

Medical Marijuana: A Serious Danger to Highway Users

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Driving under the influence of drugs (DUID) is a serious highway safety issue, and the number of persons who die annually in these crashes may be greatly underrepresented. Quantifying those affected by drugs—and, more specifically, by what classes of drugs—remains problematic, even in terms of crash fatalities. For instance, the ability to determine accurate on-scene blood alcohol concentrations (BACs) often trumps the delayed receipt of drug results collected by far more cumbersome, time-consuming, and expensive means.

According to the National Highway Traffic Safety Administration (NHTSA), only 63 percent (13,801) of the 21,798 drivers killed in U.S. traffic crashes in 2009 were tested for “drug involvement,” which neither implies impairment nor indicates crash cause.¹ The 3,952 fatally injured drivers who actually tested positive for the presence of drugs other than alcohol represented 18 percent of all of those fatalities tested in 2009 (13,801), as well as 33 percent (3,952) of those 12,055 with known drug test results.² The proportion of drivers testing positive for drugs increased between 2005 and 2009.³

Of those nighttime drivers in the 2007 National Roadside Survey who were randomly stopped on weekends and who provided oral fluid or blood specimens, 16.3 percent tested positive for drugs other than alcohol with 8.65 percent testing positive for marijuana, the most frequently encountered drug.⁴ Additionally, two Maryland studies of shock trauma center admissions revealed that more than one-quarter of injured drivers tested positive for marijuana.⁵ Finally, “drivers who test positive for marijuana or report driving within three hours of marijuana use are more than twice as likely as other drivers to be involved in a crash.”⁶

Marijuana and tetrahydrocannabinol (THC) remain classified as schedule I controlled substances under U.S. law.⁷ To this end, the U.S. Food and Drug Administration has declined to approve smoked marijuana for any condition or disease and has noted, “There is currently sound evidence that smoked marijuana is harmful,” and “no sound scientific studies support medical use of marijuana for treatment in the United

States, and no animal or human data support the safety or efficacy of marijuana for general medical use.”⁸

The DUID issue du jour involves medical marijuana. Its legalization with varying provisions in 16 states and the District of Columbia since 1996⁹ resulted in the IACP’s calling for the repeal of state legislation legalizing the manufacture, the distribution, and the possession of marijuana for medical purposes.¹⁰ Medical marijuana also challenges traffic law enforcement efforts that strive to ensure safe highways in spite of those legally entitled to inhale under state laws. For example, Colorado legalized medical marijuana in 2000, and drivers in fatal crashes testing positive for marijuana rose from 37 in 2009 to 42 in 2010, while those testing positive for alcohol declined during those same years from 138 to 112.¹¹ Montana legalized medical marijuana in 2004 and experienced between 2007 and 2010 more than a 100 percent increase in the detection of marijuana among impaired driving arrestees and in excess of a 180 percent increase in positive tests for both marijuana and alcohol among those arrestees.¹² Research has established that even a small amount of alcohol combined with cannabis increases impairment.¹³ Furthermore, an analysis of Montana’s fatal crashes in 2010 revealed that 38 percent involved drugs other than alcohol, 33 percent involved alcohol, and 14 percent involved a combination of drugs and alcohol.¹⁴

Several considerations are presented in this column to assist those police chief executives faced with medical marijuana and other DUID issues.

Consider illegal per se laws. The Office of National Drug Control Policy in its *National Drug Control Strategy* proposes reducing the incidence of DUID by 10 percent by 2015.¹⁵ One means of achieving this goal is to encourage states to enact per se drugged driving statutes rather than those based on the affected-by standard.¹⁶

On one hand, per se drugged driving statutes, which have been adopted in 15 states, simply make the presence of any illegal drug—or of any illegal drug above an established cut-off level¹⁷—in a driver’s body evidence of impaired driving.¹⁸ This standard negates the need to prove a driver’s impairment by illegal drugs,¹⁹ which is fortuitous since “there is no scientific basis for specifying a bodily fluid concentration that is indicative of impairment.”²⁰ On the other hand, affected-by DUID statutes require proof that a driver took a drug, including a lawfully prescribed one, and that it impaired the driver’s

ability to operate a vehicle.²¹ The Federal Motor Carrier Safety Administration promulgated for commercial vehicle drivers a per se standard for illegal drugs, as well as an affected-by standard for prescription drugs, more than two decades ago;²² those regulations illustrate the highway safety benefits of such a dual approach.

