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# Drug Recognition Program

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**MONOGRAPH**

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# Drug Recognition Program

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## Monograph

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April 1989

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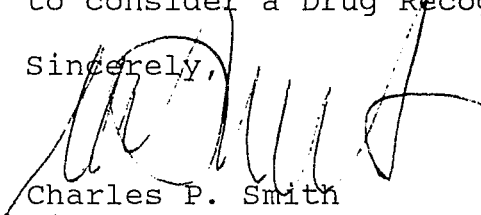
I am pleased to present to you this monograph on the Drug Recognition Program. The development of this document is just one example of the cooperation necessary among Federal agencies to combat the drug abuse crisis facing our nation.

The Drug Recognition Process is a nonintrusive, standardized and systematic method of examining a person suspected of impairment due to alcohol and/or other drug abuse. Because of its promise for local law enforcement, the Bureau of Justice Assistance (BJA) has supported the efforts of the Department of Transportation's National Highway Traffic Safety Administration to accelerate pilot site demonstrations of this new technology. In addition, BJA has provided the resources to develop this guidance document and to make it widely available.

This program should be of immediate interest to those in local law enforcement. As the Drug Recognition Process techniques become more refined and accepted by law enforcement professionals and other traffic safety experts, its nonintrusive nature may make its application possible in other social settings.

I hope this document provides you with the information you need to consider a Drug Recognition Program in your locality.

Sincerely,

  
Charles P. Smith  
Director  
Bureau of Justice Assistance

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# Introduction

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Intoxicated drivers are a common highway hazard. Law enforcement officers are armed with a wealth of information on the symptoms of alcohol intoxication; at their disposal they have simple behavioral tests to screen drivers for a high blood-alcohol level and portable devices for determining the driver's breath-alcohol level. But, there is a growing recognition among law enforcement officers that drugs other than alcohol pose serious highway safety problems. In the past decade, experienced officers have had frequent encounters with drivers who are clearly too impaired to drive safely, but whose intoxication does not stem from alcohol. Although the logical assumption is that these drivers are under the influence of other substances, proving it is often quite difficult.

During the 1970s, the Los Angeles Police Department (LAPD) began grappling with the problem of recognizing drug-intoxicated drivers and securing evidence that would lead to prosecutions and convictions. To this end, they developed and tested a series of clinical and psychophysical examinations that a trained police officer could use to identify and differentiate between types of drug impairment. This subject-examination procedure detects patterns of behavioral and physiological symptoms caused by ingesting drugs that impair the ability to drive safely. The LAPD has used this procedure since 1979 to help prevent crashes, injuries and deaths by improving enforcement of drug-impaired driving violations.

Proof of the effectiveness of the program began to accumulate as soon as it was instituted in Los Angeles. The LAPD's Drug Recognition Experts -- officers trained in this procedure -- quickly demonstrated that they could detect drug-impaired drivers. In 1984, The National Highway Traffic Safety Administration (NHTSA) and the National Institute on Drug Abuse (NIDA) sponsored a controlled laboratory evaluation of these drug recognition procedures. This evaluation, conducted by researchers from Johns Hopkins University, was so promising that in 1985, NHTSA sponsored a Field Validation Study which demonstrated that the Drug Recognition Examination is an effective means of detecting drug-induced impairment.

These findings prompted NHTSA to work with the LAPD to develop a standardized curriculum for training police officers to serve as Drug Recognition Experts (DREs). In 1987, with funding assistance from the Bureau of Justice Assistance (BJA), a component of the Office of Justice Programs (OJP), NHTSA began a pilot program to develop Drug Recognition Programs in other jurisdictions. Four locations were selected: metropolitan Phoenix, Arizona; Denver and Boulder, Colorado; Nassau County, New York; and Virginia Beach, Virginia. At least two law enforcement agencies are participating in the program in each location. In 1988, when the programs in these four sites had begun to take firm root, NHTSA selected three more pilot sites: one in Indiana, involving the Indiana State Police, the Indianapolis Police Department and the Indiana University Police Department; another in Utah under the aegis of the Utah Highway Patrol, the Salt Lake City Police Department and the West Valley Police Department; and a third in California. The California site is an expansion of the original Los Angeles program and involves the addition of the Ventura County Sheriff's Department, the Long Beach Police Department and many municipalities and law enforcement agencies in Yolo County.

