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Zolpidem and Driving – A Dangerous Mix

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Drug Evaluation and Classification Program
International Association of Chiefs of Police (IACP)**

There are numerous indicators that show prescription drug abuse is a significant problem in the United States. According to the National Survey on Drug Use and Health (NSDUH), conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2006 approximately 7 million persons 12 and older took a psychotherapeutic drug for non-medical purposes in the 30 days prior to the survey. Young adults (ages 18-25) by far showed the greatest use overall and the largest increases in past month, past year, and lifetime use between 2002 and 2006, compared to all other age groups (NSDUH, 2007).

At the same time, prescription drug abuse has become a serious threat to public health and safety, with unintentional deaths involving prescription opioids increasing 114 percent from 2001 to 2005, and treatment admissions increasing 74 percent in a sim-

ilar four-year period.⁽¹⁾ In 2006, the last year for which data are available, drug-induced deaths exceeded firearm-injury deaths and ranked second only to motor vehicle crashes as a cause of death.⁽²⁾

The increase in prescription drug abuse is also having its effects on our nation's roadways. On July 13, 2009, the U.S. Department of Transportation's National Highway Traffic Safety Administration (NHTSA) released a report on the 2007 National Roadside Survey on Alcohol and Drug Use by Drivers.⁽³⁾ In a random sample of weekend nighttime drivers across the contiguous 48 states, researchers found that 16.3 percent of the drivers tested positive for drugs, compared to 2.2 percent of drivers with blood alcohol concentrations (BAC) at or above 0.08 g/dL. This was the first national study of roadside testing for drugs in addition to alcohol. The study found that drugs

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were present more than seven times as frequently as alcohol of those surveyed.

Law enforcement officers, prosecutors and toxicologists are also encountering an increase in impaired driving cases involving a variety of prescription drugs. One drug from the CNS depressant category having an impact on roadway safety is zolpidem, brand name Ambien®. The presence of zolpidem became such a concern that impaired driving cases were studied in several states. (Washington: *Zolpidem and Driving Impairment*, 2001, by Logan and Couper; and Wisconsin: *Ambien — Drives Like a Dream? Case Studies of Zolpidem Impaired Drivers in Wisconsin*, by Liddicoat and Harding).

In the Washington study, state toxicologists at the Washington State Patrol's Bureau of Forensic Laboratory Services identified 29 impaired cases between January 1997 and December 1999 in which zolpidem was identified in the subjects' blood. In five of the cases, zolpidem was the only drug identified in the blood samples. The researchers concluded that it was reasonable to conclude that zolpidem has the potential to affect driving in a negative way.⁽⁴⁾

The effect of zolpidem on driving ability was also examined, in part, in a double-blind, placebo-controlled, crossover study of 16 healthy volunteers (mean age 24.5 years). In the study a 10-mg dose of zolpidem was given at 11 p.m. The next morning, one group of subjects was assessed in a driving simulator at 9 a.m. and another group at 11 a.m.; however, according to the researchers, zolpidem had no effect on driving ability at either time tested. (*Psychopharmacology* 1999;143:373-9)

In another study with different results, investigators tried to determine the effect of middle-of-the-night administration of zolpidem on driving ability. Thirty volunteers participated in a double-blind study to measure the effects of zolpidem (10 or 20 mg) or a placebo four hours after administra-

tion. The test subjects drove a designated distance at a constant speed. A standard deviation of lateral position (drift) was the primary performance parameter. According to the findings, a 10 mg dose of zolpidem had a small effect while 20 mg significantly impaired driving. (*J. Clin. Psychopharmacol*, 2002;22:576-83)

Zolpidem is a white to off-white crystalline powder. It is available by prescription only and is a Schedule IV controlled substance. Ambien® is available in strengths of 5 mg and 10 mg (white and pink oval tablets, respectively). Sonata® contains zaleplon. Imovane® and Lunesta® contain zopiclone. Zolpidem and the other sleep drugs are a non-benzodiazepine sedative-hypnotic, CNS depressant, sleep aid. Zolpidem is used in short-term treatment of insomnia. Zaleplon and zopiclone also are prescribed for the treatment of insomnia.⁽⁵⁾

The recommended zolpidem dose is 10 mg immediately before bedtime (5 mg in the elderly). Recommended nighttime zaleplon and zopiclone doses are 5-20 mg and 7.5 mg, respectively. Patients treated with zolpidem often use other medications such as antidepressants, narcotic analgesics, and muscle relaxants, which can create additional problems if not used carefully.

