On the frequent detection of drugged driving in Norway

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ABSTRACT

Drugged driving (DD) is detected frequently among Norwegian drivers, at a relative rate which is probably the highest in Europe. The Norwegian Road Traffic Act against DD requires documentation of "influence" (impairment), which during last 10-15 years has been developed into a system of taking a blood sample (by force if needed) on due suspicion, accompanied by a clinical examination by a police physician, analysis of all blood samples in one national institute with standardized (broad) screening and confirmation analyses, and reporting of interpreted quantitative results. Further key points are the use of written expert statements based on the results of the clinical examination and drug analysis, and the acceptance by the courts of such statements. The drugs most frequently detected the last years are THC, amphetamine and benzodiazepines, the latter usually in concentrations above therapeutic levels. In most cases the DD suspects appear to represent drug abusers with a high rate of recidivism to DD. Accordingly other countries with drug abuse problems comparable to Norway, might have a marked upward potential for detection of DD. Points of importance for the frequent detection are ample use of roadside breath alcohol screening, low thresholds for requesting blood sampling and clinical examination shortly after the driving episode and the courts' acceptance of expert witness statements integrating analytical and clinical results with general knowledge about the drugs in question.

INTRODUCTION

For several years drugged driving has been detected frequently among Norwegian drivers, during recent years, almost as often as drunken driving. In 1998 the detection rate of drugged driving was 750 cases per 1 million inhabitants compared to 190, 90, 40 and 30 in Finland, Sweden, Denmark and UK, respectively. This difference could be due to either that drugged driving occurred much more frequently in Norway than in other European countries, or that a higher proportion of the existing drugged driving was discovered by the police in Norway. With respect to the first possibility, statistics on drug abuse in general do not place Norway in a special position among European countries. There appears to be no reason to believe that drug users drive more frequently in Norway than in other countries,

although this possibly cannot be ruled out completely due to lack of information on this particular subject. If we assume that there are no substantial differences between Norway and other European countries in this respect, the second possibility should be considered. Accordingly reasons for the high detection rate in Norway should be looked for in the way the system on Norwegian drugged driving is operating to see if this procedure could give some clues to the observed difference in drug detection.

LEGAL ISSUES

The Norwegian Road Traffic Act was extended in 1959, to include driving under the influence of drugs other than alcohol. Norway had already at that time a long tradition in law regulation for driving under the influence of alcohol. As the first country in the world, a fixed blood alcohol concentration (BAC) legal limit (0,05%) was introduced in 1936. Since 1959, the police have been allowed, if drug influence is suspected, to request blood analysis for illegal and prescribed drugs affecting driving performance. There is no legal limit for drugs other than alcohol and impairment has to be proven for the court in each individual case. The court decision is based on the outcome of a clinical examination performed at the time of blood sampling, results from blood drug concentration measurements including interpretation, and in most cases an expert witness statement (see below). The sentences for driving under the influence of alcohol or drugs are fines, conditional or unconditional imprisonment, depending of BAC or the degree of drug impairment. In addition, the driving licence is withdrawn usually for at least two years (Christophersen, Mørland 1997).

