

Standard Title Page -- Report on State Project

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Supplementary Notes				
Abstract <p>Beginning on April 1, 1988, police officers in the Commonwealth of Virginia were given the statutory authority to require that drivers suspected of driving under the influence of drugs (DUID) submit a blood sample to be tested for drug content. Although there are no quantitative measures to relate drug or drug metabolite concentration with impairment (i.e., as with blood alcohol concentration), the result of a drug screen test may be able to corroborate an officer's testimony that a suspect showed signs of impairment.</p> <p>Efforts to change the law began in the 1984 Session of the Virginia General Assembly with the acceptance of House Joint Resolution No. 10, which initiated a study to improve the enforcement of Virginia's law against drug-impaired driving. Many of the recommendations of the study were included in the bill passed in the 1987 Session of the General Assembly. A major difference between the resulting Virginia law and those of other states is that in Virginia, blood, not urine, is the fluid to be screened for drug content.</p> <p>In conjunction with the revised law, federal, state, and local officials have been working to establish pilot Drug Recognition Technician (DRT) programs in the Charlottesville, Henrico County, and Virginia Beach Police Departments and in the Virginia Department of State Police. The DRTs are officers who are specially trained to detect symptoms of impaired driving and to classify the type or types of drugs a suspect may have used.</p> <p>Between the DRTs and the other police officers across the Commonwealth, more than an average of 50 DUID blood samples per month were sent to the Division of Consolidated Laboratory Services for analysis between April and November 1988. Evidence of marijuana and PCP use were found in almost half of the blood samples, and cocaine was found in 9.2 percent of the samples. In only 7.1 percent of the cases, neither drugs nor alcohol was detected.</p> <p>A major problem facing the program is that the average time between the receipt of a blood sample by Consolidated Laboratory Services and the completion of its analysis is approximately 50 days. In order to reduce turnaround time, the lab has hired additional personnel and purchased additional equipment; however, in order to prevent the dismissal of a case, it is recommended that officers set trial dates 90 days from the date of arrest to ensure that the laboratory will have sufficient time to complete the analysis.</p>				

STATUS REPORT
ON
VIRGINIA'S PROGRAM TO COMBAT DRUG-IMPAIRED DRIVING
by
Jack D. Jernigan
Research Scientist

(The opinions, findings, and conclusions expressed
in this report are those of the author and not
necessarily those of the sponsoring agencies.)

Virginia Transportation Research Council
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VTRC 89-R17

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INTRODUCTION

On April 1, 1988, the Commonwealth of Virginia took a major step forward in its fight against drug-impaired driving. Beginning on that date, police officers were given the statutory authority to require that an operator of a motor vehicle who was suspected of driving under the influence of drugs (DUID) submit a blood sample to be tested for drug content. Although there is scientific evidence to indicate that a 0.10 percent blood alcohol concentration (BAC) causes significant psychomotor impairment in virtually all drivers, no such concentration has been established for drugs. However, there is evidence to indicate that certain drugs may impair one's ability to drive safely. Thus, the results of a drug screen test may be able to corroborate an officer's testimony about a suspect's impaired behavior by showing that an impairing substance was present in the suspect's system at the time of arrest, but the results alone cannot establish impairment.

PASSAGE OF HJR 10

The effort to bring about a change in the law was begun in the 1984 Session of the Virginia General Assembly with the acceptance of House Joint Resolution No. 10 (HJR 10). HJR 10 was sponsored by Delegate George P. Beard, Jr., of Culpeper and was a response to the perceived need to improve the enforcement of Virginia's law against drug-impaired driving. HJR 10 was also a response to laws that were passed in Florida in 1982 and in California in 1983 to facilitate the detection, prosecution, and conviction of drug-impaired drivers. HJR 10 further requested that the Department of Motor Vehicles (DMV) develop procedures for detecting and prosecuting persons illegally driving under the influence of drugs.

RESPONSE BY DMV TO HJR 10

Establishment of Steering Committee

In response to this directive, the DMV established a steering committee to oversee an 18-month study of the problem and to develop potential courses of action. John T. Hanna, Deputy Commissioner for Transportation Safety of the DMV, served as the chairperson of the committee. The other members of the committee were representatives of Commonwealth's Attorneys, the Office of the Attorney General, the DMV, state and local law enforcement agencies, the Division of Consolidated Laboratory Services (DCLS), medical experts, state and local Alcohol Safety Action Programs (ASAPs), the armed forces, and the Virginia Transportation Research Council (VTRC). Several members of the VTRC also served as the staff for the steering committee and wrote the committee's report to the Governor and General Assembly.

Study by Steering Committee

The committee found that even though there was an existing law prohibiting DUID, between 1973 and 1984 there was an average of only 11 convictions for DUID per year in Virginia. The greatest number of convictions in one year during this time period was 22 in 1983, but that number was followed by only 4 in 1984. However, the committee felt that the problem was far greater in magnitude than these conviction figures would indicate and that there was clearly a need to increase the Commonwealth's efforts to prosecute drug-impaired drivers.

During the data acquisition phase of the study, other states' laws and programs were examined. Although a number of states were found to have laws similar to Virginia's law, the implementation of many of these laws was found to be less than effective. It appeared that there was significant enforcement in Florida and California, whose laws, in part, prompted the passage of HJR 10. Several representatives of the steering committee and the VTRC reviewed the programs in Ft. Lauderdale and Los Angeles (L.A.), the hubs of enforcement for their state.