A related issue involves the cutoff level: whether to establish one, and the point at which to set it. Only three of the fifteen states enacting per se drugged driving statutes adopted cutoff levels.²³ For marijuana, both Nevada and Ohio set 10 nanograms per milliliter (ng/mL) for urine and 2 ng/mL for blood. For marijuana metabolites, the cutoff levels are 15 ng/mL for urine and 5 ng/mL for blood.²⁴ For THC, Pennsylvania established 5 ng/mL for blood.²⁵ Colorado currently is wrestling with setting a THC threshold at 5 ng/mL for blood.²⁶ However, research suggests that setting a cutoff level at less than 5 ng/mL for blood would fail to identify many drivers who smoked cannabis because THC is rapidly cleared from the blood.²⁷

Increase drug recognition experts (DREs). Born in the Los Angeles Police Department in 1979, NHTSA adopted and expanded the concept of trained and credentialed drug recognition experts (DREs), eventually leading to the development of the Drug Evaluation and Classification Program (DECP) that the IACP has operated since 1989.²⁸ Prospective DREs receive more than 100 hours’ intensive training—based upon the standard field sobriety tests (SFST)—to conduct systematic and standardized 12-step evaluations consisting of physical, mental, and medical components.²⁹ One of the benefits that DREs offer is the ability to indicate which of the seven classes of drugs may be affecting an individual, so laboratory testing can be focused and its costs can be reduced.³⁰ The DECP has been evaluated and deemed effective in identifying drug impaired drivers.³¹ Currently, 49 states and the District of Columbia participate in the DECP, which has credentialed 6,336 DREs, 1,319 of whom are instructors.³² The magnitude of the DUID problem affords law enforcement agencies opportunities to expand their DRE cadre and to reduce the number of DUID offenders on highways.³³

Train Officers in Advanced Roadside Impaired Driving Enforcement (ARIDE). In this era of ever-shrinking budgets, the 16-hour Advanced Roadside Impaired Driving Enforcement (ARIDE) program is ideal for law enforcement agencies that already have trained their officers in the SFST but cannot afford to invest

the considerable time required to train additional DREs. ARIDE is a force multiplier that can enhance relatively quickly DUID enforcement efforts, inasmuch as it was created to compensate for the gap in knowledge between SFST and DRE training. While successfully completing the ARIDE program does not qualify officers as DREs, officers' proficiency in administering the SFST will be enhanced, and their ability to discern when a DRE's expertise is required will be improved.³⁴

Consider telephonic search warrants. If a non-DRE officer lawfully detains a driver who is unable to successfully complete the SFST, who has a BAC of .02 grams per deciliter (g/dL), but who refuses to submit a blood sample and from whom the officer observes no obvious evidence of drug use, the officer is at a distinct disadvantage in terms of prosecuting the driver for DUID. However, seven (Arizona, Illinois, Indiana, Ohio, Pennsylvania, Rhode Island, and Utah) of fifteen states in which it is illegal per se to operate a motor vehicle with certain drugs, including marijuana, in one's system authorize telephonic search warrants to secure an evidentiary blood sample.³⁵ This provision essentially ensures the officer is able to obtain additional evidence to support the probable cause initially developed for a DUID charge.