Section 9004 of the Anti-Drug Abuse Act of 1988 authorizes NHTSA to conduct a three-year pilot program for Drug Recognition Expert Training. Under this program, NHTSA will continue to select promising sites for establishing Drug Recognition Programs.

The purpose of this monograph is to bring this program to the attention of criminal justice planners and other state and local decisionmakers. It provides the background information necessary to permit a preliminary assessment of whether or not this program would be an asset in a particular jurisdiction. It explains how the program works, what it is designed to accomplish and how effective it is. It also outlines the site selection criteria for pilot sites, the training requirements and associated costs for sites in the pilot program.

The Drug Recognition Program will prove useful in many jurisdictions. It is an effective means of dealing with drivers who imperil others by getting behind the wheel while incapacitated by drugs.

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# The Drug Recognition Process

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The Drug Recognition Process is a standardized, systematic method of examining a person suspected of impaired driving or another alcohol and/or drug-related offense to determine:

- o Whether the suspect is impaired;
- o If impaired, whether the impairment is drug-related; and
- o If the impairment is drug-related, the broad category (or combination of categories) of drugs that is the likely cause of the impairment.

The Drug Recognition Process is a post-arrest investigative procedure, not a field test procedure. It requires a carefully controlled environment. The evidence gleaned by the process points to the presence of certain broad categories of drugs, including psychoactive drugs. For example, a trained Drug Recognition Expert can usually determine if the suspect has ingested a narcotic analgesic, but will probably not be able to tell whether it was morphine, demerol, heroin, codeine or another narcotic. The process usually supplies probable cause for suspecting that a particular category of drugs will be found in the suspect's blood or urine. However, it is not a substitute for a chemical test; a blood or urine sample should be obtained to provide corroborating evidence.

People unfamiliar with drugs often wonder why it is necessary to determine what type of drug a suspect has ingested. If the suspect is obviously impaired and if the blood-alcohol level does not account for the impairment, the direct approach of simply obtaining a blood sample and analyzing it for drugs is impractical because:

- o The courts or motor vehicle licensing agencies may not agree that the mere inconsistency between the blood-alcohol level and the observable impairment is sufficient to justify chemical tests. For example, it could be argued that the suspect is ill, injured or is simply very susceptible to the effects of even low doses of alcohol. It is preferable if the request for a blood or urine sample is founded on an articulate and credible basis for believing that the impairment is the direct result of drugs.

- o The suspect may simply refuse to submit a blood or urine sample. Although such a refusal might result in suspension or revocation of the suspect's driver's license, it will also deny the prosecution scientific evidence of drug involvement. Conviction or acquittal in such a case may hinge on the officer's ability to submit detailed and convincing testimony concerning the signs that point to a specific category or categories of drugs.
- o Analyzing blood or urine samples for drugs can be very expensive and may require a large volume of blood or urine if the experts do not know what type of drug is most likely to be found in the sample.
- o The suspect may be suffering from an illness or injury requiring medical attention rather than from drug impairment. If the suspect's blood is drawn for subsequent analysis and he or she is not examined by someone qualified to recognize the presence (or absence) of drug impairment symptoms, the medical problem may not be discovered until it is too late.
- o Chemical tests usually only disclose evidence of relatively recent use of a specific drug. Generally, they do not determine whether the drug was psychoactive at the time of an alleged event. For driving while intoxicated (DWI) arrests, the key issue is: Was the suspect impaired? The physical exam, not the chemical test, answers that question.

## Drugs that Impair Driving

The Drug Recognition Process is designed to enable officers to recognize suspects who are impaired or under the influence of drugs other than alcohol. For the purposes of this process, a drug is defined as "any chemical substance that, when taken into the human body, can impair the ability to operate a motor vehicle safely."

There are seven broad categories of drugs within this simple, enforcement-oriented definition. These categories distinguish between drugs which differ from one another both in terms of their effects and in terms of the observable signs of impairment that they produce. These seven categories do not correspond precisely to the drug taxonomies typically found in medical texts or pharmaceutical catalogs.



