

WRAP_FAV_SB309

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WASHINGTON REGIONAL ALCOHOL PROGRAM

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February 21, 2020

Members of the Judicial Proceedings Committee
Maryland Senate
Annapolis, Maryland

Re.: Support for "Drugged Driving – Oral Fluid Tests – Pilot Program," SB 309, Kagan (D-Montgomery Co.) and West (R-Baltimore)

"Collecting drug-impaired driving data is critical to understanding the scope of the problem."

– National Highway Traffic Safety Administration ("Presence of Drugs in Drivers")

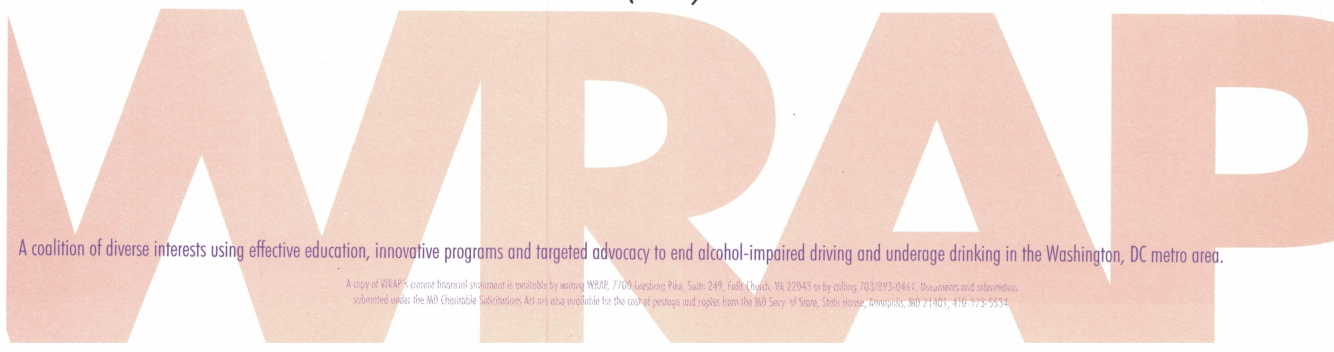
Dear Senators:

On behalf of the Maryland nonprofit Washington Regional Alcohol Program's (WRAP) Board of Directors, staff, volunteers and the more than six-million Maryland residents we serve in the fight against drunk driving and underage drinking (including having served as project director of both Maryland's Checkpoint Strikeforce campaign and "Maryland Remembers" ceremony), I wanted to formally communicate to you **WRAP's unequivocal support for Senate Bill 309, "Drugged Driving – Oral Fluid Tests – Pilot Program," SB 309, Kagan (D-Montgomery Co.) and West (R-Baltimore).**

Succinctly, SB 309 proposes the establishment of a "pilot program to examine the testing of oral fluid samples by certain police officers to assist in determining whether an individual is operating a motor vehicle while impaired by a controlled dangerous substance."

Between 2007 and 2016, the percentage of fatally injured tested drivers in the U.S. testing positive for drugs nearly doubled (25% to 42%, National Highway Traffic Safety Administration [NHTSA]). In addition and according to the Insurance Institute for Highway Safety (IIHS, "Alcohol and Drugs"), crash rates have risen in states that have legalized retail sales for recreational use.

(over)



A coalition of diverse interests using effective education, innovative programs and targeted advocacy to end alcohol-impaired driving and underage drinking in the Washington, DC metro area.

A copy of WRAP's current financial statement is available by writing WRAP, 7700 Leesburg Pike, Suite 249, Falls Church, VA 22043 or by calling 703/893-0461. Documents and information submitted under the MD Charitable Solicitations Act are also available for the cost of postage and copies from the MD Secretary of State, State House, Annapolis, MD 21401, 410-773-2534.

2018 IIHS data shows that traffic “crashes are up by as much as six-percent in Colorado, Nevada, Oregon and Washington, compared with neighboring states that haven’t legalized marijuana for recreational use (IIHS, “Status Report”).

To better measure the prevalence of drugged driving in Maryland – comports with the NHTSA recommendation to “strengthen drug testing by deploying screening equipment and devices, particularly as new drugs of abuse emerge” (NHTSA’s “Presence of Drugs in Drivers”) – and deploying that NHTSA testing methodology most preferred (due to its ease of collection) that being that “oral fluid has emerged as the specimen of choice to replace urine in many applications of testing for drugs of abuse” (NHTSA, “National Roadside Survey Pilot Test; Oral Fluid and Blood Analytic Procedures”), SB 309 proposes a limited, two-year pilot program deploying these roadside screens.

In 2018, the National Transportation Safety Board (NTSB) called on state and federal regulators to “do more to tackle the growing problem as states grapple with prescription drug abuse and adopt a more permissive stance on marijuana” specifically citing that “police need better training on how to spot drivers who may be impaired and ‘oral fluid’ drug tests that police can use after pulling people over” (Insurance Journal, “National Safety Board Calls for Standards for Drugged Driving Tests”).

We concur and ask for your consideration of favorably reporting this potentially lifesaving legislation. I may be directly reached with any questions at either 703-893-0461 or at kurt@wrap.org.

Cordially,



Kurt Gregory Erickson
President

John Flannigan_FAV_SB 309

Uploaded by: Flannigan (Ret.), Lt. John

Position: FAV

TESTIMONY OF Lt. John Flannigan (Ret).
ON BEHALF OF Flannigan Safety Consulting, LLC.
IN SUPPORT OF Senate Bill 309

Senate Judicial Proceedings Committee
Maryland General Assembly
February 21, 2020

Thank you to Chairman Smith and the Maryland Senate Judicial Proceedings Committee for the opportunity to share my law enforcement experience and insight on the importance of oral fluid testing. As you consider SB 309, I urge you to continue to demonstrate leadership in addressing impaired driving and pass this important pilot study bill into law.

My name is John Flannigan and I am a retired commander from the Vermont State Police. During my 28-year career in law enforcement, I have seen firsthand the tragedy that results from drug-impaired driving. As a state trooper and drug recognition expert, I have significant experience dealing with the offense of impaired driving, a crime that is entirely preventable. Each year, communities across this country are negatively impacted by decisions to get behind the wheel after consuming impairing substances. In my home state of Vermont and here in Maryland, so many families have experienced grief and hardship due to the loss of loved ones who are innocent victims of selfish behavior. I devoted my career to protecting public safety and, in my retirement, I continue to advocate for laws and strategies that are effective in reducing impaired driving, particularly those that can assist law enforcement. In order to reduce DUI fatalities, law enforcement agencies must have the resources, training, and tools necessary to effectively and efficiently identify and remove impaired drivers from the roadways. It is also important that the public understands that officers can identify drug impairment and that they are likely to be arrested if they choose to drive under the influence of drugs or a combination of substances.

Oral fluid drug testing is technology that can aid officers in conducting impaired driving investigations and accomplish the aforementioned goals. Prior to my retirement, I had the opportunity to participate in an oral fluid pilot study in Vermont. Our pilot involved the deployment of two devices – Abbot's SoToxa (it was the Alere DDS-2 at the time of the pilot), and Draeger's DT2000. Both instruments utilize lateral flow immunoassay and produce results in less than 10 minutes that indicate whether a driver is positive or negative for the presence of common drugs/drug classes. The number of tests completed during the pilot were limited, but we experienced good overall accuracy and reliability rates when the oral fluid screening results were compared to confirmatory quantitative blood and oral fluid tests conducted in a forensic laboratory. These findings were promising and added to the growing body of literature that identifies oral fluid screening as a viable law enforcement tool.

