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EXAMINING DRUG-IMPAIRED DRIVING

WEDNESDAY, JULY 11, 2018

House of Representatives,

Subcommittee on Digital Commerce and Consumer Protection,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 1:02 p.m., in Room 2123, Rayburn House Office Building, Hon. Robert Latta [chairman of the subcommittee] presiding.

Present: Representatives Latta, Kinzinger, Lance, Guthrie, Bilirakis, Bucshon, Mullin, Walters, Costello, Walden (ex officio), Schakowsky, Dingell, Welch, Kennedy, and Pallone (ex officio).

Staff Present: Melissa Froelich, Chief Counsel, Digital Commerce and Consumer Protection; Ali Fulling, Legislative Clerk, Oversight and Investigations/Digital Commerce and Consumer Protection; Elena Hernandez, Press Secretary; Paul Jackson, Professional Staff, Digital Commerce and Consumer Protection; Bijan Koohmaraie, Counsel, Digital Commerce and Consumer Protection; Drew McDowell, Executive

Assistant; Greg Zerzan, Counsel, Digital Commerce and Consumer Protection; Michelle Ash, Minority Chief Counsel, Digital Commerce and Consumer Protection; Jeff Carroll, Minority Staff Director; Evan Gilbert, Minority Press Assistant; Lisa Goldman, Minority Counsel; and Caroline Paris-Behr, Minority Policy Analyst.

Mr. Latta. Well, good afternoon. And I would like to call the Digital Commerce and Consumer Protection Subcommittee to order.

And before we get started, just to let our panelists know, we have had two other subcommittees running today. And so we were downstairs, but Health is still running, and we had another subcommittee in here on telecom a little bit ago. So we kind of have members here, there, and everywhere today. But I just want to let you know what is going on with the full committee and the subcommittee.

But I appreciate you all being here today. And, as I said, we will now come to order, and I will recognize myself for 5 minutes. And, again, good afternoon, and thank you for all appearing before us today.

"Drive sober or get pulled over." It is a phrase that we have heard in classrooms and television and radio ads and seen billboards along the highway. Everyone knows that driving while under the influence of alcohol is dangerous and unacceptable, and there are methods to identify and apprehend those who break the law.

Unfortunately, the consequence of driving under the influence of drugs has not been elevated until recently, and drugged driving presents new challenges to both law enforcement and health professionals. Amid the devastating opioid crisis and as more States legalize the use of marijuana, tackling this problem is now more important than ever.

According to the Governors Highway Safety Association, in 2016, the number of drivers who were fatally injured in accidents with drugs in their system surpassed the number of those with alcohol in their system for the first time.

As marijuana use increases in the general population, it continues to be the most common drug found in fatally injured drivers. Marijuana has been proven to increase drowsiness and decrease reaction speed, both of which limit a person's ability to drive safely.

Twenty percent of drivers killed in crashes in 2016 tested positive for opioids. Part of this can be tied to addiction and negligence, but legally prescribed opioids also play a role. When a patient is prescribed an opioid for pain relief, they may not understand the possible side effects. It is important that physicians and pharmacists draw attention to the warning labels and give consumers the information they need to take their medication safely.

Driving while impaired is illegal in all 50 States, but there is no definition of drug impairment, and testing practices vary from State to State. Unlike with alcohol, there is no widely used drug field test comparable to a breathalyzer. Instead, most officers learn how to recognize signs of drug impairment, including drivers' verbal and physical responses to questions and instructions. Teaching these methods has been a challenge, and the lack of data on drugged driving only exacerbates this challenge.

New methods for roadside drug testing are being developed and deployed in several States, including saliva tests. At their summit in March, NHTSA committed to examining the operation of these tests and improving the data the government has about drugged-driving-related fatalities. Understanding the problem is an important first step to fixing it.

Today, we are here to discuss what local, State, and Federal efforts are being made to combat this issue and what else needs to be done. Public education is an

essential component of fighting drugged driving. We believe that, with improvements in awareness, the dangers of drugged driving will be as well understood as drunk driving. Additionally, we believe our witnesses can detail what Congress can consider to help stop this dangerous trend.

Almost 1 year ago, this committee unanimously passed the SELF DRIVE Act. Getting safe self-driving cars on the road would prevent the senseless deaths of thousands of Americans on roadways every year. Until that day comes, we need to all do all we can to raise awareness of the dangers of impaired driving.

More recently, this committee developed a package of over 50 bills, including my legislation, the INFO Act, to address the opioid crisis. These bills were included in the bipartisan House-passed opioids package.

My bill creates a public dashboard consisting of comprehensive information and data on nationwide efforts to combat the opioid crisis. Establishing a one-stop shop makes it easier for individuals to access and analyze data that could lead to real solutions that save lives.

We are committed to the communities and families confronting this challenge on a daily basis and will continue investigating key areas that contribute to the crisis. I want to thank you all again for being with us today.

And, at this time, I yield back the balance of my time, and I would like to recognize the gentlelady from Illinois, the ranking member of the subcommittee, for 5 minutes.

[The prepared statement of Mr. Latta follows:]

******** COMMITTEE INSERT ********

Ms. Schakowsky. Thank you, Mr. Chairman.

I am happy that we are holding this hearing today on drugged driving. Today's hearing really comes down to one question: What is NHTSA doing in order to combat all impaired driving?

"Impaired driving" is a term used to describe driving while affected by alcohol or legal or illegal drugs. Impaired driving risks the lives not only of the impaired driver but everyone else as well. Everyone else is on the road. And those substances have no place in our society. It is illegal in every State.

The Foundation for Advancing Alcohol Responsibility funded a report in 2015 that found that drugs were found in the system of 43 percent of fatally injured drivers among those who were tested. While this statistic of course raises concern, I have questions and concerns about the methodology and accuracy of the statement and share many of the safety advocates' concerns that this could divert attention and resources from efforts to curb drunk driving.

Alcohol continues to cause more deaths than drugs. In 2016, according to a report from January of this year issued by the National Academies, more than 10,000 people were killed in crashes involving a drunk driver.

This issue is a complicated one because there are hundreds of drugs, whether they be prescription, over-the-counter, or illegal, that can and do impair driving. Complicating matters further, drugs of all kinds affect individuals differently. And data on drug presence, like put forth by the Foundation for Advancing Alcohol Responsibility, is often misleading.

Further complicating matters, there is no national accepted method for testing

the drug impairment of a driver. Positive drug tests do not necessarily yield accurate results, as trace amounts of many drugs can linger in a person's system for weeks, meaning that the driver may not necessarily be impaired, even when testing positive for some drugs.

The National Highway Transportation Safety Administration, NHTSA, conducted a study in 2016 that found, quote, "alcohol was the largest contributor to crash risks," and that, quote, "there was no indication that any drug significantly contributed to crash risks," unquote. And yet, in 2018, NHTSA launched a National Drug-Impaired Driving Initiative, and, in March, NHTSA held a Drug-Impaired Driving Summit to engage on this issue.

In Carol Stream, Illinois, local law enforcement is experimenting with a new swab test in order to test for a number of drugs, including marijuana, cocaine, amphetamines, methamphetamines, and opioids like heroin. The potential for such a test is undoubtedly promising, but I would urge caution, as such a test is unlikely to be admissible in court for some time. And, again, this may take precious resources away from preventing drunk driving.

On the Federal level, I hope that NHTSA is working with State and local enforcement and transportation agencies to ensure that they are widely deploying resources to protect public safety. If NHTSA is going to prioritize drugged-driving enforcement and prevention and turns attention away from other risks, it is critical to ensure that we have accurate data to suggest that shifting their focus away is justified and, importantly, must ensure that they have accurate testing to ensure enforcement action is effective and accurate.

I also hope that NHTSA continues to fulfill its mission of reducing death, injuries, and economic losses from motor vehicle crashes; that it works with other agencies to ensure that substance abuse treatment is also available for those who suffer from addiction. We, as a society and as Federal Representatives, must take a whole approach to curbing drunk and drugged driving, and that must include treating the underlying causes.

I am trying to look at time. What do I have left? Twenty-two seconds. Let me see.

I don't want to leave the impression that I don't think drugged driving is a problem. I do. And I think we need to do everything we can to make sure that we have the proper data to justify its importance. We do know about drunk driving, and we want to make sure that that effort to stop it continues.

And I yield back.