## The Seven Categories

1. **Central Nervous System Depressants.** This category includes a large number of different drugs, all of which slow the operation of the brain and other parts of the central nervous system. The most familiar drug -- alcohol -- is a central nervous system depressant. Others include barbiturates and anti-anxiety agents, such as Xanax, Valium and Librium.
2. **Central Nervous System Stimulants.** Drugs in this category cause impairment by overstimulating the brain, accelerating heart rate and respiration, and elevating blood pressure. Cocaine, amphetamines and methamphetamines are the drugs most commonly encountered in this category.
3. **Hallucinogens.** These drugs impair the user's ability to perceive the world as it really is and often produce a dazed appearance. This category includes both organic substances, such as peyote and psilocybin, and synthetic chemicals, such as LSD and MDA.
4. **Phencyclidine.** This category consists of the drug PCP and its various analogs. Although they were originally developed for use as anesthetics, these powerful drugs are unpredictable in their effects. They can act as stimulants, depressants, hallucinogens or as a combination of these drugs and can cause bizarre and sometimes violent behavior.
5. **Inhalants.** This broad category of drugs impairs performance by blocking the passage of oxygen to the brain. They tend to produce disorientation and slurred speech. Some substances in this category contain psychoactive chemicals. Inhalants include household materials, such as paint, model airplane glue and aerosol sprays, as well as anesthetics, such as nitrous oxide, ether and chloroform.
6. **Narcotic Analgesics.** Drugs in this category share three characteristics: they relieve pain; they produce withdrawal symptoms when the drug is stopped after chronic administration; and they suppress the withdrawal symptoms that accompany heroin addiction. This category includes natural opium derivatives as well as synthetic drugs, such as demerol and methadone. A person under the influence of a narcotic often has droopy eyelids, depressed reflexes and low, raspy speech.
7. **Cannabis.** This category includes marijuana and other derivatives of the Cannabis Sativa plant, such as hashish and hash oil, all of which impair the

attention process. Those under its influence often have bloodshot eyes, relaxed inhibitions and difficulty in dividing their attention. Prescriptive medications containing synthetic tetrahydrocannabinol (THC), such as Marinol, also belong in this category.

Drug Combinations: Polydrug use -- ingesting more than one drug at a time -- appears to be a common form of drug abuse, at least among people involved in impaired driving incidents. For example, a joint NHTSA-LAPD study of blood samples drawn from nearly 200 suspected drug-impaired drivers arrested in Los Angeles showed that almost 75 percent had ingested two or more drugs. Common examples of polydrug use include drinking alcohol while smoking marijuana, sprinkling PCP on marijuana cigarettes and mixing heroin with cocaine.

Polydrug use complicates the problem of determining which categories of drugs are the source of impairment. When a subject ingests drugs from different categories, three different (and often simultaneous) effects are likely to occur: additive effects, antagonistic effects and/or overlapping effects.

If the two drugs produce similar effects when taken independently, these effects may be **additive** when the drugs are taken together. For example, both central nervous system depressants and narcotic analgesics induce drowsiness. A person who has combined a depressant with a narcotic may become very drowsy and be difficult to awaken.

When taken together, **antagonistic** drugs will produce opposite effects. It can be difficult to predict which of two antagonistic drugs will produce the stronger effect; sometimes the opposing effects mask each other. For example, central nervous system 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 which are nearly normal in size. It is also possible that such a person's pupils may be dilated at one time and constricted at another, as the effects of one drug diminish or the effects of the other increase:

Finally, some drugs taken in combination have **overlapping** effects. Each has a distinct effect on the subject and, in combination, both effects may be observed. For example, PCP causes nystagmus, an involuntary, spasmodic motion of the eyeball, but does not affect pupil size. Narcotic analgesics constrict the pupils but do not cause nystagmus. A person under the influence of both drugs may exhibit both nystagmus and constricted pupils.

## Components of the Drug Recognition Process

The Drug Recognition Process enables a trained officer to determine whether a subject has ingested drugs, either alone or in combination. It is based on a variety of observable signs and symptoms that are known to be reliable indicators of drug impairment. It is a standardized examination and is conducted in exactly the same way, by every Drug Recognition Expert, for every suspect.

The Drug Recognition Process has 12 major components:

