training, administrative or toxicological resources.”¹⁴⁶ There is also a large time commitment to becoming and remaining a certified DRE. An officer must attend sixteen hours of the Drug Recognition Expert Pre-School, fifty-six hours of the Drug Recognition Expert DRE School, and put in approximately forty to sixty hours for Drug Recognition Expert Field Certification (usually completed over several months).¹⁴⁷ Once an officer is certified as a DRE, the officer must undergo recertification every two years.¹⁴⁸ In order to maintain proficiency, DREs “need to use their skills

bjs.ojp.usdoj.gov/content/pub/pdf/cslea04.pdf. In 2004, there were 731,903 sworn, full-time police officers in 17,876 agencies nationwide. *Id.* at 2 tbl.2. “There are currently 45 DRE states participating in the program with over 8,000 DREs and instructors.” Iowa Department of Public Safety, The Iowa Drug Recognition Expert Program, <http://www.dps.state.ia.us/commis/gtsb/GTSBdre.shtml> (last visited Apr. 8, 2010).

145. This cost includes lodging, meals, equipment, and manuals. Washington State Patrol Forensic Laboratory Services, Washington Drug Recognition Expert School Application, *available at* <http://breathtest.wsp.wa.gov/> (select “DRE forms and manuals”; then select “DRE expert school application 6-09” under “forms” subsection) (last visited Apr. 8, 2010).

146. PRIORITIES AND STRATEGIES, *supra* note 61.

147. The International Drug Evaluation & Classification Program, Drug Recognition Experts (DRE): DRE Training & Certification, <http://www.decp.org/training/> (last visited Apr. 8, 2010).

148. Recertification requires a DRE to

demonstrate continuing proficiency by: (1) Performing a minimum of four . . . acceptable evaluations since the date of last certification, all of which shall be reviewed and approved by a certified DRE instructor and one . . . of which shall be witnessed by a certified DRE instructor. These evaluations may be performed on subjects suspected of drug and/or alcohol impairment or during class room simulations; and (2) Completing a minimum of eight hours of recertification training since the date of the DRE’s most recent certification, which may alternatively be presented in two sections of no less than four hours, and which shall be consistent with any IACP standards for such training; and (3) Presenting an updated Curriculum Vitae and rolling log to the appropriate coordinator or his/her designee for review.

The International Drug Evaluation & Classification Program, Drug Recognition Experts (DRE): DRE Certification, <http://www.decp.org/experts/recertification.htm> (last visited Apr. 8, 2010).

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regularly . . . [,] receive training concerning changes in the program, and stay informed about emerging patterns of drug use in their communities. They also need the opportunity to testify regularly otherwise they lose confidence in their abilities to practice what they learned in training.”¹⁴⁹

The parameters of permissible DRE testimony differ between the states. This is because there is no universal decision regarding whether the DRE protocol is scientific evidence and whether a certified DRE should be treated as an expert. Some courts analyzing the DRE protocol under *Frye*¹⁵⁰ or *Daubert*¹⁵¹ standards have determined that it is scientific evidence that is subject to judicial gatekeeping,¹⁵² while other courts have held the DRE protocol is neither scientific nor novel.¹⁵³ The federal court in the District of Nevada went so far as to say that the DRE protocol is not scientific and is no more than an officer making physical observations.¹⁵⁴ Courts that have determined that the DRE protocol is scientific have decided that the twelve-step evaluation process is generally accepted in relevant scientific communities and allow testimony if the witness is a qualified DRE.¹⁵⁵ In Oregon, the court held that a DRE must complete all twelve steps of the DRE protocol before testimony of the procedures and results will be allowed in evidence.¹⁵⁶ This requirement poses a problem as the final step of the

149. PRIORITIES AND STRATEGIES, *supra* note 61, at 5.

150. *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

151. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993).

152. *E.g.*, *State v. Sampson*, 6 P.3d 543, 549-50 (Or. Ct. App. 2000); *State v. Baity*, 991 P.2d 1151, 1161 (Wash. 2000).

153. *E.g.*, *Williams v. State*, 710 So. 2d 24, 28 (Fla. Dist. Ct. App. 1998); *State v. Klawitter*, 518 N.W.2d 577, 584 (Minn. 1994); *State v. Layman*, 953 P.2d 782, 786 (Utah Ct. App. 1998).