Roadside oral fluid testing has numerous advantages and benefits and many law enforcement agencies and traffic safety advocates view this technology as holding great potential for use in drug-impaired driving investigations. The testing is easy, quick, non-invasive, and can assist a law enforcement officer to rule in or rule out whether observed impairment is being caused by drugs. These devices generally test for the most commonly abused drugs found in drugged driving cases including amphetamine,

benzodiazepines, cannabis (THC), cocaine, methamphetamine, and opiates. While not exhaustive, oral fluid screening has the ability to test for the majority of what we see on the roadways.

As a law enforcement officer, I want tools at my disposal that can be of assistance during investigations. As a DRE, I firmly believe that there is no substitute for proper training. Oral fluid testing cannot and should not replace the Drug Evaluation and Classification program or Advanced Roadside Impaired Driving Enforcement (ARIDE) training but it can supplement training and assist officers who are not certified DREs especially in cases where they observe impairment and believe drugs to be the cause.

While having tools available to law enforcement that will help officers do their job more effectively is important, creating general deterrence is also key. To discourage people from engaging in dangerous and criminal behavior, they must believe that there is a significant likelihood that they will be caught. This is one of the primary reasons why law enforcement agencies engage in high visibility enforcement efforts like sobriety checkpoints and saturation patrols. We do this type of enforcement to raise awareness and deter people from driving impaired.

In examining drug-impaired driving public opinion research, a common perception on the part of respondents is that law enforcement does not have the ability to identify or test for drug impairment. In other words, people realize that law enforcement officers can test for alcohol and an arrest for DUI is likely, but they believe that there are no tools available to test for drug use and that officers are unable to determine if someone is high behind the wheel. This, of course, is untrue. But having the ability to test for alcohol at the roadside for decades has been an important strategy in reducing the number of alcohol-impaired driving crashes. If comparable measures were available for drug testing, this could be publicized and shift public opinion. If people realize that law enforcement do have the means to accurately and quickly test for drugs, it will likely make them think twice before using and driving.

Many other countries already rely on oral fluid testing as part of impaired driving investigations, including our neighbors to the north in Canada. Roadside testing has been approved and is being implemented across the country following the legalization of recreational cannabis. While the program is still new and is being rolled out slowly in many provinces, the Canadian government and law enforcement agencies believe this is a necessary countermeasure to address an increasing public safety threat. Here in the United States, oral fluid pilots have been implemented in numerous states aside from Vermont. Currently, Michigan is leading the way with the largest pilot to date – an initiative that is statewide involving more than 50 law enforcement agencies and more than 100 DREs. Michigan's pilot has grown over time and the program advocated in SB 309 is similar to the initial oral fluid legislation in Michigan. The results from that year-long study produced data revealing a high degree of accuracy.

One of the reasons why Vermont law enforcement and policymakers were interested in oral fluid testing is because our state is one of the now 11 jurisdictions that has legalized recreational cannabis. While Maryland has yet to expand its medicinal program and permit recreational use, those discussions are ongoing. States that have legalized cannabis, such as Colorado and Washington, have seen a rise in cannabis-related social harms, especially in impaired driving injuries and deaths. Legislators have the ability to protect public safety and ensure that the resources and tools needed to improve drug-impaired driving enforcement are put in place before policy advances. By passing SB 309 and establishing an oral fluid pilot program, Maryland will be taking a proactive approach and can make data-driven decisions moving forward. Vote yes on SB 309 to protect public safety.

Curt Harper_FAV_SB309

Uploaded by: Harper, Dr. Curt

Position: FAV

SB309: Drugged Driving - Oral Fluid Tests - Pilot Program
Position: FAVORABLE

My name is Dr. Curt E. Harper and I serve as Chief Toxicologist for the Alabama Department of Forensic Sciences (ADFS). As Toxicology Discipline Chief, I oversee technical operations, method development and validation, and the quality assurance/quality control program, and develop and maintain standard operating procedures. I obtained a Ph.D. in Pharmacology and Toxicology and a Master's of Science in Forensic Science from the University of Alabama at Birmingham. I hold board certification as a Fellow of the American Board of Forensic Toxicology (F- ABFT) and serve as Chair of the SOFT/AAFS Drugs and Driving and Vice Chair of the Oral Fluid Committees. In addition, I am a Board Member for the International Association for Chemical Testing (IACT). I serve as an adjunct professor at the University of Alabama at Birmingham (UAB) in the Department of Justice Sciences and faculty for the Borkenstein Alcohol Course at Indiana University. My interests include DUI/D testing and interpretation and oral fluid drug testing. As an Alabama Peace Officer, I have been certified as a Drug Recognition Expert since 2015 and act as a member of the Alabama Impaired Driving Prevention Council.

The Toxicology Discipline of the Alabama Department of Forensic Sciences provides assistance to local, county, state and federal law enforcement agencies in Alabama in death and criminal investigations. This assistance includes laboratory analyses of biological specimens for the presence of drugs and poisons. The findings of these analyses may then be used to establish cause and manner of death or to establish or explain impairment or performance of an individual pursuant to criminal activity. The Alabama Department of Forensic Sciences Toxicology Discipline operates in the Birmingham/Hoover Regional Laboratory. We average around 6,000 submissions per year worked by 15-16 Toxicologists. Approximately 40% are DUI cases and from this point forward would include an oral fluid sample.

Despite its limited use in drugged driving investigation, oral fluid testing has been around for over a decade and is used today in workplace drug testing, pain management monitoring, and other applications. A major advantage of oral fluid (saliva) drug testing is the amenability to rapid point of collection (on-site) testing (e.g. roadside testing for drugged driving investigations). Oral fluid collection is rapid, non-invasive, and simple. Oral fluid contains the active/impairing drug which likely represents recent drug use. Oral fluid shares this advantage with blood. We are the first state to offer a comprehensive Oral Fluid Drug Testing program at the State Crime Laboratory level. The program is two parts: screening at the roadside and evidentiary confirmation testing at ADFS.

In 2016-2017, we validated and approved (3) "roadside" oral fluid drug screening devices that law enforcement can use during a DUI stop or crash to identify drug use. They screen for marijuana, cocaine, methamphetamine, amphetamine, opioids, and benzodiazepines. The devices are analogous to PBTs for alcohol and should be used to establish probable cause only. They display "positive" or "negative" and should be administered after standardized field sobriety tests to confirm suspicion of drug use. This information can also be used to assist with obtaining a search warrant to collect a confirmation specimen such as blood (or oral fluid). The three approved devices are Abbott SoToxa, Draeger DT5000, and Randox Evidence MultiStat.

Secondly, we validated oral fluid drug evidentiary confirmation testing at ADFS. After an arrest, an evidentiary confirmation oral fluid specimen should be collected in an appropriate collection device/tube provided by ADFS. In fact, we advocate collecting the oral fluid sample at the roadside or as

close to the time of driving as possible. This enhances the ability to detect drugs that rapidly metabolize or dissipate from the body (e.g. THC, cocaine). The average time between arrest and blood draw is 2 hours in AL. Therefore, the ability to collect a sample within 15-30 minutes of arrest or crash is a significant advantage. The Toxicology Section will test the oral fluid sample and issue a report of our findings. We test for over 20 drugs of abuse and therapeutic drugs commonly found in driving cases. Officers are instructed to collect both blood and oral fluid since together they paint a more detailed picture of recent drug use and the cause of impairment. However, oral fluid drug concentration cannot be used to predict blood drug concentrations or vice versa.

As with any DUI investigation, all facets of the investigation should be considered (i.e. vehicle in motion, personal contact, and SFST performance). The totality of circumstances in conjunction with the toxicological analysis should be reviewed. The first oral fluid case was submitted to the laboratory in August 2018. Since the inception of the program, we have received approximately 150 oral fluid cases. To date, we have not testified in an oral fluid case. However, it is just a matter of time.