Ft. Lauderdale Program

A key strategy in the Ft. Lauderdale program was the use of a videotape to record an officer's evaluation of a suspect for use as evidence in court to document signs of the suspect's impairment. Suspects were also required to submit a urine sample to be tested for the presence

of drugs. The problems that had developed with the program were that although some suspects showed clear signs of impairment to an officer's trained eye, persons with an untrained eye often had difficulty detecting indications of impairment from the videotape. Further, videotaping became a problem in the more rural areas of the state where the lack of equipment and trained personnel precluded the statewide success of the program. Finally, some courts were reluctant to accept the results of the drug screen of the urine sample into evidence because the metabolites of some drugs can be detected in urine as long as several weeks after the use of the drugs. Thus, the results of the drug screen of the urine sample would not necessarily corroborate the testimony of an officer that a suspect was under the influence of a drug at the time of arrest.

L.A. Program

The L.A. program also used the results of a drug screen of a urine sample to corroborate an officer's testimony that a suspect was under the influence of a drug or drugs. The California courts have generally been willing to accept such results as evidence of impairment. The LAPD developed a specialized group of officers, Drug Recognition Experts (DREs), who had received intensive training in drug detection techniques. By evaluating a number of physiological symptoms associated with various classes of drugs, a properly trained DRE should be able to detect impairment and determine the class of drug that caused the impairment. The L.A. prosecutors and courts have readily accepted the expert testimony of DREs.

A problem noted with this program was that the results of the drug screen of the urine sample, although they were accepted by the courts, did not necessarily indicate whether a substance was active in the person's system at the time of arrest or whether they reflected previous drug use. A second problem involved the DREs. Even though the DREs had an impressive record of arrests and convictions, the California Highway Patrol (CHP) had had difficulties implementing the program. Since the DRE training is time-consuming and given to only the best of the force, strong support from top management through first line supervisors is essential. This support may have been lacking in the CHP. Further, drug recognition techniques must be used frequently or an officer's ability to detect impairment and classify drugs will be reduced. Thus the DREs need to have a large enough pool of suspects to evaluate in order to remain proficient. Outside the L.A. area, the pool of potential arrestees may be limited. Hence, although the DRE program was effective in Southern California, there is some question of whether it could be successful elsewhere.

Recommendations of Steering Committee

After considering the programs in each area, the VTRC's researchers and the steering committee agreed that even with its limitations, the L.A. model had the most potential for success in Virginia. The committee recommended that Virginia adopt an approach much like that used by the LAPD and that the Virginia General Assembly change the implied consent statute to permit an officer to require a suspect to submit a blood sample, rather than a urine sample, to be tested for drug content. Since drug metabolites may remain in a person's urine long after a drug is taken, the results of blood sample testing give a more accurate picture of what was in the suspect's system at the time of arrest. In addition, the committee recommended that an officer be permitted to require a blood sample even after a BAC breath test had been administered because an officer often does not suspect drug impairment until after a suspect registers a BAC too low to be consistent with his or her apparent level of impairment.

The committee also recommended that drug recognition training be implemented in only one or two pilot communities where there was potentially a large population of offenders and a commitment on the part of the upper and middle management of the police department. This was because neither the Ft. Lauderdale nor the L.A. model had been transferred effectively into a statewide program.

Passage of Revised DUID Statute

After the committee's report was completed and forwarded to the General Assembly in 1986, a proposal for legislation based on its recommendations was defeated in committee. However, during the 1987 Session of the General Assembly, similar legislation was introduced by Senator James P. Jones of Abingdon and received strong support from Attorney General Mary Sue Terry. This bill (5.645) was passed by the House of Delegates by a margin of 81-18 and by the Senate unanimously. It was this legislation that went into effect on April 1, 1988.

IMPLEMENTATION OF REVISED DUID STATUTE

Establishment of Task Force

In order to plan for and work through the problems associated with implementing such a major change in the law, the DMV and the Department of

State Police (State Police) agreed to use an approach much like that used to conduct the study for HJR 10. Thus, the Task Force To Combat the Drug-impaired Driver was established, with John T. Hanna serving as its chairperson. The task force is composed of representatives of state and local law enforcement agencies, the DMV, the VTRC, the National Highway Traffic Safety Administration (NHTSA), the DCLS, the Office of the Attorney General, the Commission on VASAP, and the Department of Mental Health, Mental Retardation and Substance Abuse Services. Working from the recommendations in the report on HJR 10, the DMV, the State Police, and the task force have begun to encourage the development of pilot Drug Recognition Technician (DRT) programs in Charlottesville, Henrico County, and Virginia Beach and within the State Police.

DRT Training Program

Using the resources of the LAPD, the NHTSA developed a standardized training procedure to assist in establishing DRT programs throughout the nation. The NHTSA is also supporting the initial expansion of the DRT program to Virginia and several other states by supplying the resources necessary to provide and pay for the training. The Virginia DRT candidates have all participated in this training program, which includes 56 hours of classroom training and a minimum of 40 hours of field training. After receiving the training and successfully performing 15 instructor-monitored evaluations, a candidate becomes a certified DRT, but continuous application of the testing techniques is required if a DRT is to remain proficient.

As of November 30, 1988, approximately \$95,000 had been spent on the DRT program in Virginia for training, equipment, and certifying DRTs. These costs were paid by the NHTSA through a grant to the DMV. However, as part of the cooperative effort, the costs of personnel and the ongoing use of the DRTs are being absorbed by the police agencies. Further, many of Virginia's DRTs were trained in sessions held in other states, and Virginia as well has hosted three training sessions for its own DRTs and the DRTs of other states.