154. *United States v. Everett*, 972 F. Supp. 1313, 1319-20 (D. Nev. 1997).

155. *See Sampson*, 6 P.3d at 551, 555-56; *Baity*, 991 P.2d at 1161 (“DRE evidence is admissible under *Frye* because it is generally accepted in the relevant scientific communities. A properly qualified expert may use the 12-step protocol and the chart of categories of drugs to relate an opinion about the presence or absence of certain categories of drugs in a suspect’s system.”). Many critics of the DRE protocol refer to it as “voodoo science” and argue that the protocol has not been accepted in the scientific community. *See* John B. Mancke, *Driving Under the Influence (DUI) of Drugs Law Update*, 80 PA. B. ASS’N Q. 99, 107 n.36 (2009) (setting forth the questions and concerns with the scientific validity and effectiveness of the DRE protocol).

156. *State v. Aman*, 95 P.3d 244, 249 (Or. Ct. App. 2004).

[T]here is no evidence that the methodology employed—an 11-step DRE test without toxicological confirmation—generally has been accepted in the relevant field, has been used in a reported judicial decision, has a known rate of error, is mentioned in specialized literature, or is not a novel, even singular, employment in this state. To the contrary, the omission of the corroborating

DRE protocol calls for the suspect to provide a blood or urine sample and, often times, an individual is either unwilling or unable to produce such a sample.¹⁵⁷ If a defendant refuses to produce such a sample, the entire test will not be allowed into evidence and a DRE will not be allowed to rely on the other eleven steps of the procedure in forming an opinion as to impairment.¹⁵⁸ Such a result makes it easy for defendants to thwart the process.

Both the Arkansas and New York courts allow a properly certified DRE to testify as an expert.¹⁵⁹ Washington courts will allow a properly trained DRE to give an opinion about the presence of a certain category of drug but will not allow testimony that predicts a specific level, and the DRE cannot “cast[] an aura of scientific certainty to . . . testimony.”¹⁶⁰ In some states, a DRE is allowed to give an opinion that an individual is impaired but may not be referred to as an expert; instead, a DRE must be referred to as a drug-recognition evaluator, examiner, or officer.¹⁶¹ Other states have yet to address whether the DRE protocol is scientific evidence or whether a DRE’s testimony constitutes expert testimony.¹⁶²

Adding to the myriad of obstacles that frustrates law enforcement officers’ ability to detect OUI drugs and present evidence in court is the lack of training prosecutors have with these cases.¹⁶³ OUI drug cases are inherently difficult to prosecute because they deal with a body of medical and pharmaceutical knowledge that is unfamiliar to many attorneys. This lack of familiarity with a com-

toxicology report deprives the test of a major element of its scientific basis, and there is no evidence that an examiner’s reputation for accuracy constitutes an adequate substitute.

Id.

157. *Id.* at 248 (“According to the state, failure to obtain a urine sample for testing will sometimes occur in the administration of the DRE protocol, ‘based on the nature of the controlled substance a defendant has consumed.’”).

158. *Id.*

159. *Mace v. State*, 944 S.W.2d 830, 834 (Ark. 1997).

The circuit court specifically stated that it was qualifying [the police officer] as an expert for a narrow purpose—whether [the defendant] was impaired because of some kind of intoxicant. We agree that [the police officer’s] specialized training and knowledge aided the circuit court in determining this fact in issue.

Id.; *People v. Villeneuve*, 649 N.Y.S.2d 80, 83 (App. Div. 1996).

160. *State v. Baity*, 991 P.2d 1151, 1160-61 (Wash. 2000).

161. *See, e.g., Williams v. State*, 710 So. 2d 24, 37 n.23 (Fla. Dist. Ct. App. 1998); *State v. Klawitter*, 518 N.W.2d 577, 585-86 (Minn. 1994).

162. *Mancke, supra* note 155, at 112 (“Whether the DRE officer’s testimony qualifies as expert testimony under [P.A. R. EVID. 702], has not been addressed by the appellate courts in Pennsylvania.”).