There are valuable resources available to states considering implementing an oral fluid drug testing program. The SOFT/AAFS Oral Fluid committee has published a FAQ document and pilot project guidelines on the Society of Forensic Toxicology website. It is very important to involve a toxicologist in the study design and key stakeholders such as local attorneys, judges, and the State TRSP and DRE coordinator in program development.

Thank you for the opportunity to provide testimony on SB 309/HB 0808. If you have any questions or need more information, please feel free to contact me at Curt.Harper@ads.alabama.gov or 205-982-9292, x247.

Curt E. Harper, Ph.D., F-ABFT
Toxicology Discipline Chief
Alabama Department of Forensic Sciences

References:

<https://www.ads.alabama.gov/services/tox/toxicology-oral-testing-program>
<http://www.soft-tox.org/oral-fluid-faq>
<http://www.soft-tox.org/oral-fluid-pilot-project-guidelines>

Responsibility.org_FAV_SB 309

Uploaded by: Holmes, Erin

Position: FAV



**TESTIMONY OF Erin Holmes
ON BEHALF OF Responsibility.org
IN SUPPORT OF Senate Bill 309**

**Senate Judicial Proceedings Committee
Maryland General Assembly
February 21, 2020**

Good afternoon Chairman Smith and distinguished members of the committee. Thank you for the opportunity to testify in support of Maryland **Senate Bill 309**. My name is [Erin Holmes](#). I am the Vice President and Technical Writer for Criminal Justice Programs & Policy at Responsibility.org. Prior to joining Responsibility.org, I was a Research Scientist at the Traffic Injury Research Foundation (TIRF) where I published reports, evaluations, and articles and delivered presentations internationally on relevant impaired driving issues and strategies for criminal justice system improvements. As a nationally-recognized subject matter expert on alcohol and drug-impaired driving, I routinely serve as faculty for judicial organizations and have provided Congressional testimony on drug-impaired driving countermeasures.

Responsibility.org is a national not-for-profit organization and a leader in the fight to eliminate drunk driving and underage drinking. We are funded by leading distilled spirits companies who are committed to these causes including: Bacardi U.S.A., Inc.; Beam Suntory; Brown-Forman; DIAGEO; Edrington; Mast-Jägermeister US, Moët-Hennessy USA, and Pernod Ricard USA. For nearly 30 years, Responsibility.org has transformed countless lives through programs that bring individuals, families, and communities together to guide a lifetime of conversation around alcohol responsibility and by offering proven strategies to stop impaired driving. To find out more, please visit www.responsibility.org

Eliminating impaired driving through evidence-based practices

Responsibility.org researches current trends and develops policy and program initiatives to eliminate impaired driving. Our organization supports proven strategies and evidence-based practices to reduce the number of fatalities and injuries caused on our nation's roadways by individuals who choose to operate a motor vehicle while impaired. More than 10,000 deaths annually, or one-third of all motor vehicle crashes, are attributed to alcohol-impaired driving. Each one is entirely preventable.

Historically, Responsibility.org's focus has been the elimination of alcohol-impaired driving but in recent years, there has been a disturbing increase in the number of drivers who test positive for drugs or a combination of alcohol and drugs. Drug-impaired driving is the operation of a motor vehicle while under

the influence of, or impaired by, any substance with psychoactive properties (including illicit substances, prescription medications, over-the-counter medications). When ingested, drugs can impair driver performance, particularly when taken in combination with alcohol or other drugs. This preventable behavior represents a critical threat to public safety.

Senate Bill 309, which establishes an oral fluid pilot program in five Maryland jurisdictions, provides an opportunity to position Maryland as a leader in the fight against drug-impaired driving, an issue that all states are currently struggling to address. This pilot presents a unique opportunity to not only provide law enforcement with tools to strengthen impaired driving investigations, but also to learn more about the magnitude and characteristics of the drug-impaired driving problem in Maryland and create general deterrence among the public. The proposed approach is one that has been successfully implemented in Michigan (discussed below) and is supported by traffic safety organizations and criminal justice practitioners alike. **Responsibility.org supports SB 309 and strongly encourages this committee to pass this important and innovative legislation.**

Drug-impaired driving and the need for increased testing

Extent of the problem. While the true magnitude and characteristics of the drug-impaired driving problem are not known due to several significant data limitations, the statistics that are available reveal that this issue is in need of urgent attention. In 2016, the most recent year for which data are available, the National Highway Traffic Safety Administration (NHTSA) Fatality Analysis Reporting System (FARS) found that drugs were present in 43.6% of fatally-injured drivers with a known drug test result. This represents a substantial increase from 2005 when 27.8% of fatally-injured drivers tested positive (NHTSA, 2010; FARS, 2015). As in previous years, in 2016 cannabis was the most commonly found drug in the systems of drug-positive fatally-injured drivers. While 41.1% of these individuals tested positive for some form of cannabis, 19.7% of drug-positive drivers were found to have opioids in their system.

In addition to fatality data, results from NHTSA's National Roadside Survey (NRS) are also instructive in measuring the extent of drug-impaired driving in this country. In 2013-2014, NRS findings revealed that 22.4% of weekday day and 22.5% of weekend night-time drivers tested positive for illegal, prescription, or over-the-counter medications (Berning et al., 2015). The drug that has shown the largest increase in weekend night-time prevalence is cannabis. In the 2007 NRS, 8.6% of weekend night-time drivers tested positive for the main psychoactive ingredient in cannabis, Delta-9 tetrahydrocannabinol (THC); this increased to 12.6% by 2013-2014 representing a significant 48% increase over a seven year span.

Multi-substance impaired driving. Further complicating the drug-impaired driving issue is the realization that it is not uncommon for drivers to ingest several impairing substances at the same time. According to NHTSA, while many individual substances taken by themselves may not impair driving sufficiently to raise crash risk, when taken with other substances the effects may be additive or synergistic and produce an increased risk of crash involvement (Compton, et al., 2009; Romano et al., 2014). Research has continually shown that drugs used in combination or with alcohol produce greater impairment than substances used on their own (Schulze et al., 2012). Individuals who drive under the influence of alcohol and drugs are up to 200 times more likely to be involved in a crash (Shulze et al., 2012; Griffiths, 2014). In describing this increased level of impairment, the analogy of 1+1=3 is often

used to convey the risk associated with using multiple substances at the same time. The combination of alcohol and cannabis is particularly risky as it can dramatically impair driving performance. Recent simulator research has shown that the use of alcohol in conjunction with cannabis can produce significantly higher blood concentrations of THC (delta-9-tetrahydrocannabinol, the main psychoactive component in cannabis) than cannabis use alone (Ramaekers et al., 2000; Hartman et al., 2015).

The increased level of impairment and crash risk associated with combining multiple impairing substances is concerning as is the rate at which this behavior appears to be occurring. According to FARS data, in 2016, 50.5% of fatally-injured drug-positive drivers (with known drug test results) were positive for two or more drugs and 40.7% were found to have alcohol in their system (FARS as cited in Hedlund, 2018). Furthermore, recent data from Washington State – one of the first states to legalize recreational cannabis – revealed that poly-drug impairment was the most common type of impairment found among drivers involved in fatal crashes between 2008 and 2016 (Grondel et al., 2018). Among drivers involved in fatal crashes during this timeframe, 44% tested positive for two or more substances with alcohol and THC being the most common combination (Grondel et al., 2018).

Drug-impaired driving in Maryland. Reported Maryland crash data includes both alcohol and drug-impaired driving in a single category, however, the Highway Safety Office has raised concerns about increases in drug involvement in recent years as reflected by toxicology results and a greater number of citations issued for drug-impaired driving incidents. A report from the Drug Recognition Expert (DRE) Section of the International Association of Chiefs of Police (IACP), revealed that the polydrug problem is particularly significant. In analyzing DRE evaluation data for 2018, it was found that of the 863 enforcement evaluations performed, 426 cases likely involved polydrug impairment. Other common categories of drugs identified in evaluations include narcotic analgesics (opioids), depressants (benzodiazepines), and cannabis. Narcotics were identified in 50.4% of enforcement evaluations and depressants were identified in 46.1%. Refusals to submit to blood draws is also a significant concern and problem within the state.