- 1. The Breath Alcohol Test.** By obtaining an accurate and immediate measurement of the suspect's blood alcohol concentration, the Drug Recognition Expert (DRE) can determine whether alcohol may be contributing to the suspect's observable impairment and whether the concentration of alcohol is sufficient to be the sole cause of that impairment. It is always possible that a person suspected of being under the influence of drugs may have actually consumed only alcohol. However, it is also common to find that a suspect has consumed alcohol in combination with other drugs.
- 2 Interview with the Arresting Officer.** Although most arresting officers are not as knowledgeable about drugs as are the DREs, they may have uncovered some drug paraphernalia or overheard the suspect using drug-related "street" terms, without recognizing their significance. Spending a few minutes with the arresting officer often enables the DRE to determine the most promising areas of investigation.
- 3. The Preliminary Examination.** This is a structured series of questions, specific observations and simple tests that provide the first opportunity to examine the suspect closely. It is designed to determine if the suspect is suffering from an injury or from another condition (e.g., one unrelated to drug consumption). It also affords an opportunity to begin assessing the suspect's appearance and behavior for signs of possible drug influence.
- 4. The Eye Examination.** Certain categories of drugs induce nystagmus, an involuntary, spasmodic motion of the eyeball. Nystagmus is an indicator of drug-induced impairment. The inability of the eyes to converge toward the bridge of the nose also indicates the possible presence of certain types of drugs.
- 5. Divided Attention Psychophysical Tests.** These tests check balance and physical orientation and include the Walk and Turn, One Leg Stand, the Romberg Balance and the Finger-to-Nose. A substandard performance on these tests provides clear evidence of psychophysical impairment and indicates which categories of drugs are the probable cause of that impairment.
- 6. Dark Room Examinations.** Certain categories of drugs affect the eyes, especially the pupils, in predictable ways. These tests include systematic checks of the size of the suspect's pupils and how they react to light.
- 7. The Vital Signs Examinations.** Certain categories of drugs elevate blood pressure, pulse rate and body temperature and cause breathing to become rapid; other drugs depress these functions. A suspect's vital signs can provide valuable evidence of the presence of a variety of drugs.
- 8. Examination for Muscle Rigidity.** Certain categories of drugs cause the muscles to become hypertense and quite rigid. Others may cause the muscles to relax and become flaccid. This test detects muscular hypertension or flaccidity.
- 9. Examination for Injection Sites.** Users of certain categories of drugs routinely or occasionally inject their drugs. Evidence of needle use may be found on veins along the neck, arms and hands.
- 10. Suspect's Statements and Other Observations.** The nine previous components of the examination will probably have allowed the DRE to form at least a suspicion of the category of drug or drugs that the suspect has ingested. The next step is to attempt to interview the suspect concerning the drug or drugs he or she has ingested. Of course, the interview must be conducted in full compliance of the suspect's constitutional rights.
- 11. Opinions of the Evaluator.** Using the information obtained in the previous ten steps, the DRE is able to make an informed decision about whether or not the suspect is impaired by drugs and, if so, what category or combination of categories are the probable cause of the impairment.
- 12. The Toxicological Examination.** The DRE should obtain a blood or urine sample from the suspect for laboratory analysis in order to secure scientific, admissible evidence to substantiate his or her conclusions.

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It usually takes at least 30 minutes to complete all 12 steps; however, if the subject is severely impaired, it can take considerably longer. DREs always complete all 12 steps, even if it seems obvious at the outset which category of drug the suspect has ingested. They never skip a step, even if they are quite certain that it will not provide a positive indicator of the drug involved. Because standardization is one of the keys to acceptance of this evidence in court, the DREs are trained to follow the process without deviation.

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# Validation Studies

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The Drug Recognition Program was formally adopted by the Los Angeles Police Department in 1979 and was in effect for five years before formal validation studies were undertaken. In 1984, NHTSA initiated a two-part evaluation. The first of these was a laboratory study; the second, a field study. The methods and findings of both studies are outlined briefly below. Detailed reports on these studies are referenced in the Technical Citations listed at the end of this monograph.

## Laboratory Evaluation

This study was designed to obtain controlled experimental data on the examination procedures used by the DREs to detect drug-intoxicated individuals and to identify the type of drug producing the intoxication. It was sponsored by NHTSA and the National Institute on Drug Abuse and was conducted at Johns Hopkins University.

Procedure: Eight different types of drug doses were administered under double blind conditions to 80 volunteer subjects. These subjects were then evaluated independently by each of four LAPD DREs.

Each volunteer swallowed a pill and smoked a cigarette. The pills contained one of the following:

- o A placebo;
- o Secobarbital (A central nervous system depressant);
- o Diazepam (A central nervous system depressant);  
or
- o Amphetamine (A central nervous system stimulant).

Two different dose levels of drugs were administered (i.e., some of the pills and cigarettes were "weak," others were "strong"), with the exception of the secobarbital pills, all of which were "strong." However, even the "strong" doses were a good deal weaker than the drug doses typically ingested by impaired drivers encountered by police officers. No combinations of drugs were administered. Thus, if a subject was given a marijuana cigarette, then that subject received a placebo pill and vice versa. Some subjects received both placebo pills and placebo cigarettes.