163. PRIORITIES AND STRATEGIES, *supra* note 61, at 10.

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plex issue, coupled with large case loads, is a lethal combination that makes it difficult to successfully prosecute an OUI drug case. Without proper training on how to examine an expert witness (either a DRE or toxicologist), how to understand toxicology reports, and how to interpret the state's OUI drug statutes (which some state courts have yet to do), the ability to successfully prosecute OUI drug cases is nebulous at best.

III. RECOMMENDATIONS

It is clear that many variables make identifying and prosecuting an OUI drug suspect a difficult task.¹⁶⁴ It is also clear that courts have not agreed on how to handle the type of evidence and testimony that comes with an OUI drug case. As a result, there is no “easy fix” to the issues that hamper the ability to successfully fight drugged driving. There are, however, some steps that can move us in the right direction.

We need to recognize that several of the tactics used to combat OUI alcohol—albeit an inherently easier crime to fight—can and should be used to fight drugged driving. First, the public needs to become more aware that driving after taking drugs, whether illicit, prescription, or over-the-counter, is a safety risk that can amount to a violation of the law. This can be done through public-awareness campaigns and by health care professionals and pharmacists taking a more active role in educating their patients about the risks of potentially impairing medications. New Zealand recently started a “pharmacy bag sticker” campaign.¹⁶⁵ Whenever an individual fills a prescription, the bag displays the following notification: “Driving and drugs—important information: From 1st November 09, Police may carry out compulsory tests on drivers they suspect of driving under the influence of drugs. For more information check with your pharmacist or prescription information.”¹⁶⁶ Other countries have numerous television, radio, and print ads that highlight the dangers of drugged driving.¹⁶⁷ In Australia, the government has

164. See *supra* Part II.

165. New Zealand Transport Agency, Drug-Driving Advertisements, <http://www.nzta.govt.nz/about/advertising/other/drug-driving.html> (last visited Apr. 7, 2010).

166. See Pharmacy Bag Sticker (on file with *Western New England Law Review*).

167. See, e.g., Department for Transport, Drug Driving Awareness, <http://www.dft.gov.uk/think/drugdrive/home.shtml> (last visited Apr. 8, 2010) (England, Ireland, and Scotland's ad campaign proclaiming: “Drug Driving: Your Eyes Will Give You Away”). See The Transport Accident Commission, Drug Driving Advertising Campaigns, <http://www.tacsafety.com.au/jsp/content/NavigationController.do?areaID=13&tierID=2&navID=5866F85E7F000001016CE9DF936FE74F&navLink=null&>

made a significant commitment to this campaign by funding these antidrugged driving public-awareness campaigns for ten years.¹⁶⁸ These campaigns address both driving after taking prescription or over-the-counter medicine and driving after taking illicit recreational drugs.¹⁶⁹ Currently, public-awareness campaigns in the United States focus exclusively on consuming alcohol and driving, not on drug use and driving. The need for public awareness is especially true regarding the use of licit drugs, as many people do not know that licit drugs can have an impairing effect on driving ability. Broadening impaired-driving awareness campaigns to include drugged driving and thus creating public awareness and understanding is the first step to combating the crime.

Achieving public awareness of the risks of using drugs and driving must be coupled with vigorous and effective enforcement to promote deterrence. In order to deter people from engaging in this conduct, the public needs to recognize that using drugs and driving is a crime that will likely end in arrest. Therefore, law enforcement officers need to be trained to detect drug-impaired individuals and must be provided the necessary tools to do so. To that end, more officers must be trained in the DEC Program as DREs. The DRE program is the most effective tool currently available to law enforcement officers for the assessment and documentation of behavior and impairment in drug-impaired drivers. While this training may be costly, it is necessary for the detection and successful prosecution of these offenders. In order to strengthen the DRE program, more resources must be allocated to law enforcement agencies. Money to finance this effort should come from both government subsidies and self-sustaining funds consisting of OUI offender-generated fees and fines. These funds can be used to supplement budgets and facilitate the more in-depth DRE training of law enforcement officers. The funds should also be used to finance the research and development of roadside drug testing devices. As we learned with OUI alcohol, portable breathalyzers used at the

pageID=1553 (last visited Mar. 27, 2010) to view the history of Australia's public education campaign from December 2004 through its newest advertisement in July 2009: "If you drive on drugs you're out of your mind."

168. See Queensland Government, Anti-Drug Driving, http://www.transport.qld.gov.au/Home/Safety/Road/Campaigns/Anti_drug_driving_campaign (last visited Mar. 27, 2010).