Common testing concerns. Unfortunately, the prevalence of drug-impaired driving is inevitably underreported. While the majority of law enforcement officers are trained to identify drivers who are impaired by alcohol, many officers do not receive specialized training to identify the signs and symptoms of drug impairment. Moreover, it is easier for law enforcement to make an arrest and obtain a blood alcohol concentration (BAC) level from either a breath or blood sample than it is to complete an investigation for drug-impaired driving. The latter typically requires an evaluation by a Drug Recognition Expert (DRE), a law enforcement officer with extensive specialized training, who may not be readily available.

Blood tests are also needed to confirm the presence of drugs in a suspect's system. However, due to delays in obtaining this sample, test results often do not accurately reflect drug concentration levels at the time of driving on account of the rapid metabolism of these substances. In any DUI case where drug impairment is suspected, the delay in obtaining a blood sample is consistently cited by law enforcement as a substantial challenge. While impairment resulting from drug use can last for hours, chemical evidence dissipates rapidly within the body through the metabolism process.

As part of a standard DUI investigation, an officer must first conduct the roadside stop which includes contact with the driver and administration of the field sobriety tests. The officer must obtain enough evidence to establish probable cause in order to make an arrest. At this point, the individual is transported to the police station where he/she will be required to submit to an evidential breath test and a blood draw to determine if drugs are present. In instances where the suspect refuses to voluntarily submit to a blood draw, an officer must obtain a warrant. During this timeframe, drug nanogram levels within the bloodstream continue to drop. The end result is that the nanogram level detected in the evidential blood sample is unlikely to be reflective of what it was at the time of driving.

Use of oral fluid drug testing as an investigative tool

With growing concerns about increased rates of drug and multi-substance impaired driving, there must be more emphasis placed on testing impaired drivers for the presence of drugs, preferably at the roadside. The ability to do initial screening can be used for triaging purposes, determining whether it is necessary to conduct further investigation and chemical analysis. Moreover, the combination of screening results, observed signs and symptoms of impairment, and other evidence can collectively establish probable cause for an arrest. For officers who lack specialized drug impairment training, the addition of a screening tool can aid in decision-making as results can confirm the presence of drugs when an officer suspects impairment. Currently, the most viable technology that can be deployed for roadside drug screening is oral fluid testing.

Oral fluid testing can be done for preliminary screening or confirmation/evidential drug testing. **In the context of SB 309, oral fluid would be utilized for screening purposes only.** These screening devices are used by law enforcement at roadside during an impaired driving investigation to identify recent drug use. Most of the devices which have been evaluated in recent reports screen for specific drugs or drug classes including: cannabis (THC), cocaine, methamphetamine, amphetamine, opioids, and benzodiazepines.

How oral fluid testing works. Oral fluid, which is largely a reflection of the free drug circulating in the blood, can be collected and analyzed with commercially available field screening devices with the result being determined quickly (in under 10 minutes). The easy collection and rapid analysis are useful for situations where drug intake must be determined quickly in order to take further action. Oral fluid screening devices typically include an oral fluid collector (e.g., cartridge with pad) and a reader that has an internal detection system based on lateral fluid immunoassay. A suspect would be instructed by the officer to collect a sufficient oral fluid sample using the collector (cartridge) which is then inserted into the reader. For the devices that have portable analyzers, the presence of a drug can be determined by an objective reading of the test strip by the device itself.

The devices are analogous to preliminary breath tests (PBTs) for alcohol and should be used to establish probable cause only. At this stage, the officer has concluded that the driver is impaired and unable to safely operate a motor vehicle. The roadside oral fluid screen is used to identify what drug class(es) is/are likely causing the observed impairment. They display results of “positive” or “negative” and should be administered after standardized field sobriety tests (SFSTs) to confirm suspicion of drug use. The devices do not indicate the level of the drug present in the individual’s body, instead results are

qualitative and merely indicate whether that individual is positive for certain substances above device cutoff limits. This information can be used to assist with obtaining a search warrant to collect a confirmation specimen (e.g., blood) that is sent to a forensic laboratory for analysis. It is this secondary sample that is admitted as evidence in court; a field screen/roadside test should not be used for evidentiary purposes. In other words, the results of roadside oral fluid screens are considered presumptive positives until an evidentiary confirmation has been conducted. An evidentiary confirmation will indicate the specific drug present and quantification. For example, an oral fluid screen indicates whether an individual is positive for the presence of benzodiazepines whereas a confirmation test in the laboratory would indicate the specific drug (e.g., Alprazolam) and a quantitative amount.

Devices. The following images display the most common oral fluid screening devices on the market. The first image (left) is the SoToxa manufactured by Abbott and the second image (right) is the DT5000 manufactured by Draeger. These devices are approved for use in a number of jurisdictions in the US and internationally such as Canada. For example, both devices are certified for use in Alabama and in Michigan, the SoToxa is the device that the Michigan State Police certified for use in their pilot program.



Advantages and strengths of oral fluid drug testing

The use of oral fluid screening devices to test for the presence of drugs at roadside has the potential to assist law enforcement in identifying a larger number of drug-impaired drivers who would otherwise escape detection. This practice provides objective data to assist in building probable cause for an arrest when considered in the context of other evidence. In addition, on-site screening devices identify the drug categories that evidential tests should examine, which can save both time and money. These devices offer many advantages as they are quick, easy to use, minimally invasive, capture recent use, and provide a sample proximate to the time of driving (Bosker and Huestis, 2009; Moore and Crouch, 2013; Wille et al., 2014).

Additional advantages of this form of testing include:

- Identifies presence of **recent drug use**
- Tests for the drugs/categories of drugs that account for the vast majority of drug-impaired driving cases
- Easy and fast collection
- Gender neutral collections
- Minimally invasive; similar to breath test
- No warrant requirement for collection
- Rapid results (<10 minutes)
- Demonstrated accuracy, sensitivity, and specificity
- Used in conjunction with other evidence to establish probable cause for arrest
- Results may support search warrant requests for other biological samples
- Ability to quickly identify drug and multi-substance impaired drivers (including those with a BAC above .08)
- Admissible in certain hearings (e.g., probable cause)
- Creates option for administrative license suspension/revocation for drug-impaired drivers
- Can create deterrence if public is aware that law enforcement have tools available at roadside to identify drug use

Common concerns. The distinction between preliminary screening and confirmation testing is important. In the proposed pilot program, oral fluid screening results would not be used as evidence. Also, because the program is a pilot, participation is strictly voluntary (i.e., an individual has the ability to refuse to provide an oral fluid sample). Furthermore, oral fluid screening only tests for the presence of drugs. Whenever oral fluid screening is discussed, concerns frequently arise about whether samples will be collected for other purposes such as analyzing DNA. This is a common misperception as DNA testing is not a standard part of any DUI investigation; moreover, DNA could also be obtained from evidential blood samples, not just an oral fluid swab and that is not done in the context of these investigations either.