Zolpidem goes by many different brand names in the U.S. and abroad, including Ambien, Zolpimist, Adormix, Ambien CR, Edluar, Damixan, Hypnogen, Myslee, Nytamel, Sanval, Stilnoct, Stilnox CR, Sucedal, Zoldem, Zolnod and Zolpihexal. (Wikipedia)

Zolpidem and other similar sleep drugs act on the GABA_A receptor, leading to central nervous system (CNS) depression. For this reason, users are cautioned to avoid operating heavy machinery or automobiles following zolpidem administration. Driving impairment caused by zolpidem is similar to that of ethanol and other CNS depressants, with adverse effects on vision, speech, balance and coordination. Notable symptoms of zolpidem

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impairment may include a glassy stare, extremely poor balance with noted sway, disorientation, slow and raspy speech, and memory impairment. The manufacturer of zolpidem states that patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination such as driving a motor vehicle.

To determine what effects might actually be observed in persons arrested for impaired driving associated with zolpidem, 28 actual impaired driving cases involving the use of zolpidem were reviewed using drug influence evaluation reports by drug recognition experts (DREs). The cases were examined to determine (1) the cause of the stop and arrest, (2) performance on the psychophysical tests administered during the DRE evaluation, (3) results of the eye examinations, including horizontal gaze nystagmus (HGN), vertical gaze nystagmus (VGN), lack of convergence (LOC), and (4) vital signs including pulse rate, blood pressure, and body temperature.

In 27 of the 28 cases, blood samples were drawn and analyzed for the presence of drugs. In each case, the only drug detected was zolpidem. The zolpidem concentrations ranged from 0.05 to 0.69 mg/L with a mean of 0.22 mg/L. In one case, a zolpidem prescribed volunteer was examined by DREs for training purposes and no toxicology was obtained. None of the 28 cases involved the use of alcohol and in each case where a blood sample was obtained tests were negative for drugs other than zolpidem.

Overview of the 28 Case Zolpidem Study

The following chart represents information collected from the 28 actual zolpidem cases where the drivers were evaluated by a drug recognition expert (DRE). The information includes the cause of the stop/arrest, the suspect's performance on the psychophysical tests administered during the DRE evaluation; results of the eye examinations, including horizontal gaze nystagmus (HGN), vertical gaze nystagmus (VGN), lack of convergence (LOC); the suspect's vital signs including pulse rate; blood pressure, and body temperature.

Participants:	28 total	11 males	17 females
Ages:	Mean – 45	Range – 21 to 79 years	
Stop/Arrest:	Crash – 13	Other – 15 (weaving, fail to maintain single lane, disobeyed traffic signal, etc.)	
Psychophysical tests: (Romberg balance Walk & Turn, One Leg Stand, Finger-to-nose)	Stopped: (safety reasons) – 7		Completed w/ difficulty: (5-8 clues) – 21
Eye Examinations:	HGN: 6 clues – 21 4 clues – 5 2 clues – 2	VGN: 13	Angle of onset: 30° – 12 35 – 40° – 7
Pupil sizes:	Room Light: Range: 2.0–7.0 Mean: 5.0 mm	NTD: Range 3.0 – 9.5 Mean: 7.0 mm	Direct Light: Range: 2.0–7.0 Mean: 4.5 mm
Vital Signs: Pulse Rate	1 st pulse: Range: 60–118 Mean: 90 bpm	2 nd pulse: Range: 60–120 Mean: 90 bpm	3 rd pulse: Range: 56–116 Mean: 86 bpm
Vital Signs: B/P and Temperature	Systolic: Range: 88–178 Mean: 132	Diastolic: Range: 58–110 Mean: 84	Body temperature: Range: 95.4–101.2 Mean: 97.0
Internal clock: (Romberg balance)	Range: 15 – 45 seconds Mean: 39 seconds		

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Conclusion

Zolpidem and other similar hypnotics act as sleep inducers. The known and well-documented relationship between fatigue, sleepiness, and driving performance make zolpidem and other similar hypnotics potentially hazardous when used in close proximity to operating a motor vehicle. Based upon past studies addressing zolpidem and driving, and using the information collected from actual zolpidem impaired driving cases, it is reasonable to conclude that normal prescribed doses of zolpidem and similar hypnotics can adversely affect driving. It is also reasonable to conclude that when law enforcement officers encounter persons suspected of driving under the influence of zolpidem and similar hypnotics they may see a variety of impairment indicators that may or may not follow the "classic" or traditional CNS depressant signs and symptoms; however, some of the common indicators appear to be HGN, with an early angle of onset, a lack of convergence, and poor performance on the psychophysical tests.