169. *Id.*

roadside are an important tool in confirming an officer's belief that an individual is under the influence of alcohol.¹⁷⁰

In addition to training and properly equipping law enforcement officers, there must be high visibility of OUI drug enforcement programs. This would include officers making a concerted effort to detect drug impairment at traditional OUI sobriety checkpoints. These checkpoints must be staffed by officers who are trained to detect and evaluate impairment based on drug use. Once the public's perception of the likelihood of arrest for this crime is raised, more people will likely think twice before using a drug and driving a car. Because the deterrent effect created by an arrest will be short-lived if the public becomes aware that there is little likelihood of conviction, prosecutors need to receive adequate training so that they can properly present an OUI drug case. Prosecutors must be educated about expert testimony and scientific evidence, including how to establish a DRE's background and qualify such an individual to give expert testimony in court, how to conduct a proper examination of a toxicologist, and how to read a toxicology report.

Next, the standard used to determine if one is OUI drugs needs to be uniform. We must recognize that a *per se* limit is not a viable option at this time because "current research does not enable one to predict whether a driver testing positive for a drug, even at some measured level of concentration, was actually impaired by that drug" while they were driving.¹⁷¹ Research should continue to be conducted to accurately define these impairment levels, after which standards need to be created on a national level.

Because *per se* limit laws are not currently feasible, we must give a serious look at the adoption of a zero tolerance law. The implementation of such a law will certainly serve the purpose of OUI laws: to ensure public safety by stopping drugged driving. A zero tolerance law necessarily eases the burden of proving OUI drugs and is an effective tool in deterring motorists from operating after using drugs, but will likely draw fire regarding individual rights. The net cast by this standard will undoubtedly catch people who are operating while impaired, but will also catch those who have traces of drugs in their system and are no longer under the influence of any drug. Even so, this may be a palatable option for many, especially in instances where an individual is driving with an

170. *See supra* Part II.B.

171. STATE OF KNOWLEDGE OF DRUG-IMPAIRED DRIVING, *supra* note 2, at 85.

illicit substance in his body. In effect, a zero tolerance drug law is not punishing driving while impaired or under the influence, but creates a new crime of driving with any detectable amount of a drug in the body.

The alternative to adopting a zero tolerance law is drafting a straightforward effect-based law that would be less difficult to prosecute under. Current effect-based laws that require testimony regarding the exact nature of the substance used and that limit the type of substances that qualify as an intoxicant fail to accomplish what they were designed to do: protect the public from unsafe drivers. The same is true of how some courts interpret the OUI drug statute. Law enforcement officers must be allowed to testify regarding their observations and opinions concerning impairment. Judicial rulings that limit an officer's ability to so testify render the prosecution unable to prove many of these cases. Furthermore, the lack of uniformity regarding what constitutes under the influence and what evidence is admissible at trial creates an uncertain atmosphere regarding the likelihood of conviction. It also creates illogical situations where what constitutes a crime in one state is legal in another. To deal with this, the federal government must step in and wield its financial powers to compel the states to address these very serious issues.¹⁷²

Regardless of what OUI drug standard is adopted by a state, mandatory testing to confirm the presence of drugs in the body of motorists arrested for OUI drugs must be implemented. Per se and zero tolerance laws necessitate such testing in order to prove that a drug or its metabolite is present in one's system. The manner in which effect-based laws are typically construed also necessitates such testing. This is especially true in the case of a DRE's twelve-step evaluation process where the twelfth step requires obtaining a specimen for toxicological analysis.

If an individual refuses to provide a sample, the state's implied-consent laws should be applied and the motorist's license should be suspended. All fifty states have implied-consent laws.¹⁷³ The pur-

172. Congress has used its spending powers to effect change in alcohol-related laws in the past. In 1984, Congress passed The National Minimum Drinking Age Act to push each state toward enacting a minimum legal age of twenty-one to purchase alcohol. 23 U.S.C. § 158 (2006). In 2007, Congress passed legislation encouraging states to lower the legal BAC level from .10 to .08. 23 U.S.C. § 163.