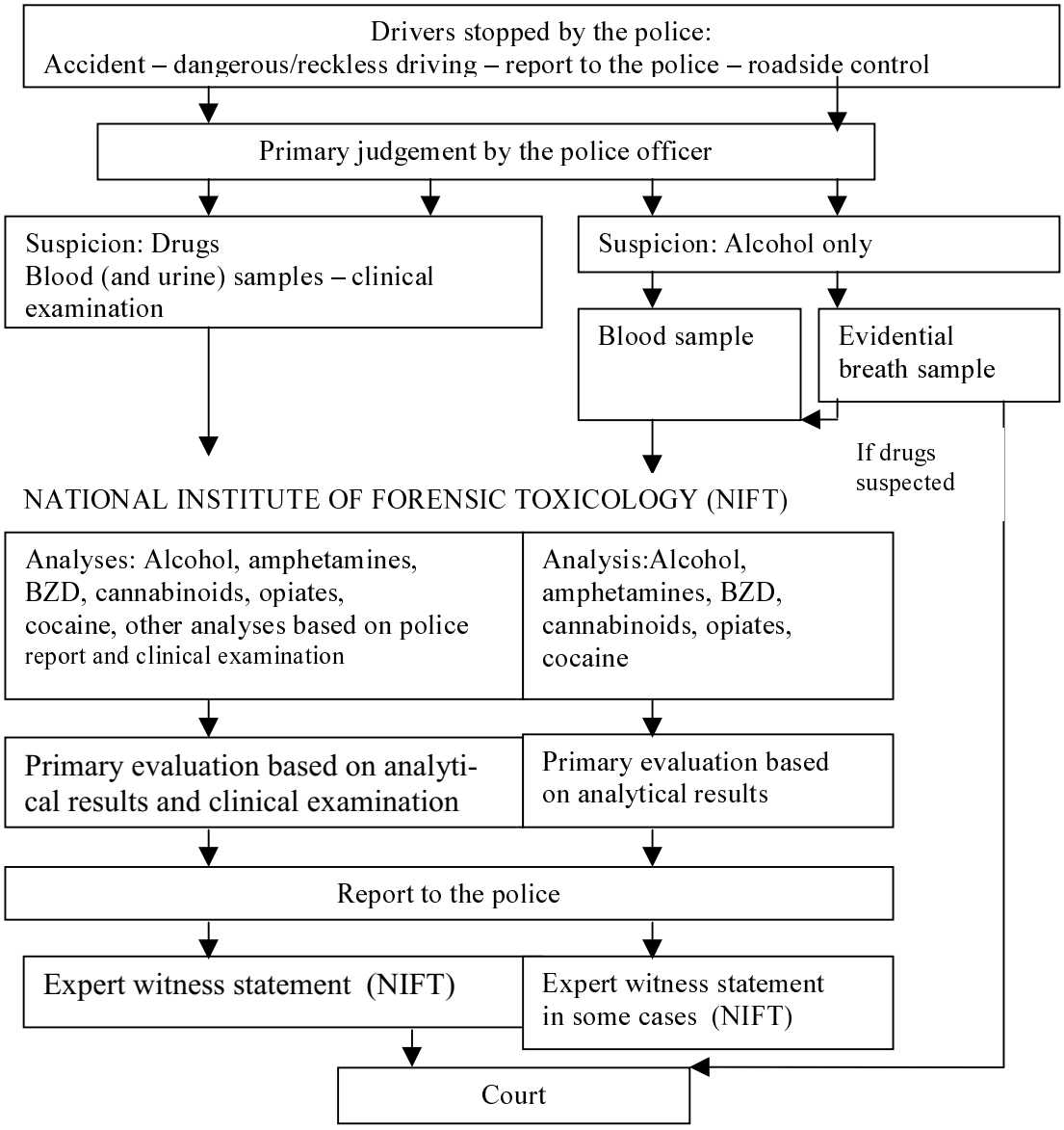
CASE HANDLING FROM APPREHENSION ON THE ROAD TO FINAL DECISION IN COURT

A drugged driving case starts in Norway by the police being called to a scene of a car accident, by the police or witness observing reckless or dangerous driving, by the police performing speed controls or sobriety roadblock checks. Some standard routines have developed during the last 10-20 years to the present state summarised on the flow chart.

Shortly after the police suspect possible drug influence, the driver is taken to a police physician or another ”neutral” physician for clinical examination combined with blood and urine sampling. The biological samples are always analysed by the same national institute (National Institute of Forensic Toxicology - NIFT) by a rather broad analytical program, encompassing most drugs of abuse as well as some medicinal drugs, which might cause impairment. In 1996, the Norwegian Parliament decided that all blood samples taken from drivers suspected to be influenced by alcohol only, should also be analysed for drugs. The decision was mainly based on former Norwegian studies documenting high frequencies of drugs among drivers apprehended due to the suspicion of alcohol only (Christophersen et al. 1990, Mørland et al. 1995). As elsewhere in forensic toxicology, all positive screening results are confirmed and quantified by GC/MS or other alternative methods. The results of the analysis are evaluated together with the results from the clinical examination (which accompany the blood samples to NIFT). This evaluation is reported back to the police with a recommendation with respect to which cases that should probably be dropped and which that could be followed up. The police might then request an expert witness statement on the chance of impairment after equipping NIFT with further information on the case. The written expert statement concludes on the probability of impairment from ”not impaired” through ”impairment cannot be excluded”, ”possibly impaired”, ”likely