Sources:

1. "National Prescription Drug Threat Assessment, 2009."
2. Office of National Drug Control Policy News Release May 20, 2009.
3. Richard Compton and Amy Berning, Results of the 2007 National Survey of Alcohol and Drug Use by Drivers, NHTSA Facts, Washington DC; July 2009, DOT HS 811.
4. Zolpidem and Driving Impairment, Logan and Couper, J. Forensic Science, 2001.
5. Drugs and Human Performance Fact Sheets, NHTSA, DOT HS 809 725.

In cooperation with



ARTICLE OF INTEREST

ABUSE OF PRESCRIPTION DRUGS AMONG YOUTHS ON THE RISE

New research suggests that, though illegal drug use is declining among children and young adults, they are abusing prescription drugs, especially pain relievers, at an increasing rate. Commonly abused prescription drugs include codeine, methadone, oxycodone, and Ritalin. The analysis of data from the National Household Survey on drug Abuse found that almost 3 million adolescents and about 7 million young adults from ages 18 to 25 had used prescription drugs for non-medical purposes at least once in their lives. Researchers also found that pain relievers are among the most abused prescription drugs, while use of stimulants and tranquilizers were also rising.

Researchers claim that young people who abused prescription drugs were also more likely to use illegal drugs, such as marijuana, cocaine, or hallucinogens. They added that once one gets caught in the pattern of abuse, it doesn't matter much, whether it is legal or illegal drugs that one is abusing. Researchers said that many abuse prescription drugs on the misunderstanding that they are safe, when in fact they can cause addiction and severe side effects. Opiate-based pain relievers are quite addictive and can slow breathing to potentially deadly slow levels.

H. Westley Clark, Director of the substance abuse treatment at the Substance Abuse and Mental Health Services Administration concluded that parents should take care to dispose of any unused prescription drugs and should also warn their children of the side effects and addictive nature of prescription pain relievers and other prescription drugs.

From: <http://www.bio-medicine.org/medicine-news/Abuse-of-prescription-drugs-among-youths-on-the-rise-1805-1/>

South Dakota's 24/7 Sobriety Program

By Paul Bachand
South Dakota Traffic Safety
Resource Prosecutor

Bennett County is a very rural county in South Dakota with a current population of 3441, with two Indian reservations bordering the county on three sides. Its high unemployment rate is matched only by the rate that alcohol is consumed in that county. Quite typically, criminal offenders celebrate their successful completion of alcohol treatment by getting drunk with their acquaintances. In the early 1980s in order to combat repeat alcohol offenders, whether it be men who abused their wives or drivers who couldn't maintain sobriety, Bennett County State's Attorney Larry Long convinced his local judge to take another approach in dealing with alcohol related offenses. The judge agreed to require offenders to present themselves twice daily to the Sheriff's office and blow into a portable breath test (PBT). The judge also agreed to incarcerate anyone who did not show up for a scheduled test or who failed the PBT despite his concerns that there would not be sufficient jail space to hold all of the offenders. The implementation of

this simple concept produced promising results. Hardcore alcoholics were able to maintain sobriety and the jail population actually decreased.

In 2004, now Attorney General Long was appointed by the Governor of South Dakota to a task force charged with examining incarceration rates in South Dakota. Felony driving under the influence, a third or subsequent offense in ten years, and vehicular homicide and battery cases accounted for approximately 35% of all felony convictions in South Dakota. Felony driving under the influence offenses, when combined with felony drug offenses, accounted for approximately 60% of the total felony convictions in South Dakota between 1996 and 2007. Fifteen percent of the state prison population constituted DUI offenders. In 2007 87% of men and 91% of women sentenced to the South Dakota Penitentiary suffered from an alcohol and/or illegal drug dependency. Although repeat offenders might be required as a condition of sentence to abstain from the use of alcohol, no effective program existed to ensure their compliance.