Current use of oral fluid drug testing

While a newer technology in the United States, oral fluid screening has been used in other countries for many years. For example, Australia first instituted a random drug screening program using oral fluid testing in 2000 to identify drivers operating under the influence of THC and methamphetamine. More recently, Canada modified its impaired driving laws following the legalization of cannabis to allow law enforcement to compel an oral fluid sample if impairment is suspected. The decision to implement this as a solution in Canada occurred following a largescale pilot. Based on the outcomes of several studies, authorities were satisfied with the performance and reliability of the technology and opted to move forward with implementation nationally (see <https://www.publicsafety.gc.ca/cnt/rsracs/pblctns/rl-fld-drg-scrnng-dvc-plt/index-en.aspx> for more information). Other countries that have introduced oral fluid

screening include Argentina, Austria, Belgium, Brazil, Chile, Columbia, France, Germany, Ireland, Italy, Netherlands, New Zealand, Poland, Portugal, South Africa, South Korea, Spain, Sweden, Turkey, United Kingdom, and Vietnam. Spain has one of the largest enforcement programs in the world with more than 800 SoToxa instruments actively deployed.

In the United States, oral fluid pilots have been conducted in numerous states including Alabama, California, Colorado, Florida, Kansas, Massachusetts, Michigan, Oklahoma, Oregon, Utah, Vermont, and Wisconsin. Other states are beginning to initiate pilots in the coming year. In addition to studying the viability of the technology, approximately 18 states have broadened either implied consent or testing statutes to allow for the use of this form of testing with others introducing similar legislation each year. The two states that are leaders in oral fluid testing are Alabama and Michigan as they have the most advanced and largest programs to date.

Alabama. Alabama became the first state to establish a permanent oral fluid program utilizing devices in both a screening and evidentiary capacity. Alabama's Oral Fluid Drug Testing Program was established under the leadership of Dr. Curt Harper at the Department of Forensic Sciences (ADFS). After piloting several devices including various oral fluid screening devices as well as Quantisal evidential testing, Alabama transitioned to a full program. The protocol utilized in Alabama is similar to other jurisdictions. As part of the initial DUI investigation, officers administer an onsite test at roadside once there is suspicion that an individual may be impaired by drugs. This test indicates whether that person is positive or negative for the presence of the most common drugs and the results can be used to help establish probable cause and justify an arrest.

Once an arrest is made, an evidential toxicology sample must be collected for forensic laboratory testing. This is where Alabama's approach differs from other jurisdictions. In the majority of states, officers collect blood samples in DUI cases to confirm the presence of an impairing substance(s) in the body. With the establishment of Alabama's new program, officers can now collect an evidential oral fluid sample to submit for confirmation testing at the state lab. The collection procedure is similar to that of oral fluid screening with the only difference being that officers have to follow a specific protocol using an appropriate collection tube and maintain a documented chain of custody. Upon collection, the Quantisal sample is sent to the lab and analyzed. Currently, ADFS analyzes evidential oral fluid samples for in excess of 20 drugs that are commonly found in impaired driving cases. More information about Alabama's program and evidential oral fluid testing can be accessed through ADFS (refer to <https://adfs.alabama.gov/services/tox/toxicology-oral-testing-program>).

Michigan. In 2016, Michigan became the first state in the nation to implement an oral fluid pilot as a result of legislation with the enactment of Public Act 242/243. Under this law, the Michigan State Police was given the authority to develop and implement an oral fluid pilot program in five counties. The pilot ran for a year and relied on DREs to administer the oral fluid test as part of DUI investigations if drug impairment was suspected. Unlike previous pilots in other jurisdictions, the Michigan program makes refusal to submit to an oral fluid test a civil infraction. In other words, participation in the pilot is not voluntary which is a key difference from SB 309.

Following the completion of the pilot which generated a total of 92 samples, a report summarizing findings was submitted to the legislature (included with testimony and accessible online:

https://www.michigan.gov/documents/msp/Oral_Fluid_Report_646833_7.pdf). The legislature deemed the outcomes to be promising and agreed to support the ongoing funding of the oral fluid pilot and the expansion of the program to additional interested, qualified counties around the state. An appropriation of \$626,000 for the extension of the Oral Fluid Roadside Analysis Pilot Program was included in the supplemental funding bill that became Public Act 618.

The MSP continues to oversee the pilot which commenced in the fall of 2019. More than 50 agencies and over 100 DREs are involved in the largescale pilot and the hope is that the statewide program will produce a significant amount of data over the course of 2019-2020. If the program continues to produce promising results, there is great likelihood that the legislature and law enforcement agencies will transition from the pilot to a permanent program and the use of oral fluid onsite screening will become a standard component of DUI investigations in Michigan.

The Michigan experience is particularly relevant for Maryland as the approach proposed in SB 309 follows that of [Public Act 242/243](#) and contains a similar structure and provisions. With another state serving as a model, Maryland legislators should have a high degree of confidence in the potential for a successful pilot. By starting small, data can be collected and reviewed by the legislature; at that time, decisions can be made regarding possible expansion opportunities.

Importance of identifying drug-impaired drivers

By following the examples set forth by Michigan and Alabama, Maryland legislators have the unique opportunity to position the state as a leader in combating drug-impaired driving. The issue is timely and relevant in the state as Maryland continues to experience high rates of opioid abuse and has established a medicinal cannabis program. As debates about recreational use are ongoing, Maryland should learn from the examples set forth in Michigan and Canada and make traffic safety a central part of those discussions. To prepare for recreational cannabis, both of those jurisdictions prioritized the piloting and use of oral fluid drug testing recognizing that it is important to be proactive and supply law enforcement with resources and tools to identify and remove drug-impaired drivers from the road.

The failure to identify these drug-impaired drivers has several implications that can lead to negative outcomes which underscores the importance of instituting a drug testing program as part of DUI investigations.

- Lack of testing leads to underreporting of the magnitude and characteristics of the drug and multi-substance impaired driving problem. Jurisdictions cannot determine how big the problem is and therefore, are limited in making informed decisions regarding policy/resource allocation.
- Failure to identify drug use at the point of arrest hinders the court in its ability to effectively dispose these cases and craft sentences that are tailored to individual offender risk and needs. Multi-substance offenders are more likely to be classified as high-risk and require more intensive supervision but if the presiding judge is unaware of drug use, it is unlikely that this will be accounted for when the sentence is imposed.
- Current laws are structured in such a way that unless drug use is identified at the outset of the case, offenders are unlikely to be subject to any drug monitoring and/or treatment. Unless the

court or probation are aware of a history of drug use, these offenders are unlikely to be subject to urinalysis or other forms of drug monitoring.

- Failure to identify drug use misses an opportunity to make informed decisions regarding supervision and treatment. In these instances, there is a lack of accountability as continued drug use is likely to go undetected. Lack of accountability and treatment for an underlying cause of DUI offending is likely to result in recidivism which places public safety at risk.

Conclusion

Responsibility.org believes that strong laws enabling swift identification, certain punishment, and treatment are fundamental elements necessary to reduce the incidence of impaired driving. Responsibility.org further believes that these elements must be coordinated into a statewide system in order to be effective. Maryland can do more to prevent impaired driving. The passage of SB 309 would ensure the identification of drug-impaired drivers in the locations where the oral fluid pilot program is introduced. This legislation will also add to the growing body of research on the feasibility of the use of oral fluid screening at roadside. Moreover, the passage of this bill will bring much needed attention to the seriousness of drugged driving and will provide opportunities to educate and raise awareness among the general public. Lastly, implementing a pilot of this nature would position Maryland alongside Alabama and Michigan as a leader in drug-impaired driving enforcement and prevention. As such, the passage of SB 309 should be a top priority for lawmakers this year. Responsibility.org thanks you for your leadership in this effort and implores you to vote yes on this legislation. Thank you.