[The prepared statement of Ms. Schakowsky follows:]

******** COMMITTEE INSERT ********

Mr. Latta. Thank you.

The gentlelady yield back, and the chair now recognizes the gentleman from Oregon, the chairman of the full committee, for 5 minutes.

The Chairman. Thank you, Mr. Chairman.

Good afternoon, and I want to thank our witnesses for participating in today's hearing. We value your testimony.

Sadly, we have all known too many lives cut short because of the reckless decision of some to get behind the wheel when impaired. About 1 in 4 traffic fatalities each year -- that is roughly 10,000 lives lost -- involves an alcohol-impaired driver.

Now, part of the problem for those trying to detect and prevent drug-impaired driving is the lack of statistics available. Even with all the advances in vehicle safety and crash avoidance systems in recent years, they are not enough to stop the fatal consequences of driving while impaired, whether by alcohol, marijuana, opioids, or a deadly combination. It is a real issue in Oregon, both for employers and others, is trying to find something that detects appropriately marijuana consumption in those who are at work or on the road.

According to one recent study by the Governors Highway Safety Association, in 2016, about 20 percent of fatally injured drivers who had drugs in their system tested positive for opioids, 20 percent, compared to 17 percent in 2006. So we are seeing an upward trend here in the presence of opioids and fatally injured drivers on the rise over the last 10 years.

The Energy and Commerce Committee is all too familiar with the lethal effects of the opioid crisis, and drug-impaired driving is yet another fact of combating this

national scourge.

More than 50 bills from this committee were included in H.R. 6 -- that is the SUPPORT for Patients and Communities Act -- to address various aspects of this crisis, including prevention, treatment, and support for both those battling addiction as well as their families.

This is a crisis we have been working to combat over multiple Congresses in a bipartisan way, and we will continue in our efforts to legislate and evaluate and legislate as we go forward.

Drug-impaired driving creates unique challenges for law enforcement. Whereas nearly every law enforcement agency in America has the resources to test for driving under the influence of alcohol, similar resources are often lacking when it comes to illegal narcotics. The lack of scientifically confirmable evidence of drug-impaired driving can make it difficult for law enforcement officers and prosecutors to keep impaired drivers off our roads.

However, statistics provided by the National Highway Traffic Safety Administration make it clear this danger is on the rise.

So I look forward to the testimony you are going to give to the committee and your answers to our questions. You are on the front lines in this battle, and I know you have the expertise to help us understand how better to deal with it.

I also want to mention that this month marks the 1-year anniversary of when this committee unanimously passed the SELF DRIVE Act. I know Ms. Schakowsky played a huge role in that, and Mr. Pallone and others on the committee. It is a national Federal framework to ensure safe and innovative testing, development, and

deployment of self-driving cars. Getting safe self-driving cars on the road would go a long way to preventing a lot of highway fatalities, the more than 100 Americans who die every day behind the wheel.

But we are waiting for the Senate. So, you know, we need them to act. Then we can get a bill down to the President's desk and America can lead in the effort on creating self-driving vehicles and safer highways.

So, Mr. Chairman, thanks for your great leadership on that effort, as well, and Ms. Dingell and others who have put so much time and energy into our SELF DRIVE Act. We need to pull out all the stops to find agreement, get the Senate to move, get agreement, get that down to the President.

So, with that, Mr. Chairman, I yield back.

[The prepared statement of The Chairman follows:]

******** COMMITTEE INSERT ********

Mr. Latta. Well, thank you very much.

The gentleman yields back the balance of his time. The chair now recognizes the gentleman from New Jersey, the ranking member of the full committee, for an opening statement for 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman.

Today's hearing explores the complex topic of drugged driving. We know that driving under the influence of some drugs presents dangers to everyone on the road, and these drugs can impair judgment, slow reaction time, or distort perception. At the same time, there are many unknowns about the correlation of drugs and car crashes, and I expect we will address some of them today.

Hundreds of different drugs, including prescription, over-the-counter, and illicit drugs, can affect a person's driving. Unfortunately, the relationship between a specific drug's effect on driving ability is still not well understood. Different substances affect different people in different ways. Drugs are frequently used together. Often, illicit drugs are used in the presence of alcohol. And the combined effects of multiple drugs on driving performance requires more consideration.

The scope of the drugged-driving problem is also unclear. Today, there is no nationally accepted method for testing whether a driver is impaired by drugs. Because trace amounts of certain drugs can linger in a person's system for weeks, a positive drug test result does not necessarily mean that the driver was impaired while driving. Moreover, the reporting of data of accidents involving drivers with drugs in their systems is inconsistent across jurisdictions, and nationwide data are incomplete.

So we should take the issue of drugged driving seriously so that we can

adequately address the problem, but because we must appropriately allocate resources, our review should be of impaired driving more broadly. We should not neglect the causes of impaired driving, especially alcohol-impaired driving, which remains the leading cause of traffic fatalities.

The statistics for drunk driving are alarming. Every 2 minutes a person is injured, every 51 minutes a person is killed in a drunk driving crash. The Centers for Disease Control and Prevention reported that, in 2016, more than 10,000 people were killed in alcohol-impaired crashes. And drunk driving accounts for about 28 percent of all traffic-related deaths.

And, as reported just last week, one-third of pedestrians killed in car crashes in 2016 were found to be over the legal alcohol limit. Of course, we should not blame the victims who try to do the right thing and not get behind the wheel when they have been drinking, but perhaps policies that encourage us to stay away from our cars also should consider that more people will be walking.

While the number of deaths linked to drugged driving is less clear than other causes of impaired driving, no one should drive impaired. If you are unable to function normally or safely when operating a motor vehicle, you should not get behind the wheel. Even common over-the-counter medicines can have adverse effects on driving performance.

And recent studies show that drowsy driving can be just as dangerous as drunk driving. In fact, my home State of New Jersey has a law that prohibits driving while drowsy. Under the law, a driver who goes without sleep for more than 24 consecutive hours and causes a fatal crash can be charged with vehicular homicide and face up to 10

years in prison and a $100,000 fine.

So impaired driving takes on many forms, but the wreckage left behind is the same. It has devastating consequences to family, friends, neighborhoods, and communities across the country. And I hope we continue to work together to fight impaired driving.

I don't know if anyone wants any of my time, but, if not, I will yield back, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

******** COMMITTEE INSERT ********

Mr. Latta. Well, thank you very much.

The gentleman does yield back the balance of his time, and that will conclude opening statements from our members.

And, also, the chair reminds members that all of their statements will be included in the record.

Again, we want to thank our panel for being with us today to testify before the subcommittee.

Today's witnesses will have the opportunity to give a 5-minute opening statement, followed by a round of questions from the members.

Our witness panel for today's hearing will include Dr. Robert L. DuPont, the president of the Institute for Behavior and Health; Ms. Jennifer Harmon, the assistant director of forensic chemistry at Orange County Crime Lab; Ms. Colleen Sheehey-Church, the national president of Mothers Against Drunk Driving; and Ms. Erin Holmes, the director of the traffic safety programs and technical writer at responsibility.org.

And, again, we appreciate your being here to give us your testimony.

And, Mr. DuPont, you will be recognized first, and you are recognized for 5 minutes for your opening statement. Thank you very much.

STATEMENTS OF ROBERT L. DUPONT, M.D., PRESIDENT, INSTITUTE FOR BEHAVIOR AND HEALTH; JENNIFER HARMON, ASSISTANT DIRECTOR, FORENSIC CHEMISTRY, ORANGE COUNTY CRIME LAB; COLLEEN SHEEHEY-CHURCH, NATIONAL PRESIDENT, MOTHERS AGAINST DRUNK DRIVING; AND ERIN HOLMES, DIRECTOR, TRAFFIC SAFETY PROGRAMS, TECHNICAL WRITER, FOUNDATION FOR ADVANCING ALCOHOL RESPONSIBILITY

STATEMENT OF ROBERT L. DUPONT, M.D.

Dr. DuPont. Thank you very much, Mr. Chairman.

Mr. Latta. Oh, and pardon me. Just press the button on your mike there, and pull the mike up there, and the little red light should go on for you. You only have to press that once. Yep. I think it was just on.

Dr. DuPont. It is on now.

Mr. Latta. There you go. Thank you.

Dr. DuPont. Okay, here we go with the 5 minutes.

Mr. Latta. Okay.

Dr. DuPont. I am president of the Institute for Behavior and Health, a nonprofit organization committed to understanding the modern drug epidemic and to develop policies to reverse that, to turn it back.