In the Charlottesville, Henrico County, and Virginia Beach police departments and in the State Police, 51 officers and troopers had at least begun the DRT training process as of November 30, 1988. Of these, 18 had completed the training process and had been certified as DRTs. The other 33 DRT candidates had completed the classroom portion of the training and were working toward completing 15 instructor-monitored field evaluations of individuals suspected of being impaired by drugs. Once a DRT candidate successfully completes the instructor-monitored evaluations, the candidate is certified as a fully qualified DRT.

The major problem with building the initial cadre of DRTs involves the instructor-monitored evaluations. Some of the DRT candidates remain uncertified 6 months or more after the completion of the classroom training because they have not completed the 15 monitored evaluations. In some cases, a drug-impaired suspect was apprehended, but there was not a qualified instructor on duty in the area at that time to monitor the evaluation of the suspect. In other cases, an instructor was available, but DRT candidates were not on duty in the area. Numerous special attempts have been made to bring instructors and candidates together during times when a drug-impaired suspect may be detected, which has been a successful strategy only some of the time.

In order to address the long-term implications of this problem, attention has been focused on enlarging the cadre of DRTs who are qualified instructors. As of November 30, 1988, Virginia had expanded the cadre of DRT instructors to 11, and 6 other DRTs were in the process of being trained as instructors. Although the number of instructors is growing, the police agencies and the task force have resolved to make the certification of each DRT candidate a top priority.

Other Programs

Although the DRT program is an innovative method of combating drug-impaired driving in several pilot jurisdictions, the enforcement of the revised statute is not limited to the pilot departments. In fact, because most of the Commonwealth's population is in other jurisdictions and beyond the reach of the initial cadre of DRTs, more than half of the arrests for DUID since the implementation of the revised statute have, as expected, been made by non-DRTs. Thus, in order to accommodate and encourage the statewide enforcement of the revised statute, the various agencies involved in the task force have cooperated to develop a statewide program in areas where the size of the offender population will support such an endeavor. The DCLS developed and distributed statewide standardized regulations, procedures, forms, and information sheets concerning the submission of blood samples for individuals suspected of driving while impaired by drugs. The DMV and the State Police joined with the Commonwealth Alliance for Drug Rehabilitation and Education (CADRE) to publicize the implementation of the revised statute through developing a public information campaign that included radio, television, and printed public service announcements. The task force also developed several policy guidance memoranda, which were sent to police agencies to encourage enforcement of the revised statute and to clarify procedures for its effective use. (Copies of these memoranda are given in the Appendix.)

Testing of Blood Samples

Between April and November 30, 1988, the DCLS received 422 blood samples to be tested for drug content for DUID cases. Figure 1 shows the monthly breakdown of submissions received by the DCLS, an average of more than 50 samples per month. Of the samples received, 354 had been analyzed fully and the rest were in the process of being analyzed.

Figure 2 shows that the DCLS reported finding marijuana (THC) and PCP present in almost half of the blood samples and cocaine in 9.2 percent of the samples. In 12.6 percent of the samples, the BAC level was higher than the 0.10 percent per se limit; therefore, no further tests were run on those samples. In 9.0 percent of the samples, no drugs were detected and the suspect had a BAC of less than 0.10 percent. In 7.1 percent of the samples, neither drugs nor alcohol was detected. However, the classification "no drugs detected" does not necessarily mean that there were no drugs present. It is possible that a drug was present for which no test was available or that a drug was present at the time of arrest at a level too low to be detected.

An area of frustration concerning the testing of blood samples for drug content is the relatively slow turnaround time. Figure 3 shows that the average time between the receipt of a blood sample by the DCLS and the completion of the sample's analysis is approximately 50 days. This is much more than the length of time required to conduct a BAC test, but tests for drugs other than alcohol are far more complex and time-consuming than the BAC test. This is exemplified by the fact that an independent laboratory analysis for a BAC test costs \$25, whereas a typical independent analysis for tests for other drugs may cost more than \$250.

In order to reduce the turnaround time, the DCLS purchased new equipment and hired additional personnel to conduct the tests. However, there is a limit to the amount of time reduction possible. Quite simply, the complex nature of the testing procedures necessarily lengthens the time required for analysis. Thus, the task force recommended that trial dates for DUID cases be scheduled 90 days from the date of arrest to ensure that the laboratory will have sufficient time to complete the analysis of the associated sample. Further, it recommended that officers and troopers who have an upcoming trial notify the DCLS one week in advance of the trial so that the analysis of the sample would be given top priority if it had not been completed.