impaired" to "impaired". The police can then decide to bring the case to court. The Norwegian courts put great emphasis on such expert witness statements based on the integration of blood drug concentrations, clinical examinations and general knowledgement about the drug(s) in question (Mørland 2000). The experience so far has shown that the driver is very often sentenced when the expert witness statement concludes on "likely impaired" or "impaired". More than 90 % of cases with these conclusions end with a court sentence (Christophersen, Mørland 1997).

Flow chart: handling of drunken and drugged driving cases in Norway



WHICH DRUGS WERE DETECTED?

During the 1990ies, the number of drivers apprehended by the police due to the suspicion of drugged driving has increased more than 100%, while the number of drivers apprehended due to

the suspicion of influence by alcohol only, has decreased more than 50%. In 1998, the average number of different drugs detected in drug positive samples besides alcohol was 2.6. The most frequent drugs found were tetrahydrocannabinol, amphetamines and BZD (mainly diazepam and flunitrazepam). In very few cases the BZD findings appeared to reflect therapeutic prescription as judged from the drug concentrations measured and coexistence of other drugs in the sample. Blood alcohol concentrations (BACs) above the legal limit of 0.05 % were found in 33% of the samples. The increase in the occurrence of amphetamine and heroin (detected as the metabolite 6-MAM) represents the most marked changes among Norwegian drugged drivers during the 1990ies. The number of amphetamine positive cases has increased more than 5 times and 6-MAM was hardly found among apprehended drivers in 1990, while detected in 320 cases during 1998.

CHARACTERISTICS OF THE NORWEGIAN DRUGGED DRIVER

The most frequently apprehended Norwegian drugged driver was a man (85-90%), 25 – 35 years old, 60-70% were multi-drug users (alcohol not included). Illegal drugs were frequently found in combination with prescribed drugs, mainly at blood concentrations representing higher intakes than recommended therapeutic doses. The majority of the drugged drivers had earlier been arrested for the same offence (Christophersen et al. 1997). A retrospective study of amphetamine drugged drivers apprehended in 1995, showed than 70% had earlier been arrested for drunken or drugged driving and alcohol was the most frequently detected drug at the first offence (Skurtveit et al. 1999). Drugged drivers had also a high risk of being rearrested subsequently for the same offence (about 50% within three years), which was approximately three times higher than the rearrest rates among drunken drivers (Christophersen et al 1997). The mortality among arrested drugged drivers was high (Skurtveit et al. 2000).

POINTS OF POSSIBLE RELEVANCE FOR DETECTION OF A HIGHER PROPORTION OF DRUGGED DRIVERS IN NORWAY

The Norwegian Road Traffic Act dealing with drugged driving (impairment law) seems at first glance not to represent a system that would lead to frequent blood sampling on the suspicion of drugged driving. The critical factor is thus probably not the law system (e.g. whether there is per se law or an impairment law), but rather the results the police observe they can obtain through the system in operation.

Control frequency of impaired drivers. Traffic accidents are often the events leading to further investigation of impaired driving, and accordingly the frequency of accidents if high, could contribute to high detection rates. This is, however, not a likely explanation, since Norway has among the lowest fatality rates from roadside accidents in Europe. Another factor might, however contribute to more frequent controls. Among Norwegian drivers there is a general negative attitude towards impaired driving, and suspicious driving behaviour is often reported to the police by other drivers on the road. The high density of cellular phones among the (driving) population, facilitates this type of communication to the police. Roadblocks and roadside controls are probably no more frequent in Norway than in other countries.