Explore training police officers as phlebotomists. If law enforcement agencies expect their officers to effect a greater number of DUID arrests, officers must possess the tools essential to secure evidence quickly. Officers generally are limited to obtaining blood, urine, or oral fluid samples. In fact, all fifteen states that enacted per se drugged driving statutes permit the collection of blood samples;³⁶ six (Arizona, Delaware, Georgia, Illinois, Iowa, and Minnesota) of those states allow the collection of urine samples;³⁷ and sixteen states authorize the collection of other bodily substances.³⁸

For example, if a blood sample is taken from an arrestee 30 to 90 minutes after apprehension, the THC concentration, like the BAC, will be lower than it was at the time of arrest,³⁹ so time is of the essence. Officers trained in phlebotomy can expedite the process of collecting an evidentiary blood sample to ensure it complies with any period of time prescribed by law.⁴⁰ Six (Arizona, Indiana, Ohio, Pennsylvania, Rhode Island, and Utah) of fifteen states in which it is illegal per se to operate a motor vehicle with certain drugs, including marijuana, in one's system permit blood to be withdrawn by officers trained in phlebotomy.⁴¹ Such a procedure improves the quality of the evidentiary sample, which is fair to arresting officers and to defendants and encourages officers to pursue a DUID charge, an alcohol impaired driving violation, or both, depending on how a state's statute was enacted.

The foregoing suggestions are not a cure-all but are intended to offer information to police chief executives who wish to attack both alcohol and drug-impaired driving offenses—including the proliferation of medical marijuana—that far too often claim the lives of, or seriously injure, our spouses, parents, siblings, children, neighbors, coworkers, and subordinates. ♦

Notes:

¹"Drug Involvement of Fatally Injured Drivers," NHTSA *Traffic Safety Facts*, November 2010, DOT HS 811 415, 1, <http://www.nrd.nhtsa.dot.gov/Pubs/811415.pdf> (accessed February 10, 2012).

²*Ibid.*, 1-2.

³*Ibid.*

⁴John H. Lacey et al., *2007 National Roadside Survey of Alcohol and Drug Use by Drivers: Drug Results*, December 2009, DOT HS 811 249, 105, <http://www.nhtsa.gov/DOC/NHTSA/Traffic%20Injury%20Control/Articles/Associated%20Files/811249.pdf> (accessed February 10, 2012).

⁵U.S. Drug Enforcement Administration (DEA), *The DEA Position on Marijuana*, January 2011, 35-36, http://www.justice.gov/dea/marijuana_position.pdf (accessed February 10, 2012).

⁶Robert L. DuPont, *Commentary: Marijuana Impaired Driving: A Serious Public Safety Problem*, 1, December 8, 2011, revised, <http://www.stopdruggeddriving.org/pdfs/IBHCommentaryMarijuanaImpairedDriving12811.pdf> (accessed February 10, 2012).

⁷21 U.S.C. § 812 (c) (1), p. 524, <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title21/pdf/USCODE-2010-title21-chap13-subchap1-partB-sec812.pdf> (accessed February 10, 2012); A controlled substance found in schedule I is a drug or other substance that has a high potential for abuse, no currently accepted medical use in treatment in the United States, and for which there is a lack of accepted safety for its use under medical supervision. 21 U.S.C. § 812 (b) (1), pp. 522-523, <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title21/pdf/USCODE-2010-title21-chap13-subchap1-partB-sec812.pdf> (accessed February 13, 2012).

⁸DEA, *The DEA Position on Marijuana*, 3.

⁹"16 Legal Medical Marijuana States and DC," *Medical Marijuana*, ProCon.org, December 23, 2011, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881> (accessed February 13, 2012).

¹⁰IACP Narcotics and Dangerous Drugs Committee, "Calling for the Repeal of State Legislation Legalizing Distribution of 'Medical Marijuana,'" IACP Resolution adopted at the 118th Annual Conference of the International Association of Chiefs of Police (Chicago, Illinois, 2011), <http://www.theiacp.org/portals/0/pdfs/2011Resolutions.pdf> (accessed February 13, 2012).

¹¹"Editorial: Sensible Limit for Smoking, Driving," *Denver Post*, January 18, 2012, http://www.denverpost.com/search/ci_19761273 (accessed February 13, 2012).

¹²DuPont, *Commentary: Marijuana Impaired Driving*, 3.