Long suggested that his program be implemented as a pilot project in three counties in South Dakota. The Circuit Court judges in those counties agreed to require, as a condition of bond, that defendants totally abstain from the

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consumption of alcohol. Every defendant arrested for a second or subsequent DUI offense was required to submit to a breath test between the hours of 7 a.m. to 9 a.m. and 7 p.m. to 9 p.m. at the local sheriff's office. Judges immediately revoked the bond of anyone who failed to show up for a scheduled test or whose PBT demonstrated that they had consumed alcohol. Over time, judges witnessed the success of the program and began utilizing it for domestic violence cases and drug offenses.

In 2007, the state legislature unanimously approved the formal creation of the 24/7 Sobriety Program. The statutes implemented by the state legislature charged the Attorney General with the responsibility to coordinate efforts among the various state and local government entities for the purpose of finding and implementing alternatives to incarceration for certain offenses that involve driving under the influence and other offenses involving alcohol, marijuana, or controlled substances. Authority was given to courts, the Department of Corrections, and the Board of Pardons and Paroles to utilize the program in a variety of ways. The statutes permitted the court to condition any bond or pre-trial release upon participation in the 24/7 Sobriety Program and payment of associated costs and expenses. The statutes indicated that the court could condition the granting of a suspended imposition of sentence, suspended execution of sentence, or probation upon participation in the 24/7 Sobriety Program and payment of associated costs and expenses. The court could also require parents of abused

or neglected children to participate in the program in order for their children to be placed back at home. The Board of Pardons and Paroles, the Department of Corrections, or any parole agent was given authority to condition parole upon participation in the 24/7 Sobriety Program and payment of associated cost and expense.

The 24/7 Sobriety Program has been implemented in virtually every county in South Dakota. The current program utilizes a number of mechanisms in order to ensure both sobriety and lack of drug use. These mechanisms include the SCRAM (Secure Continuous Remote Alcohol Monitoring) bracelet, drug patch and a presumptive urinalysis kit. The SCRAM bracelet, which is attached to a defendant's leg and monitors alcohol consumption on a set schedule, has been a useful tool due to the rural nature of South Dakota. The SCRAM bracelet automatically collects, stores, and transfers all data to the SCRAM Modem attached to a wearer's phone line and the information collected by the bracelet is downloaded on a set schedule. Long commutes to the Sheriff's office have been eliminated as have the excuses by defendants that their geographic location hampers their ability to be on the program.

Participants with drug issues are required to submit to a urinalysis test at the direction of the testing agency or they are required to wear a drug patch. The drug patch is worn on the skin of a participant for up to seven days. The drug patch screens for: marijuana, cocaine, opiates, amphetamine/methamphetamine & PCP.

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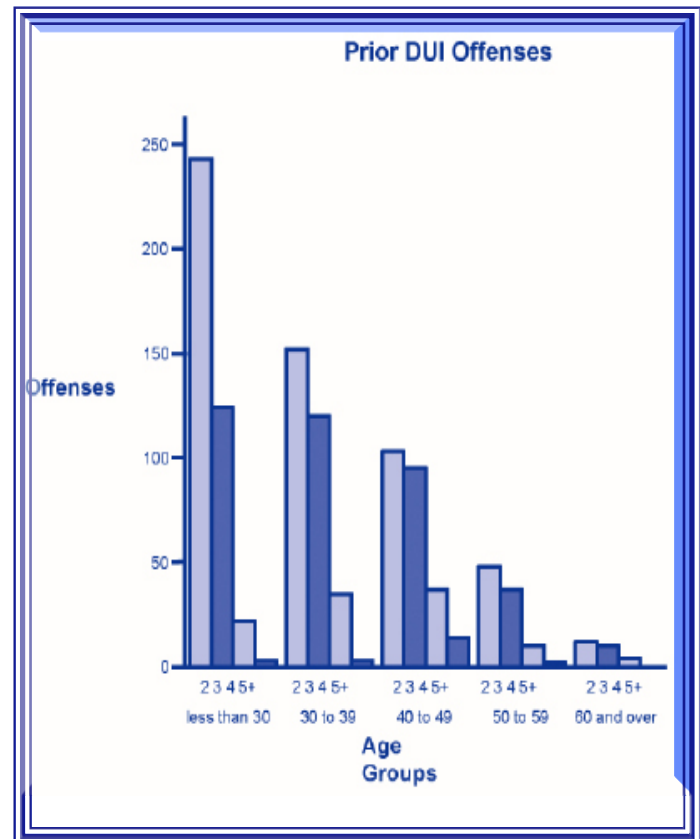
The 24/7 Sobriety Program, where 48% of participants have three or more DUI offenses, is producing significant positive results. To date, over 1.4 million alcohol breath tests have been administered to nearly 9000 defendants, who show up and blow a clean test 99.3% of the time. Over 8700 drug urinalysis tests have been administered to 893 defendants. Their pass rate is 97%. 83% of the 819 SCRAM bracelet wearers are alcohol free. The 28 drug patch participants have a 93.5% pass rate. Frequent testing and immediate sanctions can keep defendants free of alcohol and drugs.