I am a graduate of the Harvard Medical School, a physician. I did my training at Harvard and also at NIH. And I have been working on the problem of drugged driving

for four decades, including as the Director of the National Institute on Drug Abuse, the first Director. And I also served as the White House Drug Czar for two Presidents, Nixon and Ford, and have been active in that field all of my professional life.

Two trends I want to bring to everybody's attention in all the numbers we talk about. One is the fact that the highway deaths have gone up for the first time in a long time, and they have gone up by a significant number. That is very important to notice. The second trend is the increasing presence of drugs in drivers tested, whether in fatal crashes or in the National Roadside Survey.

I want to focus on four ideas that I hope will be useful.

The first is thinking about alcohol as a model for understanding impaired driving. This is very useful in many ways, but there is one area where it has catastrophic effects, and that is the search for a point equivalent to a .08 BAC. That will never happen with marijuana and other drugs. It cannot happen, because there is no fixed relationship between the blood level and impairment for other drugs. Alcohol is the exception, not marijuana, in this. And we are going to have exactly that problem with every single drug, and it cannot be fixed by additional research. That is number one.

Number two, the drug problem and alcohol problem are not just a drug like marijuana or alcohol, because what is dominant now is polydrug use. Many of the people who are arrested for alcohol have drugs present in them. Many of the people with drugs have alcohol. And so we are talking about a polydrug. To look at this drugged-driving problem as this drug and that drug misses what is happening to the drug epidemic in the United States. It is a polydrug epidemic.

The third point is that they are talking about metabolites that are present and

misleading. Let me assure you that there are no metabolites present when the parent drug is not in the brain. If the metabolite of marijuana is in the urine, at that time THC is in the brain. The metabolites are quickly eliminated. It is the THC that stays, not the metabolite.

The fourth point is a thought experiment. We have for decades -- and I was part of this -- had safety-sensitive jobs be drug-tested, with a zero-tolerance standard. The prototype is commercial airline pilots. We have a zero tolerance for that because of safety.

Now, I want you to think about the question of whether it makes sense to do that. Is that a good idea or a bad idea? And the reality is the pilots are professional at their job; the people driving in the cars are amateurs. Last year, we had zero deaths from commercial airlines and we had 40,000 deaths from the highway.

Why in the world do we have a lower standard for drivers of cars than we have for pilots? And if you don't think it is needed, why don't you stop doing it for pilots? I think if you think about that a little bit, some thoughts will come clear about what is needed here.

Now, I have, quickly running along, several points to get at.

First of all, we need local and national data. The problem is deficient in having data. That is really important.

We need to test every driver arrested for impairment. And I emphasize the testing comes after the arrest for impairment, not before. In the discussion, it acts as if we are just testing all drivers. No, we are testing drivers who have been judged to be impaired for the drugs. That is really important to understand.

Third, we want to test every driver under 21, a zero tolerance for marijuana and other drug use. It is zero tolerance for alcohol under 21. You don't have to be .08 if you are under 21; any alcohol is a violation. It should be the same for marijuana. That would be a big step forward.

We need to use administrative license revocation, which has been very helpful for the alcohol area, for the drug area as well.

We need to test all drivers involved in fatalities and serious injury crashes for drugs and alcohol, not just for alcohol. And when you get one positive for alcohol, you don't stop testing, because you want to know about the drugs too. That is really important conceptually.

And because it is a polydrug problem, we need to have penalties, additional penalties, for people who have multiple drugs. It is a different situation, and it requires a different response.

NHTSA needs to organize the FARS data and publish those results annually as it now does with alcohol. It doesn't do it for drugs. It needs to do that. And NHTSA needs to establish guidelines for what drugs to test for and what the cutoff levels are.

Finally, we need sentinel sites around the country that report on a real-time basis. I favor the shock trauma units, which are easy to get access to. And half a dozen of those around the country could give you real-time data, highly sophisticated results about traffic injuries, serious injuries, and monitor the problem on a real-time basis and not wait 5 years for the answer.

I think that the opportunity is immense right now, and this committee has a tremendously important positive role for it. I am very optimistic that we will move

forward with it. But the idea that we are going to find the magic bullet that is going to solve this problem is completely wrong. And that idea that "look for the .08 equivalent for marijuana and other drugs and we will act when we get that" is completely contrary to the public interest and public safety. We need to move now. We have lots of good ideas. They need to be implemented.

And the idea that they are going to stop our interest in alcohol is completely wrong. These things go together. They are not two sides of a teeter-totter. Enhancing one enhances the other. And you see that in the behavior of what is going on. So to pose this as just -- that is completely wrong.

Thank you very much.

[The prepared statement of Dr. DuPont follows:]

******** INSERT 1-1 ********

Mr. Latta. Thank you very much.

And, Ms. Harmon, you are recognized for 5 minutes for your opening statement. Thank you.

STATEMENT OF JENNIFER HARMON

Ms. Harmon. Thank you. And thank you again for having us here.

Drug-impaired driving is not a new problem on our roadways. However, it is an ever-increasing one. That is certainly the case in Orange County. We are the sixth most populous county in the United States.

My name is Jennifer Harmon. I am an assistant director with the Orange County Crime Lab. We are located in Santa Ana, California. Our laboratory offers comprehensive forensic testing to the county and all law enforcement entities contained within, which is over 30 municipal, State, and Federal agencies, including the district attorney's office and the Orange County Sheriff-Coroner Division.

For over 8 years, our laboratory has worked collaboratively with law enforcement, prosecutorial, and public health partners, as well as traffic safety advocates, to better toxicological testing, research, and training on drug-impaired driving in our county and the State of California.

We utilize state-of-the-art technology, comprehensively testing apprehended DUI suspect blood samples. These are post-arrest samples. For nearly a year, we have been testing every driver, regardless of their blood alcohol level. This is a practice that has been advocated for for more than 10 years by the National Safety

Council but is still not routine practice in public crime labs.

Every sample is initially analyzed for alcohol, inhalants, and seven classifications of drugs, a total of about 50 drugs currently. And we report 72 different compound blood concentrations when we test for those compounds.

Beginning in August of this year, every traffic-safety-related case, living or deceased, will be tested for over 300 drugs, to include illicit substances, prescriptions, over-the-counter medications, and new synthetic and designer drugs.

Our chemical testing methods in Orange County are a mechanism to assist in populating the scientific research and a means to collaborate with public health partners on drug-impaired-driving solutions and impacts.

As a laboratory, we test drug stability, impacts on collection methods, new technology options, including roadside saliva testing, and the correlation of drug levels on observed field impairments. Our testing schemes allow us to collect comprehensive countywide data on DUI suspects and fatally injured drivers.

Our current countywide data suggests that 45 percent of our apprehended DUI drivers test positive for at least one drug other than alcohol. Twenty-nine percent of our drivers who have blood alcohol levels greater than the per se level of a .08 are positive for at least one other drug.

Fifty-six percent of our fatally injured drivers test positive for at least one drug, nearly half of those alcohol and/or THC, the psychoactive drug found in marijuana. What is additionally alarming is that our non-alcohol-involved traffic-related cases that are drug-positive, 40 percent of them test for three or more drugs.

The success of the Orange County model over the last several years has been

due to our collaborative efforts with stakeholders. We cross-train our dedicated toxicologists with traffic safety law enforcement, prosecutors, and public and private defense. Our experts attend law enforcement training and provide reciprocal training as well.

Our team routinely interacts with law enforcement certified drug recognition experts, also known as DREs, ensuring that their expertise on drug impairments, metabolism, trends, and poly-pharmacy are a marrying of field observation and scientific theory. It ensures that our law enforcement partners are able to maintain their certifications; validate their in-field, at-roadside impairment observations; and stay current on emerging drug trends.

Law enforcement and toxicology expertise is critical to successful prosecutions of the drug-impaired in Orange County, as we have a 95-plus-percent conviction rate on DUID cases that are tried. The county also houses the statewide Traffic Safety Resource Prosecutor Program, which allows for information sharing in the criminal justice system at a statewide level.

Crime labs, in general, are severely underfunded, especially in the area of forensic toxicology. Our laboratory alone in the last 8 years has seen a 60-percent increase in the number of exams conducted on our toxicology samples and an over 100-percent increase in the number of DUID cases processed, with a 25-percent reduction in staffing.