DUID SUBMISSION STATISTICS

APRIL TO NOVEMBER 1988

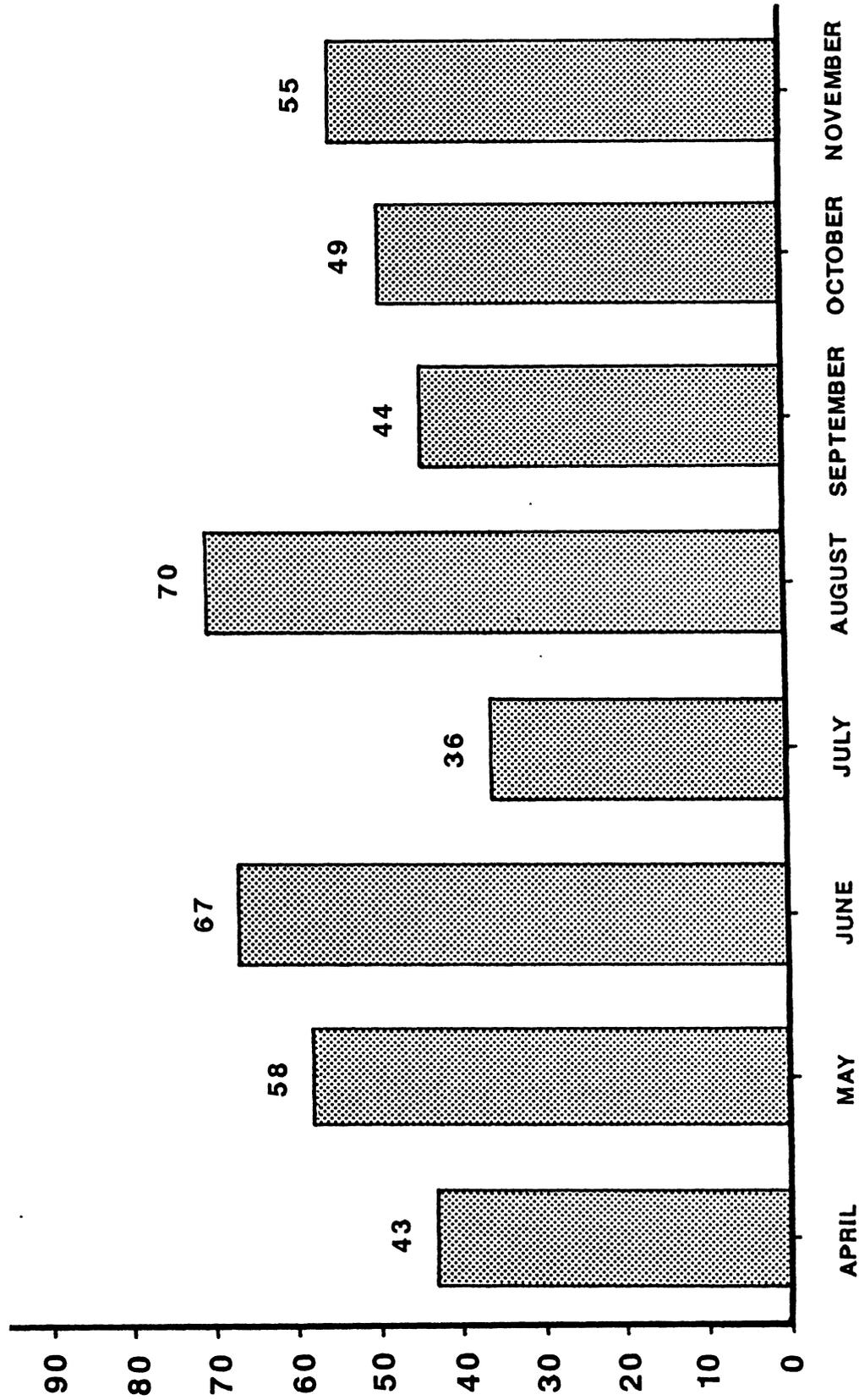


Figure 1. Monthly breakdown of DUID blood samples received by the Division of Consolidated Laboratory Services, April - November 1988.