Results: In 98.7 percent of the cases in which the subject had received a "strong" drug dose, the DREs judged the subject to be intoxicated. The DREs were able to identify the drug class administered to these "strong dose" subjects in 91.7 percent of the cases. They identified the wrong drug class in only 7 percent of these cases.

This study showed that the sensitivity of the drug recognition procedures are directly related to the strength of the dose. The DREs were less successful in identifying the volunteers who had received weak doses. For example, they classified as "impaired" only about one third of the subjects who had received weak marijuana cigarettes, and only about one sixth of those who had received weak amphetamine pills. However, it is unlikely that the subjects under the influence of weak drug doses would have been stopped by officers if they had been driving. Of the subjects who had received only placebos, the DREs assessed 95 percent as not impaired. Some of the remaining 5 percent may have been exhibiting a common "placebo effect": they expected to receive drugs, they thought they had been given drugs and, thus, may have felt and acted impaired.

## The Field Study

The results of the laboratory study were promising, though limited. Only four test drugs were used. The officers evaluated the subjects under laboratory conditions using a truncated set of procedures designed to take only 20 minutes, rather than administering the complete exam. A second study was undertaken to obtain data from a larger number of DREs who were looking for a greater variety of drugs in real suspects under actual field conditions.

Procedure: In the summer of 1985, NHTSA sponsored a field validation study in Los Angeles. Arrangements were made to have an independent laboratory analyze blood samples drawn from persons who had been arrested on suspicion of drug-impaired driving. Suspects who were involved in crashes were excluded, as were those who refused to submit to the blood test. The study ran for three months and included 173 subjects.

Initial arrests were made by regular traffic officers, who then transported the suspects to one of two central processing facilities for evaluation by one of the 25

DREs participating in the study. If the DRE concluded that the suspect was under the influence of an intoxicating substance other than alcohol, the DRE specified which type or types of drug he or she believed to be present and recorded the observations supporting that conclusion. The suspect was then asked to consent to a blood test. The blood samples were sent to an independent laboratory and screened for the presence of the following drugs or drug classes.

1. Amphetamines
2. Barbiturates (e.g., Secobarbital)
3. Cocaine/benzoyllecognine
4. Cannabinoids (marijuana)
5. Opiates (e.g., heroine, morphine)
6. Phencyclidine (PCP)
7. Benzodiazepines (e.g., Valium)
8. Alcohol

All samples showing a positive result on the screening test were confirmed using a different assay technique.

Results: When the DREs claimed drugs other than alcohol were present, drugs were detected in the blood 94 percent of the time. The DREs claimed a suspect had used drugs when no drugs were found in only 6 percent of the cases. When the DREs identified a suspect as impaired by a specific drug category, the category was detected in the suspect's blood 79 percent of the time.

The task of identifying the specific drug classes a suspect had used was complicated by polydrug use, which was found to be quite common among the suspects arrested in this study. Only 27 percent had consumed only one drug, including 10 suspects who had consumed only alcohol. Seventy-two percent

had taken two or more drugs, including alcohol; 45 percent had used two or more drugs other than alcohol. Only 3.7 percent of those who had used drugs had blood-alcohol levels over the legal limit. Thus, it is likely that most of the remaining 96.3 percent of the suspects would have been released if the drug symptoms had not been recognized by the DREs.

The DREs were able to correctly identify the presence of at least one of the drug categories that the suspect had used in more than 92 percent of the cases.

However, their performance in predicting the presence of specific categories of drugs was better for some categories of drugs than for others. The independent blood analyses confirmed the DREs' opinions in:

- o 92 percent of PCP predictions;
- o 85 percent of predictions of narcotic analgesics;
- o 78 percent of cannabis predictions;
- o 50 percent of predictions of depressants other than alcohol; and
- o 33 percent of predictions of stimulants.

### Conclusions

The results of these two studies demonstrate that the drug recognition procedures developed by the LAPD provide the trained police officer with the ability to accurately recognize the symptoms of many types of drug use. When an officer identifies a suspect as having used a particular drug, the laboratory analysis almost always will confirm his or her judgment.