However, our county has made a conscious effort to utilize resources as efficiently as possible and ensure high-quality testing on every case, regardless of the charge or the presence of the most commonly encountered substances, like alcohol.

To understand the scope of the drug-impaired-driving problem, comprehensive testing must be obligated by all laboratories conducting toxicology and traffic safety-related cases. Orange County's overall goal has been to share information, collaboratively train all stakeholders in the traffic safety system, and to collect data for overall better outcomes and educated traffic safety policy.

Knowing the prevalence of the problem will result in better preventative health measures, safer roadways, and improved treatment for the drug-impaired. It also aids in improving forensic drug testing for all types of crimes beyond traffic safety, including drug-facilitated sexual assault, death investigation, and overdose.

For those of us who work in America's crime labs, no day passes without seeing clear evidence that confirms the fact that our Nation is in the grips of a drug epidemic. As discussed in my testimony, drugs impact the safety of motorists, but, of course, the impact goes far beyond our roadways.

My colleagues and I appreciate the work Congress has done and continues to do in addressing this problem. Those of us at the local level remain committed to joining you in this worthwhile effort.

I appreciate the opportunity to share.

[The prepared statement of Ms. Harmon follows:]

******** INSERT 1-2 ********

Mr. Latta. Well, thank you very much for your testimony.

And, Ms. Sheehey-Church, you are recognized for 5 minutes.

STATEMENT OF COLLEEN SHEEHEY-CHURCH

Ms. Sheehey-Church. Thank you so much.

Chairman Latta, Ranking Member Schakowsky, and the members of the subcommittee, I want to thank you for the opportunity to testify today before your subcommittee on the issue of drug-impaired driving.

My name is Colleen Sheehey-Church, and I serve as the national president of Mothers Against Drunk Driving, or MADD. Drugged driving is a serious issue and one that is gaining attention across our country. I look forward to sharing with the committee MADD's thoughts on how best to address this problem.

I am uniquely qualified to testify today. My son, Dustin Church, was killed by a drunk and drugged driver on July 10, 2004. At only 18 years old, Dustin had graduated from high school and had his whole life ahead of him. That night in July, Dustin had not been drinking. He was doing what most kids like to do and he was hanging out with friends when they decided to go grab a pizza.

My husband, Skip, and I had told both of our sons about not drinking until age 21 and never drinking and driving. We also talked to them about the dangers of riding in a car with a drunk driver. I will never know why Dustin got into that car that night, but I am sure, because tests showed, that he was sober and had buckled his seatbelt.

Unfortunately, the driver had been drinking and had illicit drugs in her system.

That pizza run turned tragic when the driver lost control of her car, careened off the road, went over a cliff and into a river. The driver and passenger escaped, but not Dustin.

Early in the morning, Skip and I got that knock on the door that no parent should ever receive. The pain of losing someone so senselessly to a preventable crime never goes away. That is why we must work harder than ever to eliminate drunk and drugged driving.

In 2015, MADD updated our mission statement to include "help fight drugged driving." We want victims of drugged driving to know that we are here to serve their needs. We also know that the legalization of recreational and medicinal marijuana, the national opioid crisis, and the prevalence of prescription drugs in our society can only lead to more drug-impaired driving on our roadways.

What we don't know, however, is the role of drugs as causal factors in traffic crashes. This is why more research is needed. MADD is committed to a research- and data-driven agenda.

I would like to call your attention to a report released earlier this year from the National Academy of Sciences which states that alcohol-impaired driving remains the deadliest and costliest danger on the U.S. roads today. Every day in the United States, 29 people die in an alcohol-impaired-driving crash -- 1 death every 49 minutes -- making it a persistent public health and safety problem.

The Insurance Institute for Highway Safety, also known as IIHS, reports that, out of all drugs, alcohol is the biggest threat on the roads. IIHS states that the battle against alcohol-impaired driving is not won and that States and localities should keep

channeling resources into proven countermeasures to deter impaired driving, such as sobriety checkpoints.

The NAS and IIHS reports are important because recent headlines would lead you to believe that drug-impaired driving has overtaken drunk driving in terms of highway deaths. That is simply not true. The truth is that we do not know how many people are killed each year due to drug-impaired driving.

There are two major obstacles to determining the scope of the problem. First, we lack impairment standards for drugs. According to the 2013-2014 National Roadside Survey, marijuana is the second most commonly found impairing drug after alcohol. Yet marijuana has no impairment equivalent to a .08 for alcohol. For prescription drugs, there are also no impairment levels for drugs legally prescribed by one doctor.

With alcohol impairment, we know what works. MADD's Campaign to Eliminate Drunk Driving in 2006 has created a national blueprint to eliminate drunk driving in our country. The campaign is based on proven strategy and supports law enforcement, all-offender ignition lock laws, advanced vehicle technology, and asks the public to help us support these initiatives. Congress has fully endorsed the campaign by funding its initiatives as part of both MAP-21 and the FAST Act.

Mr. Chairman, MADD believes that the best way to move forward on drug-impaired driving is to do more work on drunk driving. MADD has long supported our heroes in law enforcement because we know that they are the men and women who actually get drunk and drugged drivers off the roads. Law enforcement is under enormous pressure, and nationwide arrests are down. This is a trend and must be

reversed. And this is an area we encourage this committee to further explore. We must encourage law enforcement agencies all across the country to make traffic enforcement a priority. Sobriety checkpoints and saturation patrols catch and deter drunk and drugged driving.

We also support proper training for law enforcement which helps them detect drugged drivers. Every law enforcement officer should receive the Standard Field Sobriety Testing Training. We also believe Advanced Roadside Impaired Driving Enforcement, ARIDE, training and the DRE, drug recognition expert, are important for law enforcement to be able to make drugged-driving arrests.

In the mid- to long term, we need to focus on further research and data to understand the scope of the drugged-driving problem. One important piece of research that we urge Congress to reinstate and fully fund is the National Roadside Survey. This study is conducted roughly every 10 years, and the last Roadside Survey was last conducted 2013-20 14. It is a critical tool that gives policymakers like yourselves important information about drivers who are using alcohol and then driving on the roadways.

With the prevalence of marijuana legalization, both recreational and medicinal, it is critical that more work be done to understand impairment. We agree with the recent AAA study which states a .08 equivalent may not be possible with marijuana, but we still must better understand how marijuana impairment influences driving behaviors.

In closing, I encourage the Congress to look at near-term solutions to stop recent increases in traffic fatalities. The National Academy of Sciences report made

clear that alcohol is the leading killer on the roadways. Therefore, drunk driving should be a major focus in crash prevention. The good news is that doing more to prevent drunk driving will result in fewer drugged-driving deaths too.

Law enforcement is the best defense against drugged and drunk drivers. We urge the committee to work with law enforcement leaders to make sure that traffic enforcement is a priority.

And, finally, it is critical that we have the research and data to better understand this problem, to include impairment.

Mr. Chairman, I am here because of my son, Dustin. He was killed by a drunk and drugged driver. It is my hope that the recommendations I am making on behalf of MADD will help to make progress on drunk driving and drugged driving and prevent others from the same tragedy that has devastated my family.

Thank you again for the testimony.

[The prepared statement of Ms. Sheehey-Church follows:]

******** INSERT 1-3 ********

Mr. Latta. And thank you very much for your testimony today. And on behalf of the committee and the subcommittee, you know, we mourn your loss, because what we are here for is to make sure that other families don't suffer the same loss that you have suffered, the loss of your son. So we appreciate your testimony today.

Ms. Holmes, you are recognized for 5 minutes.

STATEMENT OF ERIN HOLMES

Ms. Holmes. Thank you.

Good afternoon, Chairman Latta, Ranking Member Schakowsky, and distinguished members of the subcommittee. Thank you for the opportunity to testify on the issue of drug-impaired driving.

My name is Erin Holmes, and I am the director of traffic safety at the Foundation for Advancing Alcohol Responsibility. 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, including Bacardi U.S.A., Beam Suntory, Brown-Forman, Constellation Brands, DIAGEO, Edrington, Mast-Jagermeister US, and Pernod Ricard USA.

I would first like to begin by expressing my gratitude. Leadership is needed to address impaired driving in all of its forms, and I applaud the committee for recognizing the seriousness of this problem and the need to push for solutions to save lives.

I also would like to acknowledge the efforts of the National Highway Traffic Safety Administration under the leadership of Deputy Administrator Heidi King.