173. On October 4, 1972, the District of Columbia became the last of all the jurisdictions to enact an implied-consent law. See S. REP. NO. 92-1262, at 4 (1972) ("Comparable provisions on 'implied consent' are now law in all of the States. The District of Columbia is the sole remaining jurisdiction without an 'implied consent' law."); see also

pose of these laws is to provide a strong inducement to submit to chemical testing to effectuate the state's "interest in obtaining reliable and relevant evidence for use in subsequent criminal proceedings . . . [and to] prompt[ly] remov[e] such drivers from the road, . . . contribut[ing] to the safety of public highways."¹⁷⁴ Every state's implied-consent law mandates that all operators of motor vehicles are deemed to have consented to a BAC test if there are reasonable grounds to believe that the driver is operating a motor vehicle while under the influence of alcohol.¹⁷⁵ With the notable exception of Nevada, all states impose administrative sanctions for refusal,¹⁷⁶ setting forth "the statutory structure for suspending the license of a driver who refuses to submit to testing for alcohol concentration."¹⁷⁷ However, not every state's implied-consent law mandates testing for the presence of drugs. In Massachusetts, the implied-consent law sets forth that operators of vehicles "shall be deemed to have consented to submit to a chemical test or analysis of [their] breath or blood in the event that [they are] arrested for operating a motor vehicle while under the influence of intoxicating liquor."¹⁷⁸ When a state's implied-consent law does not cover OUI drugs, it takes away an extremely important mechanism that law enforcement can use to persuade motorists to submit to testing. In doing so, the state is effectively precluding law enforcement from gaining the evidence needed to successfully prosecute an OUI drug case. Therefore, every implied-consent law must be drafted to apply to OUI drugs, and not just to alcohol.

When an individual refuses to provide a sample to be tested for drugs, there must be severe sanctions. Most states punish such refusals with sanctions such as license suspension or revocation, but some states criminalize a refusal. Criminalization of a refusal is an effective and reasonable strategy: "[I]mposing criminal sanctions to

Matthew J. Dougherty, Casenote, *Hays v. City of Jacksonville*, 518 So. 2d 892 (Ala. Crim. App. 1987), 19 CUMB. L. REV. 177, 177 n.3 (1988) (citing the implied-consent laws of the fifty states).

174. *Motor Vehicle Admin. v. Richards*, 739 A.2d 58, 68 (Md. 1999).

175. *See, e.g.*, MASS. GEN. LAWS ch. 90, § 24(1)(f)(1) (2008); 75 PA. CONS. STAT. § 1547 (West 2006).

176. U.S. DEP'T OF TRANSP., NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS: BLOOD ALCOHOL CONCENTRATION TEST REFUSAL LAWS (2007), available at <http://www.nhtsa.dot.gov/people/injury/TSFLaws/PDFs/810723W.pdf>.

177. *Motor Vehicle Admin. v. Shepard*, 923 A.2d 100, 101 (Md. 2007); *see also* MD. CODE ANN., TRANSP. § 16-205.1 (LexisNexis 2009); ROBERT B. MCKINNEY & MARY ANNE M. PAZANOWSKI, 3A MARYLAND LAW ENCYCLOPEDIA: AUTOMOBILES AND MOTOR VEHICLES § 96 (2007), available at MD-ENC AUTOS § 96 (Westlaw).

178. MASS. GEN. LAWS ch. 90, § 24(1)(f)(1).

accompany the administrative penalty of loss of license or fine will increase the costs of refusing and thus encourage more people to take the . . . test.”¹⁷⁹ If the purpose of the implied consent is to be realized, the sanction for refusal to test must be more than nominal, and whether administrative or criminal, must be no less than what it is for a positive test.

CONCLUSION

It is every driver’s responsibility to ensure that they are safe to drive. When they are not safe to drive and do so anyway, it is the state’s responsibility to punish that behavior and deter it from happening again. Lack of uniformity regarding what type of drugs trigger an OUI drug offense, what proof is required to establish it, and what defenses are available all deter law enforcement from successfully fighting OUI drugs. When that is coupled with a lack of training and experience for both law enforcement and prosecutors and a lack of resources directed to understanding, detecting, and combating the crime, it is clear that we are nowhere close to winning the war on OUI drugs. Unless more research, more public awareness, and clearer laws are developed, drugged drivers will continue to slip through the cracks.

179. Cafaro, *Fatal Flaws*, *supra* note 24, at 121.