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# Training Requirements

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Certification as a Drug Recognition Expert (DRE) involves completing a three-stage training program. This program is designed exclusively for sworn police officers who are fully competent in administering the Standardized Field Sobriety Tests, including Horizontal Gaze Nystagmus, Walk and Turn, and One Leg Stand and who have been selected by their departments for active service as DREs. Active service is essential because the skills acquired during training can be maintained only if used frequently.

The first step is a two-day preliminary training course. Satisfactory completion of this preliminary training provides the officer with one of the qualifications for enrolling in the seven-day classroom program. The seven-day program is followed by the certification phase of the training, which is conducted on-the-job. A period of three to five months will elapse from the time the preliminary training begins until the officer is certified as a Drug Recognition Expert.

## Preliminary Training

The two-day pre-school introduces the fundamental concepts and skills required of a DRE. The candidates are taught basic drug terminology and become familiar with the seven broad categories of drugs that can be identified by the Drug Recognition Process. They also learn about the clinical and psychophysical examinations and acquire some practice in administering them. They are drilled in the divided attention tests and the eye examinations and practice checking vital signs. A controlled drinking exercise provides an opportunity for the students to practice assessing impairment on the divided attention tests. The course primarily consists of hands-on practice, although some formal lectures are given. Because the hands-on practice requires close supervision and coaching, class size is limited to 25 (a group of 15 to 20 students is ideal). All pre-school faculty are certified DREs, and the principal instructor must have completed DRE instructor training.

The pre-school classroom must have ample table or desk space for each student, an overhead projector and screen, a video tape player and one or more monitors, a chalkboard and a flip chart. It also needs sufficient open space to permit instructors to give full and unimpeded demonstrations of the various examinations. In addition, ample space is required for the students to

practice administering the various tests, either in the classroom or elsewhere.

The students need some basic equipment: a blood pressure kit (sphygmomanometer and stethoscope), an electronic aneroid thermometer, a pupliometer, an onset angle template and a penlight. Ideally, each student should have a complete set; however, one set for every two students is sufficient.

## The Seven-Day Drug Recognition School

Students are eligible to attend the second phase of the training -- a seven-day classroom training course on evaluating and classifying drugs -- if they have substantial experience in administering the Standardized Field Sobriety Tests in enforcement situations, a good command of communication skills and a demonstrated ability to testify in court. They must also have completed the preliminary training successfully.

The seven-day training course is designed to help the students acquire the knowledge and skills needed to discern whether an individual is under the influence of a drug or drugs other than alcohol, is under the combined influence of alcohol and other drugs or is suffering from an injury or illness which produces signs similar to alcohol/drug impairment. The course acquaints the students with the various types of drugs that are abused and their effects, especially their effect on the ability to operate a motor vehicle. They learn how the different drugs manifest their presence and how to examine a suspect's eyes and vital signs to detect evidence of the presence of various categories of drugs. When they complete the training, students are able to conduct a complete drug recognition examination, document and interpret the results, prepare a narrative drug influence report and discuss appropriate procedures for testifying in drug cases.

This seven-day course contains 56 hours of actual instruction time. It is normally conducted over a nine-day period (three days of training; two days off; followed by four days of training). Approximately one half of the course consists of formal lectures, supplemented by video tape segments. The remainder is devoted to demonstrations and hands-on practice. Students work in teams, developing and sharpening their skills in administering the various examinations. They also participate in several test interpretation

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practice sessions, reviewing sample drug recognition reports and identifying the category or categories of drugs responsible for the "evidence" described in these reports. The preferred class size is 15 to 20 students; the maximum is 25.

Several facilities are needed for this course. It requires a standard classroom equipped with a large screen, overhead and 35 mm slide projectors, video tape players and monitors, and a chalk board or flip chart. This room must also provide adequate space to permit the instructors to demonstrate the examination procedures. In addition, a large open area is needed for the hands-on practice sessions. It should be possible to control the lighting in this area to the point of total darkness. Ideally, there should be an adjacent room to serve as a staging area for the volunteer drinkers who will participate in the alcohol workshop conducted on the third day of school. If possible, each student should have a complete set of equipment for use during the hands-on practice sessions, although one set for every two students will suffice. This is the same equipment required for the preliminary training course. In addition, several training stethoscopes would be useful. These stethoscopes have two sets of earpieces so that an instructor can monitor what the student is hearing.

### **Certification Training**

Successful completion of this on-the-job training culminates in the student's certification as a DRE. Certification training begins as soon as the classroom training is completed. At present, the seven-day drug recognition school is held at the site of an existing Drug Recognition Program.