DUID DRUGS REPORTED

APRIL TO NOVEMBER 1988

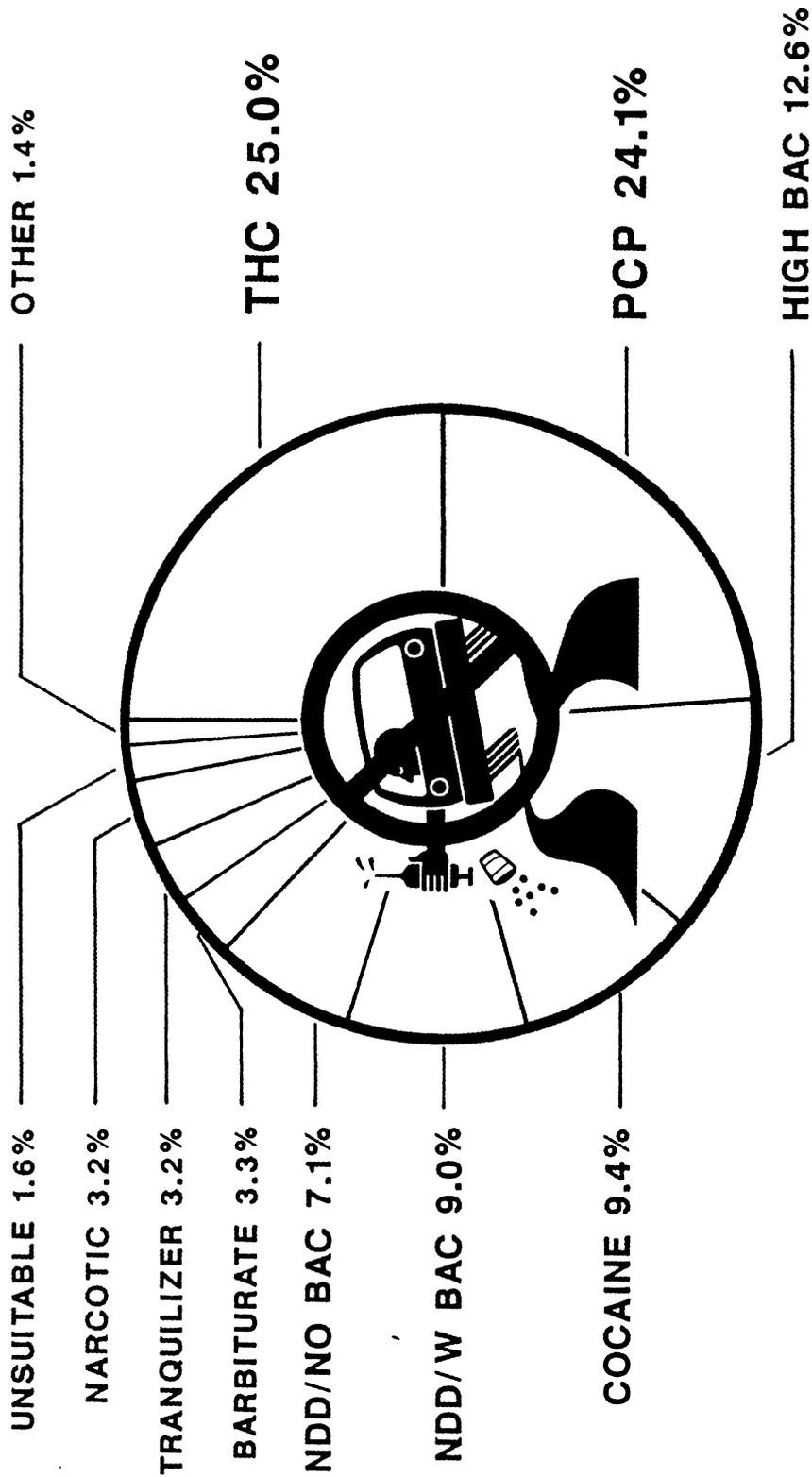


Figure 2. Breakdown of drugs detected in DUID blood samples, April-November 1988. NDD/NO BAC, No drugs detected and no BAC. NDD/W BAC, No drugs detected with low BAC.

DUID TURNAROUND STATISTICS

APRIL TO NOVEMBER 1988

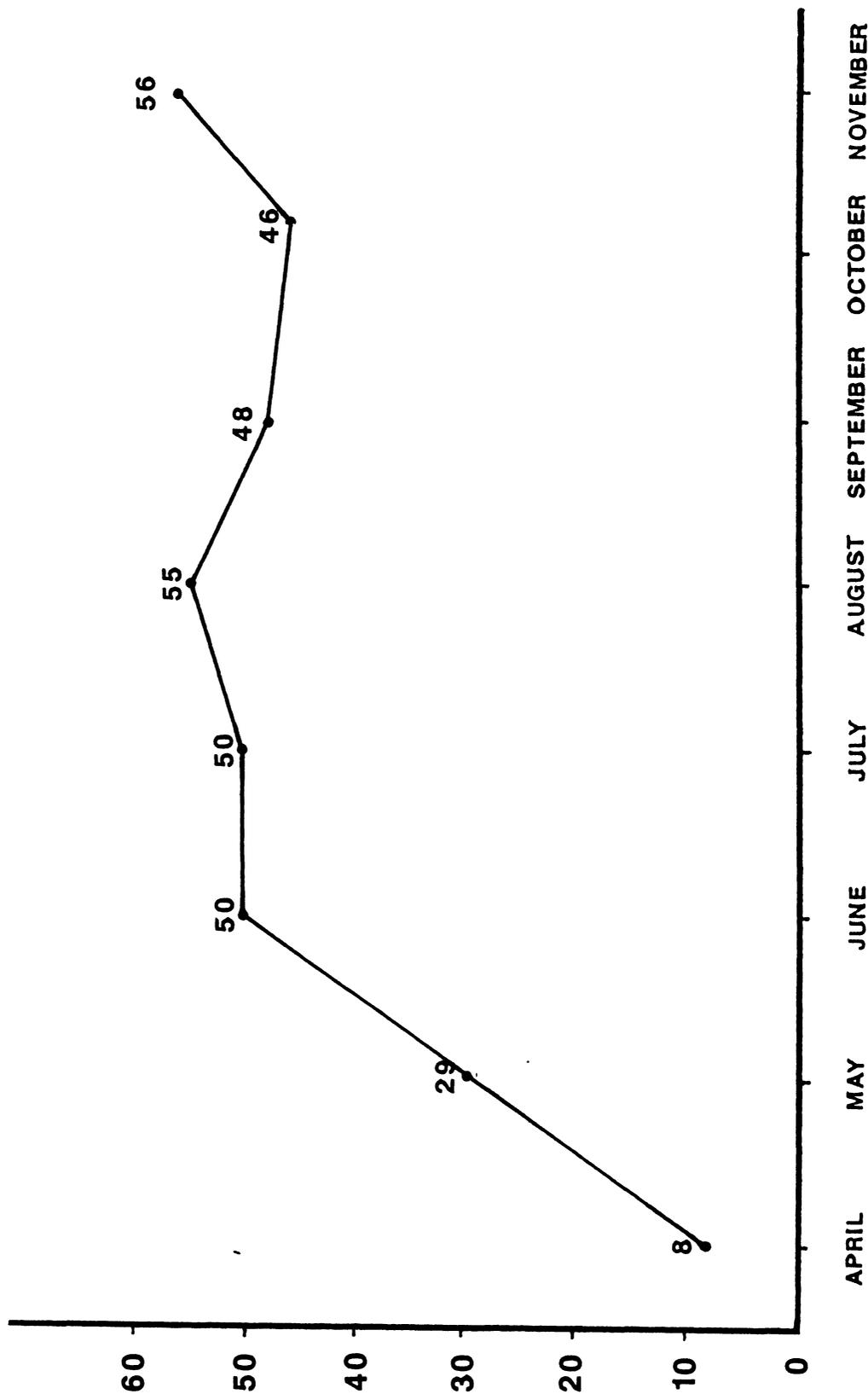


Figure 3. Average time between receipt of DUID blood sample by the Division of Consolidated Laboratory Services and completion of the analysis, April - November 1988.