¹³Robert L. DuPont, *Drugged Driving Research: A White Paper*, March 31, 2011, 14-15, http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/drugged-driving/nida_dd_paper.pdf (accessed February 13, 2012).

¹⁴DuPont, *Commentary: Marijuana Impaired Driving*, 3.

¹⁵DuPont, *Drugged Driving Research: A White Paper*, 25.

¹⁶*Ibid.*

¹⁷*Ibid.*, 8.

¹⁸*Ibid.*, 50.

¹⁹*Ibid.*, 9.

²⁰"Drug Per Se Laws: A Review of Their Use in the States," NHTSA *Traffic Tech*, September 2010, no. 393, 1,

http://www.nhtsa.gov/staticfiles/traffic_tech/tt393.pdf (accessed February 13, 2012).

²¹DuPont, *Drugged Driving Research: A White Paper*, 23, 25-26, 43.

²²*Ibid.*, 39, 43; also see 49 CFR § 392.4 Drugs and other substances, <http://www.fmcsa.dot.gov/rules-regulations/administration/fmcsr/fmcsruruletext.aspx?reg=392.4&keyword=drugs> (accessed February 13, 2012).

²³John Lacey et al., *Drug Per Se Laws: A Review of Their Use in States*, July 2010, DOT HS 811 317, 5, http://www.nhtsa.gov/staticfiles/nti/impaired_driving/pdf/811317.pdf (accessed February 13, 2012).

²⁴*Ibid.*, 82, 88-89.

²⁵*Ibid.*, 185.

²⁶John Ingold, "Colorado May Set Limits for Driving after Marijuana Use," *Denver Post*, December 5, 2010, http://www.denverpost.com/news/marijuana/ci_16780152 (accessed February 13, 2012).

²⁷DuPont, *Drugged Driving Research: A White Paper*, 13.

²⁸The International Drug Evaluation and Classification Program (DECP), "About DECP," <http://www.decp.org/about> (accessed January 12, 2012).

²⁹DECP, "DRE Training and Certification," <http://www.decp.org/training> (accessed February 13, 2012).

³⁰DuPont, *Drugged Driving Research: A White Paper*, 18.

³¹*Ibid.*, 31-32.

³²DEC Program Manager Carolyn Cockroft, personal interview with author, January 13, 2012.

³³For more information on the DECP, the DRE, and the ARIDE, contact Carolyn Cockroft at 1-800-843-4227, extension 206, or cockroft@theiacp.org.

³⁴DECP, "DRE Training and Certification."

³⁵For additional information, see J.H. Hedlund and D.J. Beirness, *Use of Warrants for Breath Test Refusal: Case Studies*, October 2007, DOT HS 810 852, <http://www.nhtsa.gov/DOC/NHTSA/Traffic%20Injury%20Control/Articles/Associated%20Files/810852.pdf> (accessed February 13, 2012); Lacey et al., *Drug Per Se Laws*, 14, 71, 75, 91, 96, 100, 105.

³⁶For additional information, see Robert L. Ticer, "The Role of the Law Enforcement Phlebotomist," *The Police Chief* 72 (September 2005), http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display&article_id=708&issue_id=92005 (accessed February 13, 2012).

³⁷Lacey et al., *Drug Per Se Laws*, 14, 48, 62, 67, 71, 79.

³⁸DuPont, *Drugged Driving Research: A White Paper*, 39.

³⁹*Ibid.*, 13.

⁴⁰For example, Maryland law allows only a single specimen of blood to be taken and tested to determine alcohol concentration within two hours after the accused is arrested. Maryland law allows only a single specimen of blood to be taken and tested for the drug or controlled dangerous substance content of the person's blood within four hours after the accused is arrested. *Maryland Courts and Judicial Proceedings Code Ann* § 10-303 (2011), <http://www.lexisnexis.com/hottopics/mdcode> (accessed February 13, 2012).

⁴¹Lacey et al., *Drug Per Se Laws*, 14, 75, 91, 96, 100, 105-106.