The 24/7 Sobriety Program may also be impacting South Dakota's public safety and prison population. South Dakota had 191 alcohol-impaired driving fatalities in 2006. That number decreased to 146 in 2007, a 23.6% reduction. The South Dakota prison population has dropped from 3,428 to 3,378 in 2007 and dropped again to 3,344 in 2008. This reduction follows an average annual population increase of 152 for the previous ten years.

The 24/7 Program also won a Council of State Governments' 2008 Innovations Award. This award is given each year and highlights outstanding state programs that address a trend affecting the states and their future policies. This has been a great opportunity to give the program national exposure. Other states have expressed interest in the program and the North Dakota Attorney General's Office began a pilot of the 24/7 program

in January of 2008. A complete listing of the administrative rules, copies of forms and program statistics can be found at the South Dakota Attorney General's Web site at: <http://www.state.sd.us/attorney/DUI247/index.htm>.

In short, the 24/7 Sobriety Program has helped decrease both traffic fatalities and prison population. But even more valuable is the positive impact that freedom from alcohol and drugs is having on the lives of the offenders and their families. These long-term benefits are priceless.



*This article was originally found in **Between the Lines**, which is published quarterly by the American Prosecutors Research Institute's (APRI) National Traffic Law Center. Visit the website at http://www.ndaa.org/publications/newsletters/between_the_lines_contents.html.*

LAW ENFORCEMENT SENSITIVE



EL PASO INTELLIGENCE CENTER

DOMESTIC DRUG MOVEMENT TEAM BULLETIN EB08-101

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The Dangers Associated with Smoking Oxycontin® and Indicators of Its Use
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This document is the property of the Drug Enforcement Administration (DEA) and is marked Law Enforcement Sensitive (LES). Further dissemination of this document is strictly forbidden except to other law enforcement agencies for criminal law enforcement purposes. The following information must be handled and protected accordingly.

Overview

OxyContin® was introduced in 1996 and is commonly known on the street as OC, OX, Oxy, Oxycotton, Hillbilly heroin, and kicker. A marked escalation of its abuse has been reported by drug abuse treatment centers, law enforcement personnel, and health care professionals. Although the diversion and abuse of OxyContin® appeared initially in the eastern United States, it has now spread to the western United States, including Alaska and Hawaii. Oxycodone-related adverse health effects have increased markedly in recent years. (Source: DEA Website — <http://www.usdoj.gov/dea/concern/oxycontin.html>.) OxyContin® tablets are a controlled-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Approximately 50 percent of the OxyContin® tablet consists of sugars and time-release ingredients. The time-release component is a hydrocarbon that has a “greasy” characteristic (potential to coat the lungs). OxyContin® is an opioid agonist and a Schedule II controlled substance that can be abused in a manner similar to other opioid agonists, legal or illicit. The time-release ingredients slow down the effects of the drug, but when the OxyContin® is smoked, the user feels the effects in about 5 seconds

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(similar to the crack cocaine “high”). The immediate “high” of OxyContin® has an extremely strong addictive property. Additionally, Oxycodone HCl is highly acidic and chronic users may develop accelerated tooth decay — “meth mouth.”

The Food and Drug Administration has strengthened the warnings and precautions sections in the labeling of OxyContin®. There have been numerous reports of OxyContin® diversion and abuse in several states.

Some of these reported cases have been associated with serious consequences, including death. (Source: Food and Drug Administration Website at <http://www.fda.gov/NewsEvents/Testimony/ucm115180.htm>)

Smoking OxyContin®

The OxyContin® tablet can be ground into powder or left whole for smoking. However, if the tablet is ground, the charred residue appears as spots. Normally, the user rinses or rubs off (“sucks off”) the tablet coating before igniting the drug or “chasing the dragon.” The phrase similarly is used to describe opium and heroin use. Burning OxyContin® produces copious smoke, and the user puts his/her head over the smoke to inhale the fumes. The smoker may use a straw or tube to get a more direct concentration of the smoke. Pipes could be used to prevent loss of drug fumes, but normally are not, due to the high temperatures at which Oxycodone burns. The open foil provides a cooling effect and avoids burning the users’ lips. Individuals with legal prescriptions of OxyContin® do not perceive the “smoking” of OxyContin® illegal; the method simply produces the effects of the drug more rapidly than oral ingestion. The danger lies in the difficulty of controlling the amount of the drug that is inhaled leading to a high potential for overdose.