Students who have successfully completed this school remain at the site for two days to begin their

certification training under the supervision of qualified instructors. These students then return to their home agencies and continue their certification training over a period of approximately two months. During this time, qualified instructors are sent to the student's home agencies to supervise their training.

During the certification phase, students conduct full drug recognition examinations of people who have been arrested on suspicion of drug impairment. To satisfy certification requirements, a student must complete supervised on-the-job training, which includes participating in a minimum of 15 complete examinations. In addition, the student must have examined, and/or witnessed the examination of, at least four of the seven drug categories.

### **Instructor Training**

Sworn law enforcement officers who have been certified as DREs are eligible for the instructor training course sponsored by NHTSA. Candidates for this training are selected by the Governor's Highway Safety Representative from among the ranks of certified DREs. Instructors must continue to work as DREs to maintain their ability to train others competently.

Candidates for this training need not have prior experience as instructors. The first two days of the five-day training event are devoted to imparting instructional techniques. The next two days are concurrent with a preliminary training course to enable the students to acquire hands-on training experience. The student instructors conduct the preliminary training course under the supervision of certified instructors, who then critique their performance. On the last day, the students learn how to conduct the certification training.

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# Site Selection Criteria

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A Drug Recognition Program is an effective means of improving enforcement of drug-impaired driving violations. Those jurisdictions which have instituted this program have demonstrated that their DREs have the ability to conduct examinations which lead to the conviction of drug-impaired drivers. Not all jurisdictions are in a position to implement this program. The following characteristics, which have served as selection criteria for pilot sites, are, in essence, prerequisites for conduct of the program.

## Demographics

A Drug Recognition Program site must be of manageable scale. It should be a political subdivision of a state rather than a whole state. Experience to date has demonstrated that a Drug Recognition Program will take firm root only if resources are concentrated in a relatively small geographical area. The four pilot sites provide examples of the kind of community focus which is needed: a single city (Virginia Beach); a single county (Nassau County in New York); a cluster of adjacent cities (metropolitan Phoenix); and a pair of neighboring, but not adjacent, cities (Denver and Boulder).

A community scale allows the DREs to quickly reach the facility where a driver suspected of drug impairment will be taken for processing. The drug recognition examination should begin within a half hour of the suspect's arrival at the testing facility. A program which is able to concentrate its forces can assure that a qualified DRE is always able to reach the processing facility quickly. If a state were to attempt to operate a Drug Recognition Program, there would be many instances when no DRE would be available to examine a suspect, and the individual DREs would have few opportunities to conduct examinations.

## Policy

A high level of DWI enforcement is essential. A jurisdiction should be able to produce enough arrests for drug-impaired driving to justify the expense of training the DREs and to provide an opportunity for each DRE to conduct at least one examination per week. Because most jurisdictions instituting this program train at least 15 DREs, this means that a Drug Recognition Program site should average a minimum of 15 DWI-drug arrests per week or nearly 800 per year.

## Legislation

It is pointless to evaluate drivers for drug-induced impairment unless those found to be so impaired can be prosecuted successfully. Thus, it is essential that a Drug Recognition Program be located in a state with an implied consent law that:

- o Explicitly allows the chemical test sample to be analyzed to determine the presence and/or concentration of drugs other than alcohol;
- o Explicitly indicates that the "consent" applies to multiple tests, i.e., that the person is "deemed to have given consent to a test or tests of blood, breath or urine." This multiple test requirement is essential because both a breath test and a blood (or urine) test are integral components of the drug recognition process; and
- o Empowers the arresting officer and/or the law enforcement agency to select the types of chemical tests to be taken, rather than giving the suspect the option of choosing the tests.

In addition to this crucial implied consent legislation, the effectiveness of Drug Recognition Programs are greatly enhanced by legislation permitting the fact of a suspect's refusal to submit to the chemical test to be introduced as evidence in court. Finally, it is helpful if the state has passed legislation making it an offense to be under the influence of drugs, whether or not the suspect is operating a motor vehicle.

## Law Enforcement Agency Operations

Staff: If a Drug Recognition Program is to be successful, the law enforcement agency operating it must meet certain operational prerequisites. The first of these concerns the Standardized Field Sobriety Tests (SFST). At least 80 percent of an agency's traffic law enforcement officers must be fully proficient with these tests. It is preferable if the agency's SFST training program is consistent with NHTSA's model curriculum. In particular, the training must be at least 16 hours long and include at least two practice sessions with volunteer drinkers.