OVERVIEW

In the first nine months after the implementation of the revised DUID statute, numerous expected and unexpected challenges were encountered. However, the task force approach, which has encouraged interaction among the various agencies involved, has contributed to a well-orchestrated effort against drug-impaired driving. In fact, this approach is being considered or adopted by several other states.

The Commonwealth's program to combat drug-impaired driving not only provides the potential to detect drug-impaired drivers but also provides for the training and support that could enhance the detection of alcohol-impaired drivers. The overall effectiveness of this program is not yet known, but the substantial attention that DUID cases have received in the past year has kept alive the potential of the revised statute to enhance traffic safety in the Commonwealth. A three-year evaluation of the program has been approved by the task force, and this evaluation will attempt to document the strengths and weaknesses of the program and to recommend ways to remedy any weaknesses so that the full potential of the revised statute may be realized. Each phase of this evaluation will be documented in future interim and status reports.

APPENDIX

Policy Guidance Memoranda

Commonwealth of Virginia Task Force

to

Combat the Drug-impaired Driver



Policy Guidance Memorandum #1

Date: March 15, 1988

On April 1, 1988, Virginia's revised law against drug-impaired driving becomes effective. Beginning on that date, a police officer who suspects that an individual is under the influence of a drug or drugs other than alcohol may require the driver to submit to a drug test either before or after a blood-alcohol test has been administered. Although the drug test cannot in itself establish impairment, the results of the drug/blood test may be useful as corroborating evidence of the driver's impairment.

In order to prepare for the effective implementation of the revised statute, the Commonwealth has created a task force to identify key implementation issues, to coordinate activities, and to develop strategies for implementation that will maximize the resources to be applied to this traffic safety problem area. The task force has spelled out the goals and objectives of the law's implementation, as well as the roles and responsibilities of the major participants in the early stages of the effort.

One of the major needs is effective communication between the task force and local law enforcement and judicial personnel. Because effective prosecution of the revised statute will not be easy, the task force has elected to use a series of policy guidance memoranda to disseminate information and to promote statewide cooperation.

The first strategy employed by the task force is the Drug Recognition Technician Program. This program is modeled on the drug-enforcement strategy employed by the Los Angeles Police Department, and training will be provided in Los Angeles by its department's police officers. Training

includes recognizing impairment and the class of drug(s) causing the impairment. However, because of the length and expense of the training; and some uncertainty about whether the program will work in Virginia, initially only a few officers will receive the training. The state and local police officers in the Charlottesville and Virginia Beach areas were selected to be the first in the Commonwealth to be trained as drug recognition technicians. If the program is effective, it will be expanded statewide as available resources permit.

Before this expansion takes place, however, there are ways that enforcement and judicial personnel in other areas of the Commonwealth can take advantage of the revised drug-impaired driving statute. However, drug tests are expensive -- and excessive or unwarranted use of the tests may lead either to the repeal of the law or to a series of precedents against the law throughout Virginia's judicial system. Hence, the task force has endorsed the following measures to guard against the misuse of the chemical test and to facilitate the effective use of the revised statute.

1. ESTABLISH IMPAIRMENT

Because drug tests may never be able to establish a presumptive or per se level of impairment that will parallel the BAC test, the police officer must clearly establish that the driver of a vehicle is "under the influence to a degree which impairs [his or her] ability to drive safely."

The task force believes that the best method of establishing impairment is the use of standardized field sobriety tests. The task force encourages all localities to train

and retrain all field officers in other use of these tests and how to testify effectively in court.

2. ADMINISTER BLOOD-ALCOHOL TEST

If the driver is impaired, the officer should administer a blood-alcohol test. If the test results are 0.11% BAC or higher, no other drug test needs to be administered even if the driver is suspected of using other drugs.

3. ESTABLISH PROBABLE CAUSE FOR ADMINISTERING DRUG TEST

If the driver is impaired to a degree that the blood-alcohol test results are inconsistent with the level of impairment (0.10% BAC or less), and the officer has reason to suspect the use of other drugs (drug possession, odor, etc.), then the officer should request a drug/blood test. This evidence, though relatively expensive to acquire, may be a critical piece of corroborating evidence to the officer's testimony that the suspect was impaired.

The members of the task force encourage you to continue the fight against the impaired driver and to take advantage of the revised statute. If you would like a copy of the implementation plan the task force has prepared, or if you have any questions or comments about the revised law or its implementation, please contact:

Mr. John T. Hanna, Chairman
Task Force to Combat the Drug-impaired Driver
Department of Motor Vehicles
P.O. Box 27412
Richmond, VA 23269
or call
(804) 367-6620

The Task Force to Combat the Drug-impaired Driver is under the sponsorship of the Virginia Department of Motor Vehicles
Donald E. Williams, Commissioner

Task Force to Combat the Drug-impaired Driver

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Commonwealth of Virginia Task Force

to

Combat the Drug-impaired Driver



Policy Guidance Memorandum #2

Date: June 1, 1988

Virginia's revised law to combat the drug-impaired driver took effect April 1, 1988. Under the revised law, a police officer may request that an individual suspected of driving under the influence of drugs provide a blood sample to be analyzed for drug content.