Foil Used to Inhale OxyContin®

Foil Backside Heated

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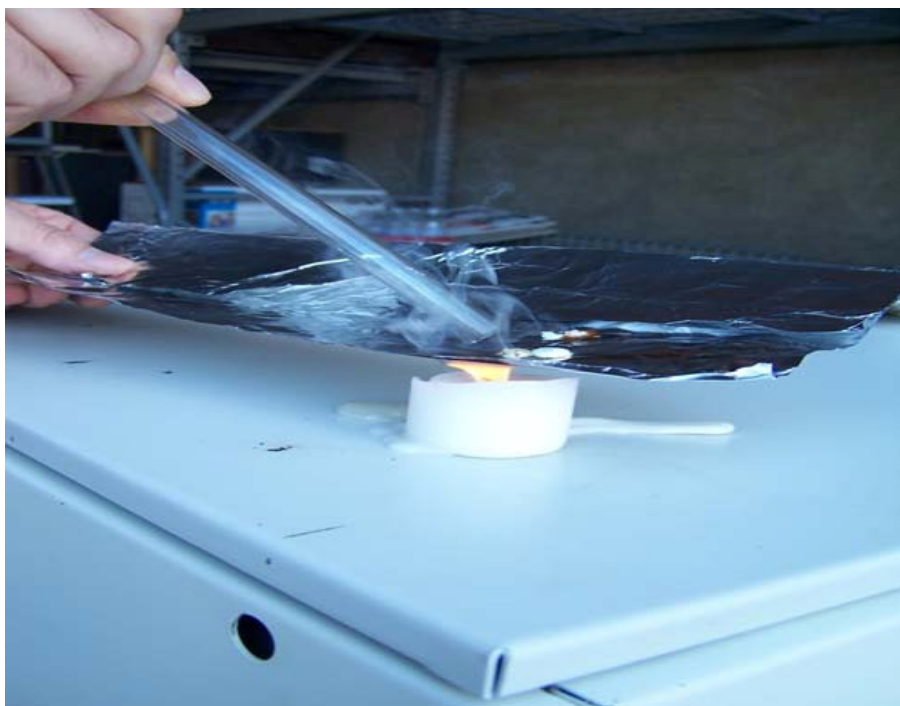
DEA San Diego Case

In late October 2008, the DEA San Diego, California, Field Division initiated an investigation involving a suspected distributor of OxyContin® in Southern California. The target was distributing the OxyContin® tablets from his residence in Poway, California. After a series of controlled purchases of the drug (\$60.00/tablet 80-OC) from the suspect, a search of the suspect's residence and vehicle produced the subject's arrest and the seizure of over 20 OxyContin® tablets, a variety of pills including Valium and Buprenorphine, gram-quantities of hashish /marijuana, and paraphernalia such as aluminum foil, a grinder, a pill splitter, a scale, prescription bottles, and syringes. Pieces of foil containing drug residue resembling magic marker lines/tracks (photos shown above) were seized from the vehicle and sent to the DEA Southwest Laboratory for analysis. Burnt drug residue on pieces of foil tested positive for Oxycodone. (Source: DEA San Diego, CA Field Division)

Officer Alert

According to a chemist at the DEA Southwest Lab, a field test for Oxycodone would not be accurate, since the overwhelming majority of the tablet vaporizes during the smoking process. Testing of the drug indicates that Oxycodone HCl burns at about 275 C compared to methamphetamine HCl (175 C) and cocaine base (100 C). The decomposition of the Oxycodone is a viable risk, since OxyContin® burns and melts at such high temperatures. However in this case, the Oxycodone remained intact.