Bridget Lorenz_FAV_SB309

Uploaded by: Lemberg, Bridgett

Position: FAV



For: The State of Maryland

February 17, 2020

From: Forensic Fluids Laboratories Inc. (FFL), Kalamazoo, MI 49007

Bridget Lorenz Lemberg, Lab Director/CEO/Toxicologist

Oral fluid = OF

About the Lab Director: Bridget Lorenz Lemberg graduated in 1987 with a Masters' degree in Toxicology from the University of Kentucky, and has been practicing Toxicology since that time. She has worked at the KY State Police Central Crime Lab, South Bend Medical Foundation (SAMHSA lab) and one of the first Oral Fluid testing labs in the US, Comprehensive Toxicology Services (2001), moving to another Oral Fluid Lab, ASL Testing, then to FFL (2005). Bridget was instrumental in developing extremely accurate methods for testing Oral Fluid with both ELISA screening and methods for LCMSMS (Liquid Chromatography Tandem Mass Spectrometry for confirming positive drugs down to 0.1ng/mL). She has been testifying about Oral fluid test results, in court, since 2001 in OH, IN, MI, WI, IL, and AZ. She has always qualified as an expert and FFL's OF test results are admitted in court.

About the Lab: Forensic Fluids Laboratories was opened in 2005 as the only exclusive Oral Fluid drug testing lab in the US. FFL has tested over 3.5 million Oral Fluid samples in 23 states, and has a CLIA certification. FFL can test for over 150 different compounds ranging from THC, PCP, Synthetic Fentanyl's, to GHB and Ketamine (date rape drugs). The main customers for FFL are Child Protective Services in many states. FFL started working with the Michigan State Police (MSP) for their first year-long roadside OF pilot of 5 counties, in November 2017. The DRE's have been the only ones collecting samples, so a field test could also be obtained. MSP only collected 62 laboratory OF tests (with a second lab collection using a Quantisal device), and 92 OF roadside screens using a DDS2/Sotoxa. These were all compared to blood tests collected at a later time. This study was so successful that MSP and FFL started their second year-long pilot, state-wide, in October 2019. To date there has been over 200 laboratory OF samples collected!

About Oral Fluid testing: Oral fluid comes from several major glands, not just the salivary gland (parotid, sublingual, etc.)! It is a reflection of what is in your blood at the time of collection, AND can be collected at the roadside, as close to the time of the accident or incident as possible! Blood samples normally need to have the donor transported somewhere, find a phlebotomist, sometimes get a court order.....this may take several hours, so by the time the blood is collected it will **NOT** reflect what the levels were at the time of the accident (and could even be negative!). There are many, many scientific papers validating the use of OF as reflective of blood levels. Roadside studies have correlated blood results with OF results at > 98%, when blood is collected in a timely fashion. Roadside OF testing is being conducted in several states: CA, VT, CO, OR, UT, OK, AL, KS, WI, MASS, and MI. There are many countries using OF roadside testing (some of which have picked OF levels for impairment purposes); Argentina, Australia, NZ, Belgium, Brazil, France, Spain, Ireland, Italy, Netherlands, Portugal, Sweden, UK, and our neighbors, Canada. As you can imagine, OF is simple and fast to collect (minutes). FFL turn-around time for positive test results (time for you to receive test results) is 18 to 24 hours after we receive the sample.

Conclusion: Oral Fluid is an excellent sample to collect for DUID as it can be collected at the roadside, fast and easily, and reflects what is in the subjects' blood at the time of collection.

Thank you for the opportunity to provide testimony on SB 309/HB 0808. If you have any questions or need more information, please feel free to contact me at BLemberg@forensicfluids.com or 866-492-2517.

MoCo_Morningstar_FAV_SB 309

Uploaded by: Morningstar, Sara

Position: FAV



Montgomery County

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SB 309

DATE: February 21, 2020

SPONSOR: Senators Kagan and West

ASSIGNED TO: Judicial Proceedings

CONTACT PERSON: Sara Morningstar (Sara.Morningstar@montgomerycountymd.gov)

POSITION: SUPPORT (Montgomery County Department of Police)

Drugged Driving – Oral Fluid Tests – Pilot Program

Senate Bill 309 would establish a pilot program to allow law enforcement officers to test oral fluid samples as part of determining whether a suspected impaired driver is under the influence of a controlled dangerous substance. Montgomery County Department of Police supports this legislation.

The proposed pilot program would allow select Maryland Drug Recognition Experts to request a voluntary submission of oral fluid from a determined drug impaired driver. This oral fluid sample would be collected solely for data analysis purposes as it relates to the oral fluid pilot program. There would be no identifying personal information attached to the sample, aside from an analysis number for laboratory confirmation purposes. Once the sample was analyzed, and the results recorded, the sample would be destroyed. The oral fluid test would have no weight on an arrest decision and would be used for informational purposes only.

According to a 2018 National Survey on Drug Use and Health, 12.5 million people drove under the influence of illegal substances over the previous year compared to 20.5 million people who drove under the influence of alcohol that year. For drug impaired drivers, the National Institute on Drug Abuse reported that those individuals exhibited slower reaction times, impaired judgment of time and distance, aggressive and reckless behaviors, and dizziness and drowsiness. These are alarming findings that should prompt the State to seek new technologies that can be used by law enforcement to detect drugged driving and ultimately lead to improved traffic safety in Maryland.

Montgomery County Department of Police respectfully request the Committee to adopt a favorable report on SB 309.

Sen. Kagan_FAV_SB309

Uploaded by: Senator Kagan, Senator Kagan

Position: FAV

CHERYL C. KAGAN
Legislative District 17
Montgomery County

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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

SB309: Drugged Driving - Oral Fluid Tests - Pilot Program
Judicial Proceedings Committee
Friday, February 21, 2020

Marylanders are all too familiar with the dangers of drunk driving. Unfortunately, Driving Under the Influence of Drugs (DUID) is on the rise. In the past five years, nearly twice as many Maryland drivers were stopped for suspicion of drugged driving. Technology has become available that allows police to test drivers they suspect are impaired. In light of the ongoing conversation about legalizing recreational marijuana, it is time to create a pilot program to study the new roadside oral fluid screening instruments. The opt-in pilot would allow police officers to take oral fluid samples during traffic stops to screen for drug presence.

Alabama and Michigan are the national leaders in oral fluid testing, with nine other states having authorized their own programs. Alabama conducted its pilot in 2016 and launched its permanent program in 2018. In 2017, Michigan launched a one-year roadside drug testing pilot program, and recent reports indicate that their tests were confirmed accurate, by a second lab test.

According to a 2018 study by the Rocky Mountain High Intensity Drug Trafficking Area, marijuana-related traffic deaths in Colorado increased from 55 in 2013 (when recreational marijuana was legalized) to a shocking 158 in 2017. These are worrisome statistics at a time when Maryland is considering loosening our marijuana laws further.

Roadside oral fluid screening devices for drugs should be analogous to breathalyzers used to detect alcohol impairment. Local jurisdictions could choose their preferred testing instrument with the stipulation that the machines must:

- Mix the sample and reagents; analyze the contents; and interpret results within the machine;
- Print and store the results internally; and
- Process results in 15 minutes or less.

To confirm a positive test result, the sample would be sent to the lab for verification. To bring the screens to the highest standard, a positive sample, wherein an impairment is evident and an arrest is made, would be sent for further laboratory verification. The confirmation would be completed to assess the accuracy, validity, and specificity of the roadside screening device. During the pilot period, oral testing results would not be permitted as evidence for prosecutorial purposes.

This pilot program will help us develop permanent strategies to combat drugged driving. Our residents are trusting us to keep Maryland roads safe, and SB309 will help us protect our constituents.

I urge a favorable report on SB309.

THE BALTIMORE SUN

Most Americans don't think it's a problem to drive high.
Here's why it is.

baltimoresun.com/health/marijuana/bs-md-legalizing-marijuana-20190627-story.html



Maryland has seen a steady climb since 2012 in the number of drivers under the influence of cannabis and the number of crashes it caused, according to state data. (Joel Saget / AFP/Getty Images)

In the past month nearly 15 million people drove a car within an hour of using marijuana, according to a survey released Wednesday by AAA Foundation for Traffic Safety.