The suspect may request that one vial of the blood sample be sent to an approved laboratory for independent evaluation in much the same manner as a blood-alcohol evaluation. However, the independent laboratory will charge a \$10 handling fee and an additional \$80 for each test. Thus, if a suspect had three drugs present in his or her blood, the independent laboratory fees would total \$250. These fees are to be paid by the Commonwealth, not by localities or local law enforcement departments. If the suspect is convicted, the cost of the independent evaluation may be included as court costs charged to the defendant.

The proper payment procedure for independent laboratory fees incurred for a DUI case for blood-alcohol or drug tests are to be "out of the appropriation for criminal charges §18.2 - 268(d3)." This refers to the Commonwealth's "criminal fund," which is used for various expenses relating to criminal trials not covered by any other line item. In the fiscal year 1986, this fund paid \$274,152 statewide for laboratory testing for DUI suspects and will now be used for DUID suspects as well.

The Task Force recommends that the following steps be followed in dealing with independent laboratory fees incurred for alcohol or drug tests in a DUI or DUID case:

1. A voucher should be issued for the independent laboratory fees.
2. The voucher should be sent to the Supreme Court Offices either by the testing laboratory directly or by the local court hearing the case.
3. The Supreme Court Offices will pay the laboratory.
4. If the defendant is convicted, the fees may be recovered as additional court costs.
5. These additional fees should then be turned over to the Commonwealth's general fund.

Many localities charge alcohol-impaired drivers under local ordinances instead of the appropriate state law and have thus designed alternate payment methods. Such alternative payment methods are not consistent with the procedures spelled out by the statute. All payments should follow the procedures outlined here whether the DUI or DUID charge is under local ordinance or state law.

The revised DUID law is a state initiative and, at least temporarily, there will not be a local version. The Task Force, therefore, suggests that DUI suspects be charged under the state law rather than a local ordinance if impairment is believed to be related to drugs other than alcohol.

Clearly, police departments will not be burdened by the costs of enforcing the revised DUID law if they only follow the proper procedure dictated by the law.

Should there be any further questions or concerns please contact:

Mr. John T. Hanna, Chairman
Task Force to Combat
the Drug-impaired
Driver
Department of Motor Vehicles
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Richmond, VA 23269
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Virginia Beach Police Department

Commonwealth of Virginia Task Force
to
**Combat the
Drug-impaired Driver**



Policy Guidance Memorandum # 3

Date:
September 15, 1988

Five months have now passed since the implementation of Virginia's revised law against drug-impaired driving (Code of Virginia, Section 18.2-268). During that time, a number of procedural issues have arisen concerning the manner in which the blood samples of suspected drug-impaired drivers are to be handled. Specifically, the Task Force has identified the following areas of difficulty:

1. Marking Secondary Blood Samples for Drug Analysis.
2. Obtaining and Handling the Blood Sample.
3. Identification of Possible Drugs Used.
4. Handling of Drugs Seized During Arrest.

1. MARKING SECONDARY BLOOD SAMPLES FOR DRUG ANALYSIS

Under Virginia law, when a blood sample is provided by an individual suspected of driving under the influence of alcohol or drugs, one vial is automatically sent to the Division of Consolidated Laboratory Services for analysis. In addition, the suspect may request that an independent laboratory analyze a second vial of blood. The second blood sample, however, is often not marked for drug analysis when sent to the independent laboratory. As a result, the independent laboratories routinely analyze the blood samples for alcohol alone and then dispose of the

vial's contents, thereby eliminating the possibility of testing for drug content. In the process, potential DUID prosecutions may be lost.

The standard procedure for delivering the primary blood sample to the Division of Consolidated Laboratory Services for analysis is to include a laboratory request form filled out by the arresting or accompanying police officer. This laboratory request form should indicate whether the blood sample is to be tested for drugs.

As per instructions mailed to all Virginia law enforcement agencies, a copy of the Request for Laboratory Examination form should be mailed together with the blue container to the approved independent laboratory. The cooperation of local and state enforcement authorities in this area would greatly help to reduce confusion associated with independent analysis of the blood sample. By clearly indicating that the blood is to be analyzed for drug content and not merely alcohol, the officer will help to ensure that drug tests are performed and pending criminal prosecutions preserved.

2. OBTAINING AND HANDLING THE BLOOD SAMPLE

One problem that has arisen in this area involves the quantity of blood drawn in the vials that are delivered to the Division of Consolidated Laboratory Services and the independent laboratories. Because drug content accounts for an extremely small portion of the

blood sample, it is vital for the laboratories to receive a full vial of blood in order to conduct an accurate analysis. In addition, a full vial of blood is necessary since the laboratories run multiple tests for a variety of drugs.

Another problem is that the blood sample needs to be drawn as soon as possible. Some drugs metabolize rather quickly; consequently, identification of drug content in the blood sample becomes more difficult as the time between arrest and extraction of the blood sample lengthens.

Finally, after obtaining a blood sample, it is important that it be kept in a cool environment. At higher temperatures, blood samples tend to coagulate, making it impossible to administer drug tests. Extra care should be taken to see that the blood samples are not left in hot places and that they are transferred to the testing facilities as soon as possible.