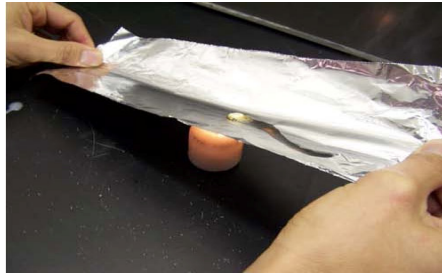
The photograph on the right depicts the process of "chasing the dragon." A chemist at the DEA Southwest Lab wiped off the outer green coating of the OC80 (Purdue Pharma) tablet, placed it on a piece of aluminum foil, and heated it using a candle. The vapors that were emitted would have been inhaled using a tube or some sort of pipe. In the lab, it showed that Oxycodone vapors would



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survive this heating process and were in fact analyzed using mass spectrometry. The other components in the tablet, the sugars and time-release materials, also vaporize and would be inhaled as well.

The picture at right shows the streak or “skid” that would result in the process of melting the tablets. The other picture shows the skid marks, which were confirmed to contain Oxycodone residue.



Please direct questions/inquiries to the DEA San Diego Field Division Group Supervisors John Partridge or Marilyn J. Andrews at 858-616-4100.

If you have any comments in reference to this report, please contact the EPIC Research and Analysis Section, Tactical Bulletins Unit, Acting Unit Chief Monika Barnum at (915) 760-2747.

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Five-Year Update on the Occurrence of Alcohol and Other Drugs in Blood Samples from Drivers Killed in Road-Traffic Crashes in Sweden

February 18, 2009

Jones AW, Kugelberg FC, Holmgren A, Ahlner J.

Department of Forensic Genetics and Forensic Toxicology,

National Board of Forensic Medicine,

Artillerigatan 12, SE-587 58 Linköping, Sweden.

According to statistics provided by the Swedish National Road Administration (Vägverket), a total of 1403 drivers were killed in road-traffic crashes in Sweden between 2003 and 2007. Forensic autopsies were performed in approximately 97% of all deaths and specimens of blood and urine were sent for toxicological analysis. In 60% of cases (N=835) the toxicology results were negative and 83% of these victims were men. The blood-alcohol concentration (BAC) was above the legal limit for driving (>0.2g/L) in 22% of cases (N=315) at mean, median and highest concentrations of 1.7g/L, 1.7g/L and 4.9g/L, respectively. The proportions of male to female drivers with BAC>0.2g/L were 93% vs 7% compared with 83% vs 17% for those with drugs other than alcohol in blood. Drivers with a punishable BAC were over-represented in single vehicle crashes compared with multiple vehicle crashes (67% vs 33%). The opposite held for drivers who had taken a prescription drug (39% vs 61%) and also for drug-negative cases (31% vs 69%). Drugs other than alcohol were identified in 253 cases (18%); illicit drugs only in 39 cases (2.8%), both licit and illicit in 28 cases (2.0%) and in 186 cases (13.3%) one or more therapeutic drugs were present. Amphetamine was the most common illicit drug identified at mean, median and highest concentrations of 1.5mg/L, 1.1mg/L and 5.0mg/L, respectively (N=39). Blood specimens contained a wide spectrum of pharmaceutical products (mean 2.4 drugs/person), comprising sedative-hypnotics (N=93), opiates/opioids (N=69) as well non-scheduled substances, such as paracetamol (N=78) and antidepressants (N=93). The concentrations of these substances in blood were mostly in the therapeutic range. Despite an appreciable increase (12-fold) in number of arrests made by the police for drug-impaired driving after a zero-tolerance law was introduced (July 1999), alcohol still remains the psychoactive substance most frequently identified in the blood of drivers killed in road-traffic crashes.

http://www.ncbi.nlm.nih.gov/pubmed/19232848?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum





22nd Annual
***Symposium on Alcohol and
Drug Impaired Driving Enforcement***

June 7 - 9, 2010; Naples, Florida

Keynote Speaker: Ms. Candace Lightner, MADD Founder

Candace Lightner founded Mothers Against Drunk Driving (MADD) in 1980 and is recognized by the American public and its leadership as the moving force behind reshaping the nation's attitude toward drunk driving. As MADD's Chief Executive Officer, President and Chairman of the Board, Ms. Lightner built MADD from a small California grass roots organization into an international corporation. Recognizing her years of dynamic leadership, the media voted Ms. Lightner one of the most influential American citizens of the twentieth century. Ms. Lightner's political acumen led to the successful passage of over 500 bills at the state and national levels, including legislation raising the drinking age to 21 -- a move credited with saving thousands of lives. She has testified before Congress, statehouses and committee hearings and has formed coalitions, such as SOS (Save Our Students) as powerful political tools.