NHTSA has made drug-impaired driving a priority and is actively engaged in identifying countermeasures that work, furthering research, and increasing public awareness.

While not a new issue, drug-impaired driving has come into greater focus in recent years due to the increasing number of States that have legalized marijuana and the spread of the opioid and heroin epidemic.

Let me be clear: Drug-impaired driving is a serious public safety concern. In 2016, the most recent year for which we have data available, drugs were present in 43.6 percent of fatally injured drivers with a known drug test result.

Further complicating the issue is the realization that it is not uncommon for drivers to have more than one substance in their system. Research has continually shown that drugs used in combination or with alcohol can produce greater impairment than substances used on their own. In 2016, 50.5 percent of fatally injured drug-positive drivers were positive for two or more drugs, and 40.7 percent were found to have alcohol in their system as well.

Unfortunately, polysubstance-impaired drivers are often not identified if they have a blood alcohol concentration above the illegal limit of .08, which then, of course, has implications for supervision and treatment decisions.

So what can be done to address this problem? To effectively reduce drug-impaired driving and save lives, a comprehensive approach must be employed. Drug-impaired driving is more complex than alcohol-impaired driving, and we have heard some of those explanations here already today as to why that is so. Therefore, different policy approaches are needed to address certain aspects of the problem. However, it is constructive to examine the policies and programs that have been

effective in reducing alcohol-impaired driving and replicate these tactics when feasible. Some examples may include administrative license suspension, zero-tolerance laws for individuals under 21, and enhanced penalties for polysubstance use.

I encourage Congress to take a multifaceted approach that involves a combination of education, policy, and enforcement initiatives, which are outlined in detail in my written submission.

First and foremost, ongoing support and funding is needed to increase the number of law enforcement officers trained in Advanced Roadside Impaired Driving Enforcement, or ARIDE, and certified as drug recognition experts. Understanding that more resources are needed at the State level to accomplish this goal, responsibility.org partnered with the Governors Highway Safety Association to offer grants, which is now in its third year. Since that began, that program has resulted in more than 1,500 officers receiving drug-impaired-driving training in 13 different States.

We also recommend supporting NHTSA in expediting oral fluid testing research and exploring the creation of minimum standards for these devices, like with breath testing or ignition interlocks. Oral fluid screening devices test for the presence of the most common categories of drugs. They are quick and easy to use and minimally invasive. These devices could be another tool for law enforcement to use as part of a DUI investigation.

But identification of impaired drivers is only the first step. To improve outcomes, assessment must guide decisionmaking in the justice system. The screening and assessment of impaired drivers, whether drunk, drugged, or polyusers, for both substance use and mental health disorders is imperative to determine

individual risk level and treatment needs. Congress should continue to support and make appropriations for assessment and treatment interventions and evidence-based criminal justice programs, such as DUI and treatment courts.

Other important recommendations to consider include supporting the creation of national minimum standards for toxicological investigations, allocating additional highway safety funds to improve the capabilities of State labs, monitoring NHTSA's progress in creating large-scale education campaigns and providing appropriations to expand those should they be deemed effective, continuing to invest in research initiatives to better understand drug impairment and identify effective countermeasures.

Congress, NHTSA, State highway safety offices, and traffic safety organizations must continue to work collaboratively to prevent the occurrence of this behavior, improve the administration of justice, and further knowledge in the field.

Thank you so much, and we look forward to working collaboratively with you on these issues.

[The prepared statement of Ms. Holmes follows:]

******** INSERT 1-4 ********

Mr. Latta. Well, thank you very much.

And we appreciate all your testimony given to the subcommittee today.

And I just want to let members know that they did just call votes. So, if we could, I will try to get my first questions in first before we have to run down to vote.

But if I could start, Ms. Holmes, with you, just following up on what you were talking about on what States are doing out there to address the drug-impaired driving, are there any States that can be models for others? And why do you believe that some States are at the forefront in addressing this issue?

Ms. Holmes. I think there are a number of different things that are being done well, depending on the area. Each State has individual and unique challenges and can be constrained by their laws.

I would look to Colorado as a leader and example on public education and information campaigns. I believe they have done a phenomenal job, and they have worked towards expanding their messaging.

They were put in a difficult position when Amendment 64 became law back in 2012. They weren't prepared and had to put together a campaign relatively quickly. But since that time, their "Drive High, Get a DUI" campaign has expanded in its messaging, first from focusing and educating the public in Colorado that, while, yes, it is now legal to use marijuana, it is not legal to use and drive, because you can, in fact, get a DUI.

They have also focused on increasing messaging around crash risk associated with marijuana-impaired driving. And they have also looked at different aspects of the problem, like consuming edibles and driving. And now they are implementing a

new campaign called The Cannabis Conversation, where they reach out to communities of users.

Other States, like Washington, have done a very good job with data collection. They have been able to go back and do a lot of analysis on fatally injured drivers to get a better sense of what the data is telling them: not only what percentage of fatally injured drivers over a lengthy period of time are testing positive for marijuana, but also who is testing positive for the active psychoactive component -- that is the Delta-9-tetrahydrocannabinol -- versus the inactive metabolites. They have also focused on being able to identify which drivers tested above or below their per se limit of 5 nanograms.

I would also commend California for the work that they have done on laboratory testing and investing in lab capabilities. They have also looked to establish a blueprint to be able to guide decisionmaking in the future.

What I would always encourage all States to do is to look at this issue irrespective of what challenges they are facing with drug policy and with drug use in their States. The sooner you can start to plan ahead, the better prepared you will be. And States that have not gone down that road or have not been extremely hard-hit by either legalization or by the opioid epidemic, they are in the best position to learn the lessons from other jurisdictions and implement them or plan for the future.

Mr. Latta. Thank you.

Ms. Harmon, given your unique perspective on this issue, just talking about California, from the local level, what are some of the day-to-day obstacles in combating drug-impaired driving that you have seen?

Ms. Harmon. Certainly, I think one of the largest obstacles that we continue to have in California is the relationship that our public has with law enforcement. Law enforcement is key to dealing with drug-impaired driving. Their impairment models that they are using, we have published research that we believe that they are effective even with drugs like marijuana.

The other issue is the resources that the system as a whole has in addressing the type of testing that really needs to be done at a comprehensive level. Almost every jurisdiction, with the exception of two, only tests drivers above a .08 percent. In the last few years, we have been able to convince coroners' offices and medical examiner offices that marijuana or the active drug, THC, is an important drug to be testing. So we do now have our fatally injured drivers tested for marijuana.

But the scope of testing that is done in our State is limited because of the resources that the laboratories have and the access they have in improving the technology, as well as the staffing resources that they need in order to deal with the problem.

The other issue is that we are dealing with a vast number of drugs. Our five most prevalent drugs in our jurisdiction involve both illicit and prescription drugs. And the drugs are all tested slightly differently. And so you have to have state-of-the-art technology in order to effectively do that and to be able to test for all of the drugs in a timeframe that is reasonable. Because drugs break down not just in a person's system but also in the samples. So if the samples are sitting for extended periods of time and not getting tested or only being screened and then at a later time being tested, you are affecting the quality of that evidence for a prosecution.

Mr. Latta. Well, thank you very much.

And my time is about ready to expire. And, as I said, we can go run down and vote. Would that be all right?

Ms. Schakowsky. Right now?

Mr. Latta. Right. We will recess?

Ms. Schakowsky. Okay.

Mr. Latta. Yep. And we will vote and come right back.

Thank you.

We will stand in recess.

[Recess.]

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Mrs. Walters. [Presiding.] All right. We are going to reconvene with questions and I am going to recognize Ranking Member Schakowsky.

Ms. Schakowsky. Thank you very much.

So here we are again, and I appreciate your waiting. I know it's kind of a drag, but that's our schedule. So I wanted to start by asking or actually just saying to Ms. Sheehy-Church I just appreciate you so much and, certainly, my heart goes out to you and the fact that you have made this a mission of yours I think is so incredibly important.

Moms Against Drunk Driving, as you pointed out in your testimony, has really changed the face -- you know, we are not at zero, that's for sure, but the 21 years old, the zero tolerance, the .08 -- those are really attributed to the kind of grassroots activism often of coming out of tragedy.

So I just want to say that. I am so grateful to you.

So I am just wondering, would actually going further and lowering the legal blood alcohol level help reduce deaths from drunk driving? Is that even on the table or realistic?