The effects from marijuana can be experienced anywhere from one to four hours after usage. Those under the influence of the drug are twice as likely to be in car crash, according to AAA.

Yet, 70% of Americans believe they're unlikely to get caught by law enforcement while driving high, the survey found.

Tom Woodward, coordinator of Maryland's drug recognition expert program, said it's just as dangerous to drive under the influence of marijuana as alcohol or other drugs, such as opioids, even though the impairments are not the same.

“We do know that marijuana certainly does cause impairment,” said Woodward, whose job it is to train law enforcement officers to recognize such impairment in drivers. “But because it’s different than alcohol, people don’t view it as being bad.”

The AAA survey found 7% of Americans said they approved of driving under the influence of marijuana more than other drugs such as alcohol or prescription drugs. More than any other age group, millennials are most likely to drive under the influence of marijuana at 14 percent, followed by Generation Z at 10 percent. Men are more likely than women to drive after using the drug.

But the idea that most Americans find it acceptable to drive while high on marijuana did not surprise Woodward. He related it back to educating people about the dangers of driving drunk, which began nearly 40 years ago. He hopes it won’t take as long this time.

“People used to think they couldn’t get caught for driving under the influence of alcohol either until public information campaigns,” Woodward said. “But that perception has changed. And I think it can change with marijuana, too.”

Maryland has seen a steady climb since 2012 in the number of drivers found under the influence of cannabis, another name for marijuana, and the number of related crashes, according to state data. From 2017 to 2018, marijuana-related crashes nearly doubled from 34 to 60. That means cannabis accounted for 32% of all drug-related crashes last year.

Woodward said he is working with the Maryland Highway Safety Office to create campaigns around marijuana and the dangers of driving after using the drug. Additionally, he said his office and law enforcement statewide have increased training for officers to detect those behind the wheel who are under the influence.

Officers use clues such as the inability to cross eyes, swaying or having a driver touch their finger to their nose to try to determine whether they are under the influence of marijuana. It's different from tests that might be used when alcohol is involved because someone's balance won't change as much with marijuana, Woodward said.

A survey from AAA Mid-Atlantic earlier this year revealed that nearly half of Marylanders, 48 percent, support legalizing recreational marijuana usage. The state decriminalized marijuana possession of up to 10 grams in 2014. Medical marijuana usage was legalized more than four years ago in Maryland but became accessible to residents only last year.

Mike Gimbel, former Baltimore County drug czar, said the survey results and prospect of the drug becoming legalized for recreational use is alarming. "I think we are really going down the wrong road here because we're trying to pretend like it's 1969 and it's just not," he said. "This is not your daddy's marijuana."

Gimbel said the drug has become increasingly stronger over the past several years with a predominantly higher THC content than before. The former drug addict now does advocacy work across the state and said he has visited more schools this year than ever before. He said he feels like parents are sending a message to their children that it's better to smoke marijuana than to drink.

"I have kids who told me they have hallucinated on wax, a type of marijuana before," Gimbel said. "And we're just blowing it off like it's no big deal. It scares me, it should scare everyone and it should especially scare parents."

-- End --

MADD_FAV_SB309

Uploaded by: Spicknall, Lisa

Position: FAV



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Lisa Spicknall
State Program Director
Mothers Against Drunk Driving, Maryland
Written Support of Senate Bill 309
21 February 2020

Thank you for the opportunity to register support for SB 309, which would create a 2 year pilot program allowing counties to opt in, using new technology to detect drugged drivers.

Drugged driving is an emerging issue and one where we are still gathering facts. We do know that alcohol remains the number one drug on the roadways causing death. It is important to make sure that law enforcement and our criminal justice system have the necessary resources to address the issue of drug impaired driving.

Also, as this bill includes the ability of the driver to opt out of testing and the fact that the results could not be used as evidence or probably cause we feel this pilot program will truly bring to light the dangers of drugged driving on our roadways. Not only will it show the dangers, but also give law enforcement the opportunities to use some of the new technology now available.

That is why MADD supports the intent of SB 309. As you know, MADD wholeheartedly supports members of law enforcement and we want to make sure that they have every tool available to stop drunk and or drugged drivers. Drugged driving is an emerging issue. We still are learning about drugs, impairment, and what all of this means to a driver.

MADD also supports initiatives like the Drug Recognition Expert (DRE) program and the Advanced Roadside Impaired Driving Enforcement (ARIDE) program which equips law enforcement officers with training necessary to detect, stop, and arrest drugged drivers.

We support SB 309 because it could be another way to help stop death and injury by getting impaired drivers off the road.

Thank you.

Brian Swift_FAV_SB 309

Uploaded by: Swift, Brian

Position: FAV

**TESTIMONY OF Brian Swift
IN SUPPORT OF Senate Bill 309**

**Senate Judicial Proceedings Committee
Maryland General Assembly
February 21, 2020**

Thank you to the Maryland Senate Judicial Proceedings Committee for hearing SB 309. This important piece of legislation introduced by Senator Cheryl Kagan has the potential to save lives and position Maryland as a leader in reducing drug-impaired driving, a crime that has personally affected me and shattered my family.

Drug-impaired driving is a deadly public health and safety problem. The tragic consequences associated with the decision to drive impaired is something I know all too well. Unfortunately, my life was forever changed on March 20th, 2013. On that day, my sister and I received a call that no one should ever have to hear. It was a call that dramatically altered the course of my life.

The person on the other end of the phone told us that my parents were involved in a crash. My dad was dead, and my mom was being transported to a hospital to treat her injuries. After three additional agonizing days of watching my mother cling to life, she succumbed to her injuries and died.

We would come to find out that the driver of the logging truck who ran a red light, struck, and killed my parents was operating a commercial motor vehicle with a suspended license, driving recklessly, and driving the truck while under the influence of a controlled substance. He tested positive for THC, the main psychoactive and impairing component of cannabis.

After another battle, just to get a trial, the driver would eventually be convicted and sentenced to a mere five years for his crimes. Under the circumstances, this seemed like an incredibly light punishment. My parents were robbed of their golden years and my family was torn apart. All we have are memories because this selfish act robbed us of holidays, celebrations, and milestones with my mom and dad. Every act of impaired driving has the potential to inflict widespread pain and every single day more lives are lost to a crime that is entirely preventable.

It is hard to put into words the uncertainty, doubt, anger, and other emotions you feel in a time of tragedy. While we have had some time to deal with our reality, many victims and future victims of these selfish acts of violence will never get justice or get their loved one back.

But what we can do is create positive change. Out of tragedy comes the opportunity to change the status quo, to do things differently in order to save lives. We can pass new laws and use tools and technology already available to prevent this problem in the first place. That should be the goal of every person who wants to protect public safety – ensuring that we have the ability to protect innocent people by identifying and removing impaired drivers from the roadways.

Michigan's Oral Fluid Roadside Analysis Pilot Program

Following the death of my parents, I advocated for change in Michigan and the legislators listened. More importantly, they acted. Public Act 242 and 243 of 2016, otherwise known as the *Barbara J. and Thomas J. Swift Law*, initiated an oral fluid drug testing pilot in five Michigan counties in November of 2018. The pilot program is run by the Michigan State Police (MSP) and involves other law enforcement agencies. Under the law, only certified Drug Recognition Experts (DRE), officers who have specialized training in identifying drug impairment, are permitted to participate in the pilot. While oral fluid testing has been piloted numerous times in multiple states, the enactment of this law was groundbreaking because it was the first time that a state legislature mandated and funded a pilot. It is now considered a model that other states should replicate.

Under the pilot program, a DRE may require a person to submit to a preliminary oral fluid analysis to detect the presence of a controlled substance in the person's body if he or she suspects the driver is impaired by drugs. Refusal to submit to a preliminary oral fluid analysis upon a lawful demand of a police officer is a civil infraction.