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Management Information System: The second prerequisite is a well-maintained management information system (MIS). It is important that the agency have the ability to maintain accurate and timely records of:

- o Alcohol- and drug-related arrests and convictions;
- o Alcohol- and drug-offense processing time;
- o All drug recognition examinations; and
- o All toxicological examinations.

Central Booking: Finally, an agency must have the ability to institute centralized processing of DWI arrestees. The ideal situation would be one in which all persons arrested for DWI were taken to a single location for processing. One or two DREs could then be stationed at that location at all times to ensure prompt access to all suspects apprehended for drug-impaired driving. However, it is feasible for a jurisdiction to have a few centralized processing facilities as long as there are enough DREs to staff them adequately and enough DWI arrests to ensure that the DREs conduct frequent examinations.

Facilities: Each DWI arrest processing station must have adequate facilities for conducting drug recognition examinations. These facilities include:

- o A room sufficiently large to permit unobstructed administration of the Standardized Field Sobriety Tests;
- o A separate room which can be completely darkened for the eye examination;
- o Storage space for test data forms, reference documents, blood pressure kits, etc; and
- o Access to breath testing equipment producing on-the-spot results and resources for collecting blood and/or urine samples.

### **Laboratory Resources**

To conduct a successful program, the jurisdiction must have access to laboratories that are capable of identifying the presence of the most commonly abused drugs when these drugs are present in sufficient concentrations to produce impairment. Ideally, the laboratories will also be able to identify the concentration of these drugs. In any case, the accuracy of the chemical analysis should be consistent with state-of-the-art drug testing. In other words, screening tests are not sufficient; a jurisdiction should be able to produce a confirmatory analysis. Although either blood or urine samples are acceptable, it is best if the jurisdiction has the ability to test both.

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# Implementing a Drug Recognition Program

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## The Pilot Program

Section 9004 of the Anti-Drug Abuse Act of 1988 authorizes NHTSA to conduct a three-year pilot program for Drug Recognition Expert Training. It is NHTSA's intention to make this training available to interested jurisdictions that meet the site selection criteria outlined above. With few exceptions, candidate sites will fall under the jurisdiction of two or more law enforcement agencies. For this reason, the following endorsements are necessary:

- o The State's Governor's Representative for Highway Safety;
- o The chief elected official of each political subdivision which would be included in the site;
- o The Commanding Officer of each participating law enforcement agency;
- o The Administrative Judge of each court which tries people arrested for DWI within the jurisdiction;
- o The Chief Prosecuting Attorney for each court in the jurisdiction; and
- o Representatives of any other agencies which would be involved in covering the costs of developing and sustaining the Drug Recognition Program.

In most cases, the State Highway Safety Office will serve as the funding source and so will be the first avenue of approach. The initial expression of interest will be evaluated by the State Highway Safety Office and forwarded to the NHTSA Regional Office for transmittal to NHTSA's Office of Alcohol and State Programs in Washington.

## Program Costs

Once a jurisdiction has been selected as a pilot site, NHTSA will organize and conduct the three-step training program which results in police officers earning certification as Drug Recognition

Experts. The trainers are certified instructors from established programs. Through a grant to the International Association of Chiefs of Police, NHTSA pays the trainers' travel, lodging and subsistence costs. NHTSA also provides the student manuals and audio-visual materials used in the training courses.

In most cases, each jurisdiction instituting a Drug Recognition Program will select an initial cadre of 15 to 20 officers. Each jurisdiction is responsible for the following costs associated with this training:

- o Salaries of the trainees. In addition to the time required for the seven-day drug recognition school, the jurisdiction should budget two days per student for the preliminary training and from 14 to 20 days for the certification training.
- o Travel costs, lodging and subsistence associated with the seven-day drug recognition school and the first two days of certification training. The certification training begins as soon as the drug recognition school ends and is held at the same site to minimize travel costs.
- o Equipment needed to conduct the examinations. This includes a sphygmomanometer, a stethoscope, an electronic aneroid thermometer, a pupliometer, an onset angle template and a penlight. A complete set of high-quality equipment costs approximately \$200.

## Conclusion

The Drug Recognition Program can be an effective means of identifying and prosecuting drug-impaired drivers. This monograph is intended to provide an overview of the program in sufficient detail to permit officials to decide if this program has potential application in their jurisdictions. A list of the Governors' Highway Safety Representatives is included for the convenience of those who wish to explore implementing this program.

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