Ms. Sheehy-Church. Well, obviously, heard from NTSB that they were recommending, you know, .05. But the reality is once the recommendation comes in they kind of walk away and leave us to do the work and others -- advocacy groups -- to do the work to try to go to you all to try to see if there is an appetite and a willingness to do that.

We are not there yet, and I think if we stick to the campaign that we currently have right now, which is really supporting law enforcement, we will save more lives faster than taking a look at that down the road.

I mean, there is -- impairment is impairment, and when we look at someone who has been arrested or accused of a DUI the fact is they are impaired no matter what it is.

So I think spending that time right now maybe down the road. But I think right now, more research is needed but, more importantly, we need to stop what's happening on the roads.

I hear a lot about the fatalities and the blood draws and everything on fatalities. We need to do something that's in advance. We have got to stop something now.

We need a silver bullet now, and right now the only thing we have now is law enforcement -- their ability to be boots on the ground and make sure that we do something before tragedy occurs.

Ms. Schakowsky. Thank you.

Let me acknowledge, by the way, we have dueling hearings, which is why I was not here for most of your -- I heard your testimony. But so let me apologize if I repeat things that have already been said.

I am just wondering if I could ask any of you, what else should be done to help stop drunk or impaired driving that can be done at the federal level?

Any suggestions for us? And can I start with Dr. DuPont?

Dr. DuPont. Yes, that was a point of my testimony. I gave a list of eight things that I thought were very important.

Ms. Schakowsky. Okay. I can go back to that, but maybe it bears repeating.

Dr. DuPont. No. No. We need data, I think, is the most important thing of the nature and extent of the problem, and I think as we have that, it drives everything else.

So that's the most important thing. For example, getting the FARS data -- the fatally injured drivers -- having all those drivers tested for drugs and alcohol and having --

Ms. Schakowsky. So not just drunk drivers over .08 that get tested for other --

Dr. DuPont. Every fatally injured driver --

Ms. Schakowsky. Got it.

Dr. DuPont. -- should be tested for drugs and alcohol. That's what I am thinking, and that NHTSA can establish guidelines for how to do that. Right now, it's hit or miss. One state will do one thing, another another.

If NHTSA had a standard package -- here's what we recommend for testing for fatally injured drivers -- that would be a very helpful thing to -- for us to do, for example.

The simple thing to me is a law that -- encourage laws for under the age of 21 to have zero tolerance. Its -- marijuana is illegal in every state in the country under 21.

If a young driver -- a 20-year-old driver has alcohol at below .08, it's still a violation, and we can do that with marijuana. And doing that with younger drivers -- that's the 16 to 20 -- that makes a difference.

That would be a step that would make -- you know, it would make things better, I think, that would be.

The poly drug problem we talked about it's where the -- it's where you are now and it's where we are going, into more and more of that. We need to have additional penalties for people who are using multiple --

Ms. Schakowsky. I am looking at the clock. I guess I just ran out of how fast five minutes goes. I apologize.

I will definitely look at all of your testimony and I think this is a bipartisan issue. I don't think there is any question about it, and if there are things that we should do.

But I think data -- does everybody agree -- is really important for us to do.

Thank you.

Mrs. Walters. The chair will recognize the gentleman from Indiana, Mr. Bucshon.

Mr. Bucshon. Thank you, Chairman.

I was a surgeon before I was in Congress so I have had patients -- you know, trauma patients who have been in car crashes and other things and seen some of this -- the results of impaired driving, from that perspective.

I also had another hearing in the Health Subcommittee so I am sorry I wasn't here for your testimony. But I've read through your testimony.

One of the things as a physician that concerns me is across the country, you know, we are legalizing marijuana for recreational use. I personally oppose that based on medical grounds.

Evidence has shown that in the developing brain, which would be a young person all the way up through their mid to late 20s that there is substantial evidence of permanent long-term cognitive changes and that I think we are going to find later on are going to be substantial.

That said, the other thing I am concerned about is in the short term, putting in legally -- legal sustainable ways to determine how impaired people are when they are

driving when they are using marijuana exclusively, it's easier if they have alcohol at a high level or something.

But I think you're going to see -- start seeing more of that. You're going to start seeing more impaired driving.

We had a case in my district where a young lady, a teenager, was sledding and was hit by an impaired driver -- unfortunately, was hit by an impaired driver.

It's complicated, but the gist of it is the impaired driver didn't have any alcohol in their system.

But, clearly, in the field, they -- the officer felt that they were impaired and then, of course, when you go to court there is no substantial legal evidence that they were impaired at the time other than the word of the officer, because, as you know, THC is not -- doesn't stay in the bloodstream very long.

Someone pointed that out in their testimony. It gets distributed into your body. It can stay in your hair and your fat for a long time. But in the short term, you can't determine, at least at this point, legally what determines impairment.

So I would -- the question I have -- and anyone could start to address this -- is how do we -- how do we begin to get a national legal standard for impairment?

Ultimately, the states will do it but, you know, how we did with the .08 -- we have ways of having the states adopt a national standard.

How do we get to that point? Because I am pretty concerned about it. Indiana, honestly, it's not -- it's not a partisan issue. Indiana is pretty red, but the legislators are talking about legalizing recreational use in our state.

So we will start with Dr. DuPont and how can we get to a legal standard for impairment with marijuana use that will hold up in court?

Dr. DuPont. Well, I think we do have tests for impairment. The DRE -- we have the field sobriety test and the ARIDE test. Those are tests for impairment.

People are not drug tested unless they fail those tests. When they fail those tests and they have drugs present, that should be sufficient for the penalty, right there, and once you start to try to find a tissue level for any other drug, you're lost, and I use a simple example to make this point involving drug treatment and methadone is a treatment for drugs.

Mr. Bucshon. Right.

Dr. DuPont. And if you take a methadone dose of 40 milligrams, that's lethal to a nontolerant person.

Mr. Bucshon. All right.

Dr. DuPont. A single dose. Okay. For a methadone maintained patient, they typically take 100 milligrams a day and have no impairment -- no impairment. I want you to hear that -- no impairment.

Mr. Bucshon. Oh, yeah.

Dr. DuPont. So if you have a tissue level for methadone, you can't say this one's impaired and that one isn't. The ultimate impairment is death.

We don't have to have a scientific study. If they are dead, they are impaired, and that's at 40 milligrams. But at 100 milligrams, there is no impairment. That's tolerance.

Mr. Bucshon. Right.

Dr. DuPont. And that's true for these other drugs. It's true for marijuana.

Mr. Bucshon. So we got a ways to go to try to determine -- for example, in this --

Dr. DuPont. You can't do it with a tissue --

Mr. Bucshon. -- in this particular case, this person's attorney is arguing that they were not impaired and there is no evidence that they were impaired other than the field sobriety tests and the opinion of the officer.

Dr. DuPont. And we need to take that seriously along with the finding -- the positive finding.

Mr. Bucshon. Right.

Dr. DuPont. That's what that --

Mr. Bucshon. Anyone else have any comments?

Ms. Holmes, I see you want to comment.

Ms. Holmes. Yes, sir. I would really just emphasize what Dr. DuPont just said and that's why I think everybody in the traffic safety field emphasizes training officers in both ARIDE or certifying them as DREs so that they can confidently identify the signs and symptoms of drug impairment and then be able to articulate that in court in a convincing manner, and that becomes a training issue.

So more appropriations for that type of law enforcement training is key.

Mr. Bucshon. Makes sense. Thanks. My time is up. I yield back.

Mrs. Walters. The gentleman yields, and the chair recognizes the gentleman from New Jersey, Mr. Lance.

Mr. Lance. Thank you, Madam Chairman, and I may be asking questions that have already been asked. We have had a series of hearings today and I apologize for not being at this hearing for all of its aspects.

I am from New Jersey and the new governor of New Jersey, Philip Murphy, wants to legalize recreational marijuana by the end of the year. This would occur through legislation at the state level in Trenton, our state capital.

I am open to expanding access for medicinal use of marijuana but I strongly oppose legalization for recreational purposes.

I am especially worried about the legalization of recreational marijuana's effects on our roadways. New Jersey is the most densely populated state in the nation.

As has been previously stated, the number of American drivers killed in automobile accidents in which drugs have been detected, that number has surpassed those killed in accidents where only alcohol was found. At least that's my understanding of the situation.