As part of oversight of the program, the Michigan State Police are responsible for developing regulations and selecting/certifying devices for use. The device that MSP chose for the pilot is the SoToxa Mobile Test System made by Abbott. This handheld device can test for six classes of drugs in oral fluid including THC (cannabis), cocaine, methamphetamine, amphetamine, opiates, and benzodiazepines. SoToxa was chosen for Michigan's pilot program because it is portable (necessary for roadside use), accurate, easy to use, and produces rapid test results. This technology was recently selected by Popular Science for its list of "*Best of What's New 2019 Tech Innovations.*" The device is also used in other roadside oral fluid programs including Alabama, Canada, Spain, etc.

It is important to note that nothing in the pilot program changes the normal protocol in a drugged driving investigation. Even though the SoToxa can indicate the presence or absence of drugs in a driver's oral fluid, it cannot determine whether that driver's ability to operate a motor vehicle is impaired. That is an important distinction. Unlike with alcohol, there is no scientific impairment standard for drugs at this time. Therefore, to establish probable cause, an officer must determine an individual is impaired. Officers in the pilot program still need to establish impairment through a roadside investigation, which includes observations of driving, physical observations, driver's admissions, and performance on the standardized field sobriety tests. The results of the oral fluid screening can help establish probable cause within the context of the broader impaired driving investigation. The oral fluid swab also does not substitute the 12-step drug evaluation that DREs are trained to perform on suspected drugged drivers. Oral fluid screening is a tool that can enhance current practice, not replace it.

Drugged driving investigations also require the collection of a chemical sample for confirmatory or evidential testing at a forensic laboratory. In most states, that sample is blood. If a driver refuses to voluntarily submit to a blood draw, then a warrant must be obtained in order to collect the sample. In Maryland, DRE data reveals that the refusal rate remains high and the delay this causes leads to the loss of evidence because drugs metabolize rapidly within the body. The longer it takes to get the blood, the lower the drug levels are likely to be when it is analyzed. While oral fluid is being used for screening purposes at the roadside, it is also possible to collect a sample to be sent to the laboratory for confirmation testing. This latter process is far more sophisticated than initial screening and provides

quantitative results (i.e., the amount of drug detected in the sample); only confirmatory test results are used for evidentiary purposes in court. In Michigan, the sample collection process is as follows. An initial oral fluid sample is collected to complete the roadside screening. This provides rapid results that indicates whether someone is positive or negative for the drugs the device tests. A second oral fluid swab is collected to be sent to Forensic Fluids Laboratory in Kalamazoo for confirmatory testing. This second swab is voluntary and there is no penalty if a driver refuses to provide the sample (unlike with the initial screening). In addition to the two oral fluid samples, a blood draw is also taken and sent to the MSP Forensic Laboratory for confirmatory testing. MSP then compared the findings of the roadside oral fluid screening with the two laboratory confirmation tests (blood and oral fluid) to see how closely the results aligned.

The oral fluid samples collected pursuant to the pilot program are not admissible in court. Under Michigan law, only breath, blood, and urine samples are admissible as evidence in impaired driving investigations. The oral fluid results are to be used like preliminary breath test results in drunk driving cases. Again, this is because the roadside tests are for screening purposes.

While the pilot initiative was underway, a ballot initiative to legalize recreational cannabis use in Michigan passed in 2018. Cannabis sales commenced in late 2019. States that are considering expanding access to cannabis should take into consideration the potential for increases in impaired driving and proactively provide law enforcement with the resources needed to increase training, high visibility enforcement efforts, and drug testing.

In February of 2019, officials released the results of the five-county pilot to the legislature as required by the law. They were remarkable. Eighty-eight of the 92 results collected at the roadside were later confirmed by an independent laboratory or blood test. The high degree of accuracy demonstrates the great promise this technology holds to identify drug-impaired drivers and get them off the roads. Not surprisingly, cannabis was found to be the most prevalent drug found by the roadside testing program which aligns with national fatality data and roadside surveys.

Due to the success and need to collect more sample data, we pushed for more funding to help Michigan officials expand the pilot. In October, lawmakers appropriated an additional \$626,000 to expand the pilot to almost all of Michigan's 83 counties. More than 50 law enforcement agencies and over 100 DREs from around the state are actively participating in the pilot which is set to conclude this fall. The results of the second pilot will be reported by the end of 2020. Our next step is to work with a coalition of committed stakeholders to make Michigan's law and oral fluid program permanent in all 83 counties and expand the use of this technology to all law enforcement agencies.

Opportunity for Action in Maryland

The state of Maryland has an opportunity to follow an established model for change. For several years, Senator Kagan has advocated for an oral fluid pilot program comparable to the approach that Michigan enacted with Public Act 242/243. It is my hope that every state in the country will recognize the tremendous life-saving potential of roadside oral fluid testing and I am committed to educating and working with policymakers to make this a reality. In Maryland, the fact that these discussions have been occurring for some time demonstrates that there is interest in and support for drug-impaired driving prevention and enforcement.

The success of Michigan's initial five-county pilot and subsequent investment in its expansion should give you confidence and evidence on which to advance this piece of legislation. Through this pilot, you will gain a better understanding of the nature of the drug-impaired driving problem here in Maryland – which can vary from one county to another. Being able to examine this data can inform other decisions about how best to target this problem whether it be through enforcement, public messaging and awareness campaigns, or a combination of countermeasures. The added benefit of instituting this type of initiative is that it communicates to your constituents your commitment to protecting their safety and the safety of their loved ones when they are driving on Maryland roadways. I would venture that there is no other crime that affects the lives of so many people from every walk of life. Anyone can become a victim of impaired driving at any time. My parents and my family were unfortunate enough to fall into that category.

In addition to listening to my experience, I also encourage you to take into consideration the opinions of the experts. Victims are not the only people who support this type of legislation. Respected national traffic safety organizations such as Responsibility.org, MADD, and We Save Lives support SB 309. You also have support from criminal justice practitioners here in Maryland including law enforcement agencies in some of your largest counties and prosecutors. You have testimony from experts in the field including Lt. John Flannigan who was involved in an oral fluid pilot in Vermont, and forensic toxicologists in Alabama and Michigan who are actively involved in oral fluid programs. All of these stakeholders are focused on a singular goal – eliminating impaired driving. I trust that you will take their support into consideration and recognize that they make these decisions based on science, data, and proven effectiveness. The international community has already embraced this approach and it is time for the United States to catch up.

I would like to thank Senator Kagan and her co-sponsors for being leaders on this important safety issue as well as the members of this committee as I understand that many of you have advanced impaired driving legislation, as well. Every Maryland legislator can save lives by supporting this pilot and putting it into practice. We have done it in Michigan, and we will support you in your efforts to implement it just like we did.

This is NOT a debate about which drugs are more or less harmful. It's not about alcohol vs. cannabis vs. opioids, etc. This is about protecting public safety. This issue is about as non-partisan as it can get. SB 309 is about stopping people who get behind the wheel of a vehicle while impaired and choose to put other people's lives at risk. We have had tremendous success reducing alcohol-impaired driving by instituting enforcement and testing. It is time to replicate this proven approach for drugs. The good news is that we finally have the technology available to be able to do this consistently. This pilot is an important and necessary first steps towards actualizing change and reducing drug-impaired driving.

I'm confident this pilot program will open the eyes of the public as to how many people on our roads are driving under the influence of drugs and the danger they pose. When you consider the number of people who drink, take drugs, and are texting while driving, it's a scary proposition. If you don't think tragedy can't happen to you, my experience proves otherwise. Vote to implement SB 309 and make Maryland a national leader. More importantly, vote yes to protect the lives of your constituents and your own family. Thank you.