3. IDENTIFICATION OF POSSIBLE DRUGS USED

Law enforcement authorities can give additional assistance to laboratories conducting the drug tests by indicating, whenever possible, the drug or drugs suspected of having been used. Specific odors, the actions or admissions of a suspect, or the seizure of drugs and/or paraphernalia in the automobile may enable police officers to make a reasonable estimation of the drug or drugs involved. The Task Force recommends that in such situations, the arresting officer indicate the drug or drugs suspected on the laboratory request form submitted with the blood sample sent to the Division of Consolidated Laboratory Services.

4. HANDLING OF DRUGS SEIZED DURING ARREST

State and local police officers should be aware that problems in prosecuting DUID cases can arise when actual substances suspected of being

drugs are delivered to the state's DUID laboratory along with the blood samples of arrestees. No materials other than the blood tube should be submitted to the DUID laboratory. Instead, the suspected drugs should be retained by the law enforcement agency.

If the law enforcement agency anticipates prosecution for the possession of a controlled substance (or marijuana), then the sample should be submitted to the Bureau of Forensic Science in the same manner as for any drug evidence. By sending the suspected narcotics to the blood analysis lab, it may be difficult to document the "chain of custody," which may create problems in prosecuting the offender. The Task Force recommends that extra caution be taken to separate substances seized during arrest from blood samples to be analyzed for drug content.

It is still too early to determine the success of the revised law. Nevertheless, preliminary results indicate that arrests have increased and the revised law is helping to combat drug-impaired driving on Virginia's roads. Should you have any questions or concerns about any aspect of the revised law, please contact:

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The Task Force to Combat the
Drug-impaired Driver is under the
sponsorship of the
Virginia Department of Motor Vehicles
Donald E. Williams, Commissioner

Commonwealth of Virginia Task Force
to
**Combat the
Drug-impaired Driver**



Policy Guidance Memorandum # 4

Date: Feb. 1, 1989

There has been much interest statewide in Virginia's revised law against drug-impaired driving (Code of Virginia, Section 18.2-268). The major revision to the law was the provision that an officer, under implied consent, can require a suspect to submit a blood sample to be tested for drug content. The blood sample for DUID suspects is analyzed by the Division of Consolidated Laboratory Services, which provides a report of its findings. A report of an independent laboratory analysis may also be provided at the suspect's request.

A number of questions concerning the meaning of the laboratory results in DUID cases have been raised in recent months. Particularly, Commonwealth's Attorneys, defense attorneys, and police officers have had questions about interpreting the report and how the report for drugs differs from the report for alcohol. To clarify matters, the Consolidated Laboratory has provided answers to some of the most frequently asked questions.

Q: What drug levels cause impairment?

A: For most drugs, impairment levels have not yet been established nor is it likely that they will ever be established with the same scientific certainty as for alcohol. We hope to learn

more about drug concentrations versus driving impairment as we go. This question emphasizes the importance of well-documented field observations and sobriety tests.

Q: Are the drug levels (on a particular case) high or low?

A: Again, the numbers often do not mean that much on their own. Different individuals may be affected quite differently at the same drug concentration. Factors that can affect impairment include age, physical and mental condition, various types of tolerance, and interactions with alcohol and/or other drugs.

Q: What does the result "no drugs detected" mean?

A: "No drugs detected" means that none of the more than two dozen specific drugs being screened by the lab is present at a concentration above its "limit of detection". This limit of detection varies from drug to drug. Also, to some extent, the condition and amount of blood submitted affect the limit of detection. Thus, it is important that the lab receive a full vial of blood that has been stored properly in a cool place. Even normal variations in laboratory instrumentation can influence the limit of detection on a day to day basis.

Q: What is the significance of a

drug metabolite being found in a blood sample?

A: While most drug metabolites are pharmacologically inactive and therefore do not adversely affect driving, they do indicate "recent" drug use. Some drug metabolites may be the only detectable evidence that drugs have been used in certain situations. The "parent" drug (e.g. cocaine) may disappear from blood within a few hours of use leaving only the longer-lived metabolite (e.g.. benzoylecgonine). Even though the parent drug may have been present at the time of driving, it may have been completely metabolized and excreted before the blood was sampled.

Q: Why are the units so small?

A: In general, drugs are much more potent than alcohol. Many drugs can cause significant effects at a concentration of one-millionth that of alcohol in the blood. Consequently, different units and low concentrations are seen on DUID reports.

Q: What does the phrase "less than" (e.g. concentration less than 0.001 mg/L) mean on a DUID report?

A: It means that the substance was found and confirmed but that the concentration was below our limits of quantitation. It does not mean that the amount of the substance was insignificant.

Some typical limits of detection:

<u>Drug</u>	<u>Limit</u>
Alcohol	100 mg/L
Benzoylecgonine	0.1 mg/L
Cocaine	0.1 mg/L
PCP	0.005 mg/L
THC-carboxylic acid	0.005 mg/L
THC	0.001 mg/L

"No drugs detected" does not necessarily mean that a person did not use any drugs. They may have used a drug that is currently not detectable with existing methodologies; or as a result of metabolism and elimination, detectable amounts of the drug are no longer present.

The Task Force would like to thank the Division of Consolidated Laboratory Services, particularly Dr. Jim Valentour, Dr. Paul Ferrara, and Randall Edwards, for this information.

Any questions or concerns that you may have regarding the revised law may be directed to:

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