Several states, of course, have already legalized marijuana for recreational use. To the distinguished and to each of you, could you please comment on trends or data that have been produced from the states that have legalized recreational marijuana as it relates to impaired driving?

And I will start with you, Dr. DuPont.

Dr. DuPont. I don't have the data for comparing the states. So somebody else will have to answer that.

Mr. Lance. Thank you very much.

Anybody on the panel who would like to respond to my question? Yes.

Ms. Harmon. I can speak to what we have seen in California. We legalized in 2016 but recreational sales did not go officially online until January of this year.

Currently, in our fatally injured drivers, we are in the range of 17 to 20 percent that are testing positive for the active drug found in marijuana, THC.

We do know that both Colorado and Washington, once they legalized, saw almost a doubling of their fatally injured drivers originally from the pre-legalization to post-legalization.

We are not sure yet what California is going to look like because that data is as of 2017. We do expect the numbers to increase in 2018 and 2019. But, again, we are waiting because the access -- the full access didn't go online until this year.

That being said, California had decriminalized marijuana since 1996 so our numbers may not be as substantial as Colorado and Washington.

Mr. Lance. And, of course, there is a difference between decriminalization and legalization, as I understand it, and this debate is now occurring in New Jersey.

But without final figures, it's your view, at least in California, that, unfortunately, tragically, the number of fatalities will increase or have increased as a result of this change in legislation?

Ms. Harmon. Yes, and we are seeing an increase in drug-involved fatalities.

Mr. Lance. Others on the panel?

Ms. Sheehy-Church. I would say that, in terms of the statement marijuana being ahead of alcohol is not true.

Mr. Lance. Mm-hmm.

Ms. Sheehy-Church. But what I would agree with is that we are seeing a rise. I have my own opinion relative to marijuana, whether it's medicinal or whether it's -- that it's not.

Mr. Lance. I seek your opinion. That's why you're on the panel.

Ms. Sheehy-Church. Yes, I won't --

Mr. Lance. And that's why I've asked everybody on the panel to comment.

Ms. Sheehy-Church. I still think, though, that, speaking for MADD, that what we have to do is stick with our model that does work --

Mr. Lance. Mm-hmm.

Ms. Sheehy-Church. -- and what works is exactly what Ms. Harmon says that we -- and Ms. Holmes says is really looking at our -- is our law enforcement being the first step, as putting the tools in the toolbox that they need so that they can better understand and stop the fatalities.

These are accidents, by the way. These are crashes, because a crash is something that is done that could have been 100 percent preventable.

Mr. Lance. I see. My staff used the word crash. I changed it to accidents. So that's my fault, not the fault of my very competent staff.

Ms. Sheehy-Church. It's okay.

Mr. Lance. Ms. Holmes.

Ms. Holmes. I'll very briefly speak to Washington State.

Mr. Lance. Yes.

Ms. Holmes. AAA FTS did a study that looked at trends both pre- and post-legalization for drivers testing positive for active THC and they found an increase from 8 to 17 percent.

Mr. Lance. So that's double.

Ms. Holmes. Washington Traffic Safety Commission has also done a lot of data analysis and the recent data shows that the number-one impairing substance in their fatal crashes is actually poly use, so either a combination of alcohol and drugs or multiple drugs on board, which is what we are primarily concerned about.

Mr. Lance. I thank you and I thank the distinguished panel.

And let me reiterate that it is my considered judgment, and I was the minority leader in the state senate in New Jersey before coming here, that it is not good policy, at least for our state, to legalize recreational marijuana.

I thank the chair.

Mrs. Walters. The chair recognizes the gentleman from Florida, Mr. Bilirakis.

Mr. Bilirakis. Thank you. Thank you, Madam Chair. I appreciate it very much.

Ditto what the gentleman from New Jersey says as far as recreational marijuana as well. Yes, what's the -- I have some questions here and I want to go through it.

But what is the drug that -- certain drug that -- besides alcohol and maybe marijuana too that is -- impairs the individual the most? Can you point to one particular drug with regard to driving?

Ms. Sheehy-Church. I cannot answer that question if there is one over another. Impairment is impairment and it reacts -- you know, different drugs, whether they are prescription or illicit, will react to an individual differently all the time.

So I don't know whether anybody else has the data.

Dr. DuPont. I don't think you'd find one drug that would stand out. Those are the two that are most prevalent. But there are lots of other drugs -- methamphetamine, for example, cocaine, and all the new synthetic drugs.

So it's an incredible long list, and all of them are impairing. There aren't any drugs that aren't impairing.

Mr. Bilirakis. Yes, and also, you know, if you take the drugs legally -- the prescribed -- they could interact with each other and that's very important that we get the word out.

How do you propose getting the word out besides the doctors, you know, telling the patients, look, you absolutely should not drive when you're under the influence, even though it's legally prescribed, you know, for example, pain medication or what have you?

Do you all have any suggestions on that?

Ms. Holmes. I think in addition to physicians, also pharmacists. I think one of the things that we would certainly recommend to safeguard against opioid-impaired driving, particularly when we are talking about prescriptions used according to therapeutic doses, is to really make sure that at that point of contact where the patient is prescribed a new medication with impairing side effects that both the physician and pharmacists are having a conversation with that patient that very clearly outlines that they should not be operating heavy machinery and that a vehicle constitutes having machinery. We are not just talking about crane operators

Mr. Bilirakis. That's right.

Ms. Holmes. But I think sometimes that doesn't occur and sometimes that fine print warning label is simply not sending a strong enough message.

Mr. Bilirakis. Yes. I agree. I agree.

Anyone else want to comment on that?

Dr. DuPont. I think one of the things that's striking is that people often don't know they are impaired.

Mr. Bilirakis. Yes.

Dr. DuPont. When people do know they are impaired, that's, clearly, a sign to say if you feel impaired -- if you feel high, don't drive. That's clear.

Mr. Bilirakis. Yes.

Dr. DuPont. The problem is that a lot of people feel just fine or even feel they are driving better when they are impaired and I think that makes it very difficult to say you're going to educate them about it.

I think the answer is really to not drive after you use drugs.

Mr. Bilirakis. Exactly.

Dr. DuPont. But with respect to prescription drugs, I often prescribe myself medicines that are potentially impairing. When you start with a drug that is potentially impairing you want to be very concerned with that with a patient.

Once they are on a stable dose, usually it's not a problem unless they add something else to it.

Mr. Bilirakis. And that's the thing. The mixture of alcohol and a drug, whether it's marijuana or what have you.

Dr. DuPont. To be sure, it can be very disturbing. But it becomes difficult to communicate that because the same drug as I use in my methadone example -- the same dose of the drug, which is nonimpairing for a person who's used to it is very impairing to a

person who isn't, and that makes it difficult to broaden these bright lines that people want to have.

Mr. Bilirakis. Yes, I know. We got to get the message out. But you're right, everybody's different.

So earlier this year, there was an article in our local newspaper in Pasco County, Florida -- the Laker/Lutz News -- that shared a tragic story of a constituent, a couple whose daughter and family were, sadly, killed by a drug-impaired driver.

I'd like to insert that the article be in the record, Mr. Chairman -- or Madam Chair, please. I'd like to insert that into the record.

Mrs. Walters. So without objection.

[The information follows:]

**********INSERT**********

Mr. Bilirakis. Thank you.

These parents have since become strong advocates for raising awareness and education about drugged driving and I personally met with them and heard their heartbreaking stories.

It highlights the urgency that we have today to address this issue and reverse the trends we have been seeing over the past few years.

And, again, I have one other question here. Dr. DuPont, your testimony talks about the essential element of public education to help reduce drug-impaired driving.

We are all aware of the don't drink and drive messaging that has been effective over the years. You say we should have an equivalent don't use drugs and drive messaging as well and that it should be backed by clear policies and enforcement.

What should these policies look like at the federal level to help with this -- with an education initiative? And did see something the other day on TV, and I am not exactly sure what this means because I am 55 years old, but don't be baked and drive.

So but anyway, if you could answer that question for me I'd appreciate it.

Dr. DuPont. The don't be high and drive is what people in the marijuana field talk about and I think that's good advice not to be high and drive.

I think that that's good. But I think -- I like the don't use drugs and drive, to be clear, and I think once you get past that, you get into very murky waters about safety.

Mr. Bilirakis. Okay. You also mentioned the additional concern regarding prescription drugs. I don't have time.