Tentative Topics

- Realities and Myths of Eye Movements and Intoxication
- Principles of Eye Tests for Intoxication
- High Energy Drink Impairment
- Becoming Your Own Expert Witness: Perception vs. Testimony
- DUI Case Law Update
- Legislative Update
- Traffic Crash Reporting Workshop
- National Highway Transportation Safety Administration (NHTSA) Update
- Hardcore Drunk Driver Judicial Education Program
- Grant Writing Workshop
- Motorcycle DUI
- In-Car Video Use in DUI Enforcement
- Death Notification
- Advanced Scene Mapping with Lasers
- DHSMV Administrative Hearing
- Low Manpower Checkpoints

You must be present at 5:00pm on June 9th to receive your certificate.

Stay one extra day after the Symposium to take advantage of the following 8-hour training opportunity:

June 10, 2010; Naples, Florida

DRE Recertification Training*

As required by the Drug Evaluation Classification Program international standards, every DRE must receive a minimum of 8 hours of recertification training within two years of their most recent certification. This program will fulfill the requirements of the mandatory 8-hour training.

Hotel Information:

The Naples Beach Hotel & Golf Club
851 Gulf Shore Boulevard North • Naples, Florida 34102
Reservations: (800) 237-7600
Phone: (239) 261-2222 • Fax: (239) 261-7380
Website: www.naplesbeachhotel.com

The rate for single/double occupancy is \$99 per night. The cut-off date for that rate is May 6, 2010. Please identify yourself as an **IPTM Symposium on Alcohol and Drug Impaired Driving Enforcement** student when calling for reservations to receive the group rate.

Course Fee

The course fees include tuition, a student reference manual and study materials. We accept checks, cash, agency purchase orders, VISA, MasterCard, Discover and American Express cards.

Lodging

Lodging and food are the responsibility of the student. However, the Naples Beach Hotel & Golf Club is offering a special rate to IPTM program participants. For more information, please visit our website at iptm.org or call us at (904) 620-IPTM.

Transportation

The Naples area is served by several major airlines. Ground transportation information will be included upon confirmation of enrollment.

Registration

To enroll, complete the attached registration form and return it to IPTM or register on-line at iptm.org. You will receive a confirmation letter acknowledging your written registration.

Note:

Please do not make airline or hotel reservations until you receive written enrollment confirmation from IPTM.

Continuing Education Credits

Continuing Education Units (CEUs) are available for a \$7.00 fee through the Institute of Police Technology and Management, a division of the University of North Florida. One unit is awarded for each ten contact hours. Forms will be provided in class for interested participants.

American Disabilities Act Program Accessibility

Individuals who require reasonable accommodations in order to participate must notify the registrar at (904) 620-IPTM at least five working days prior to the class.

Website

For the latest listing of all IPTM courses, please visit our website at: iptm.org. While there, you can check out dates, locations and course descriptions, learn about tuition grant availability for Florida officers and visit our on-line store.

Contract Courses

Bring IPTM to your agency by hosting one or more of our professional training programs at your location. You can reduce your training costs while providing your employees with courses that are tailor made for your agency. Contact our On-Site Training Coordinator at (904) 620-4786 for more information on this cost saving training alternative.

Institute of Police Technology and Management University of North Florida

Registration Form

(Please type or print)

NAME _____ SS# _____

ORGANIZATION _____ TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____ FAX _____

E-MAIL _____

Course Title: **Symposium on Alcohol and Drug Impaired Driving Enforcement**

Course Dates: June 7 - 9, 2010; Naples, Florida

Course Fee: \$395

Yes, I would like to attend the following 8-hour course being held on June 10, 2010:

Course Title **DRE Recertification Training; \$195**
and fee:

Please do not make airline or hotel
reservations until you receive written
confirmation from IPTM.

You can also register on-line at: www.iptm.org

Americans with Disabilities Act Program Accessibility: Individuals who require reasonable accommodation in order to participate must notify the registrar at (904) 620-IPTM at least five working days prior to the class.

Authorizing Official

NAME _____ TITLE _____

REGISTERING PERSON'S E-MAIL _____

PURCHASE ORDER NUMBER _____ or [] FEE ENCLOSED

Make checks payable to: Institute of Police Technology and Management

[] SEND INVOICE TO _____



Return to:
Institute of Police Technology and Management
University of North Florida
12000 Alumni Drive
Jacksonville, Florida 32224-2678
Phone: (904) 620-IPTM ~ Fax: (904) 620-2453
website: www.iptm.org