All right. Well, I'll enter it into the record and I appreciate it, Madam Chair. Thank you. I yield back.

Mrs. Walters. The gentleman yields.

I am going to recognize myself for five minutes. As we have heard in Ms. Harmon's testimony, my home of Orange County, California, is a national leader in the fight against drug-impaired driving.

The alarming statistic that more Americans are killed in crashes in which drugs are detected compared to those which alcohol was found are reflected in the fact that Orange County saw a 40 percent increase in drug-impaired driving submissions to the crime lab from 2015 to 2016.

In response, the OC crime lab and DA have developed a multi-agency drug-impaired driving initiative focusing on investigation, prosecution, and toxicology examination.

The OC model serves as the foundation for California statewide drug-impaired driving model and the district attorney coordinates training for all of southern California.

These local and state initiatives must be in collaboration with federal efforts and I am assured knowing that former Orange County resident Deputy Administrator Heidi King is executing NHTSA's drugged driving initiative.

Last Congress, we enacted the FAST Act, which included language I championed that required NHTSA to study marijuana-impaired driving and how it affects individuals while driving, and I would like to submit the report for the record.

[The information follows:]

**********COMMITTEE INSERT**********

Mrs. Walters. The state also authorized NHTSA to work toward a roadside test for impairment.

Ms. Harmon, you mentioned the OC crime lab studies, roadside saliva testing, and other field test options. Can you further describe the challenges in developing an effective field test and the progress made toward that goal?

Ms. Harmon. So we have done a couple of studies. We have published in 2016 and 2018 of this year where we looked at -- we went back and looked at marijuana -- drivers with marijuana -- active THC in their system and looked at the current field work that's being done by law enforcement -- the standardized field sobriety tests and the drug recognition expert program -- and our studies concluded that although you can't correlate to a level to a level of impairment, the current tools that law enforcement is using are very effective of finding THC-impaired drivers.

Of the additional work that we have done, we did a pilot study with the Fullerton Police Department, looking at roadside saliva testing and the effectiveness of that testing versus our blood collection model that we have had in our county.

We have contract phlebotomy for over 30 years, which allows us to reduce the time frame in which the blood is actually collected and how it's submitted to the laboratory and tested, and what we found is that the roadside saliva model testing is effective for illicit drugs -- methamphetamine, heroin.

It was okay for marijuana and it was not effective for prescription drugs. In Orange County, we have our third most prevalent drug -- with the exception of including alcohol -- is benzodiazepine, which is Xanax, which this would exclude many of those cases if we went to a roadside saliva model.

So we continue to advocate that if we can get effective blood collection that it is a matrix that we can work with and that we already have literature that supports, you know, what levels are therapeutic, what levels are toxic, and what levels are fatal, which we can provide during testimony in drug-impaired driving cases.

Mrs. Walters. What can Congress do to help develop an effective field test?

Ms. Harmon. I think what's really needed is that we have effective tests and so what we really need from Congress is support in doing that.

The standardized field sobriety tests model that law enforcement is using is not mandated in academies -- in police academies.

The California Highway Patrol mandates that this class -- it's 40 hours of training for every one of their officers. They also mandate the 16-hour ARIDE, which Ms. Sheehy-Church had mentioned before.

They also mandate that 16-hour class as well. And, again, these are classes that are not mandated of all folks who are in law enforcement now.

The additional thing is that the testing component needs to be available. The toxicology labs need to have the resources.

Much like what the federal level has done for DNA, they need to do that for toxicology, and it will enhance any type of case work that involves drugs if those models are used, and ensuring that the laboratories actually have the resources they need to test all drivers and to test decedent drivers for the drugs that may be in their system.

Mrs. Walters. Okay. And you said according to the DA marijuana and prescription drugs that count for the majority of drug-impaired driving cases in Orange County and you mentioned the crime lab will soon begin testing for over 300 drugs in every traffic safety related case.

Can you explain what factors led the crime lab to expand the types of drugs tested?

Ms. Harmon. We expanded the testing because this is what we are seeing. We did a proof of concept research project a couple of years ago and saw that over 30 percent of drugs were being missed in our cases.

So we have led efforts over the last several years to become more comprehensive in the testing that we do because many of our cases are, as already reflected by this panel, poly pharmacy cases.

Over -- as I mentioned, over 40 percent of our nonalcohol DUIs have three or more drugs in their system. We want to be able to give a comprehensive picture on the data that's being provided.

Mrs. Walters. Okay. Thank you, and I am out of time.

Ms. Schakowsky. Can I ask one more?

Mrs. Walters. Sure. I'll yield to the gentlelady.

Ms. Schakowsky. Thank you, Madam Chair. I really appreciate it.

So I am trying to -- what you said, Dr. DuPont, about different people having different levels of tolerance.

Now, we set .08. I am assuming that someone like me, who's a horrible drinker -- I mean, probably one little glass of wine and I might be impaired -- I don't know -- but yes, we set a firm level.

Does that -- what you were saying, I mean, can we set levels that are just for everyone for these other drugs, for these other -- for marijuana, et cetera, because I would think that otherwise it's impossible to define what's impaired and what isn't.

So I don't know. Whoever wants to answer that but --

Dr. DuPont. Well, I think the answer is no, you can't do that, and let me just mention about with alcohol. It's not as clear cut as you may think that somebody who's under .08 is not impaired and somebody who is over .08 is. That's called a per se standard.

There are many people who are alcoholics who are above .08 and they pass the field sobriety tests. There are other people who are under .08 who fail the field sobriety

tests. And you can see this very easily from some of the field sobriety data that when people -- if you look at the people who fail on alcohol, the average level is not .09.

The average level is .15, because many people who are heavy drinkers can pass the field sobriety tests.

So what I am saying is this is a political decision what the number is. It's not a science decision, and --

Ms. Schakowsky. But there is a practicality about it, too.

Dr. DuPont. It's very important. It's a wonderful thing.

Ms. Schakowsky. Yeah.

Dr. DuPont. I am in support of it. But the missing -- not to understand the science behind it leads you to want to find that for other drugs and I am telling you you can't do it -- that what you do -- what's happening now, which is tragic, is that the search for that tissue level for other drugs is stopping us from doing the things we can do right now.

We say we have got to wait for that. We have got to have new research. That is very destructive to say that sure, let's have more research.

But let's do the things we can do now -- there is lots of things to do, and the field sobriety test is a wonderful test. It does detect the impairment very well.

Ms. Harmon was talking to me -- when they fail the field sobriety tests, 96 percent of the people have drugs or alcohol present. That tells you that field sobriety test is a very good test. You don't need another test. That test is good.

Let's use it right now. Yes, do more research. But use what we have got now because what we have got now is good, and what's happening in Orange County is a model for the country.

Ms. Schakowsky. Okay. I am just -- is there any, like, really, difference of opinion to weigh in at all? Okay. Did you want to?

Ms. Sheehy-Church. I just -- there is no difference of opinion. I absolutely agree with the doctor.

Ms. Schakowsky. Ms. Holmes as well?

Ms. Holmes. Yes, and to that, I would add that we already have impairment-based laws in every single state, which is why that somebody who's impaired with below .08 can be prosecuted for a DUI -- similarly, for drugs.

So the emphasis really then should be making sure officers are, again, trained to be able to --

Ms. Schakowsky. Okay.

Ms. Sheehy-Church. -- identify and articulate signs of impairment.

Ms. Schakowsky. Okay. And Ms. Harmon, you're on board with that too? Yes?

Ms. Harmon. I agree completely.

Ms. Schakowsky. Okay. Great. Thank you. That's helpful.

Mrs. Walters. Thank you. Seeing that there are no further members wishing to ask questions, I'd like to thank all of our witnesses for being here today and thank you for being patient with us while we had to go vote.

Before we conclude, I would like to include the following documents to be submitted for the record by unanimous consent: an article from the Heritage Foundation, a policymakers checklist from responsibility.org, a report from the governor's Highway Safety Association, a report from the Institute for Behavioral Health, an article from the Police Chief magazine, and an article from Impaired Driving Update.

[The information follows:]

**********COMMITTEE INSERT**********

Mrs. Walters. Pursuant to committee rules, I remind members that they have 10 business days to submit additional questions for the record and I ask that witnesses submit their response with 10 business days upon receipt of the questions.

Without objection, the subcommittee is adjourned.

[Whereupon, at 3:21 p.m., the subcommittee was adjourned.]