Low thresholds for further investigation by the police. There are thus no data indicating that encounters between drivers and police occur more frequently in Norway than in other countries. The point seems however, to be that a request for a blood sample for drug analysis is a much more frequent result in Norway than elsewhere. Approximately 1 million alcohol breath

screening tests are performed each year, in a population of 4.3 million. There is a very low threshold for performing such tests and in general no suspicion on impaired driving is needed. The undertaking of this test gives the police officer time to talk with the driver, to observe the driver and his behaviour, also in relation to the result of the alcohol screening test. Based on these informations and observations, the police officer often get the suspicion that drugs are involved and further action can be taken, according to the routine illustrated in the flow chart. There is generally a low threshold for further action, and a blood sample can be taken by force if found necessary. The frequent use of alcohol breath screening in Norway might be an important factor in the frequent detection of drugged driving and probably also in preventing drunken driving. Roadside test devices for drugged driving have so far not been in use in Norway.

A clinical examination is performed in more than 95 per cent of the cases of suspected drugged driving, usually within two hours after the driving episode. The role of the police physicians should particularly be mentioned. By performing the clinical examination and taking a drug history shortly after the apprehension they often add important information to the case and provide objective evidence on impairment observed to the courts. It should also be stressed that these physicians have no possibility of rejecting a case where e.g. the driver shows a prescription of a certain drug or make other claims that possible drug findings might be referred to treatment for disease. The physician is operating as a consultant for the police he makes observations and notes, but has no right to interfere with the further handling of the case.

Analytical repertoire. The Road Traffic Act is based on the impairment principle covering all psychoactive drugs affecting the driving performance and is not restricted to specific drugs. The system opens for an extended analytical program to be performed by NIFT, based on information from the clinical examination or the police report, but not restricted to the repertoire suggested on the police or the police physician. This might contribute to some extent to frequent drug detections.

Correctness of primary suspicion. The high nationwide detection of drugged driving could have been a result of (uncritical) submission of a large amount of samples with a low percentage of drug findings. This appears not to be the case. From the table it appears that one or more drugs were found in (55.4 + 12.6) 68 per cent of the samples submitted on the suspicion of drugged driving.

	Drugged driving		**Drunken driving**	
	n	%	n	%
Samples positive for drugs only	2404	55.4	42	1,5
Samples positive for alcohol only (BAC >0,05%)	887	20.5	2124	76,8
Samples positive for both drugs and alcohol	547	12.6	221	8
Samples with no detections	498	11.5	378	13,7
Total	4336	100	2765	100

On the other hand, in blood samples submitted to NIFT where the primary suspicion was drunken driving, drugs were detected in 9.5 per cent of the cases (n=263), in most cases together with alcohol (see table).
There is no obvious reason for the correct suspicion by the police in so many cases. The

Norwegian police officers are not particularly well trained with respect to recognise symptoms of drug influence. Drug recognition expert programs have been introduced recently, but have not been a part of the education of the major part of the Norwegian police force. Still drugs are demonstrated in blood samples of 68 % of the cases sent to analysis, indicating a rather high degree of correct police suspicion.
Which other clues exist then to explain the frequent and correct suspicion by the police? Two factors might be of importance. The Norwegian police force is organised in rather small units, which in general have obtained a high level of knowledge about the local population. This local police often know the suspects as people with previous drug problems. As drugged drivers have a high rate of criminal recidivism, they might be known to the police as previous and potential drugged drivers when they are observed behind the wheel. In such cases the police suspicion will be present by the mere observation of the driving of the former drugged driver. Another factor is a routine, which the police have developed during the later years. Any time findings of tablets, cannabis, other drugs, needles or syringes are done in a car or on people in a car, the driver is suspected of drugged driving regardless of overt signs of impairment.

Sensible use of evidential breath testing instruments. In 1996 evidential breath testing of drunken driving was introduced and approximately 50 % of the drunken driving cases in Norway is presently covered by this method. How police officers are trained to handle a case after the use of evidential breath alcohol testing appears to be critical. In some police districts, a setback for the detection of drugged driving was observed when evidential breath test instruments were introduced. By focusing on the question on whether alcohol was present at the time of testing or not, it appeared that some police officers forgot to think of other possibilities underlying impairment, although it was stressed that they should consider the involvement of other drugs in such cases. This problem seems to be better under control now, but shows that too much focus on alcohol can in fact be counterproductive to the detection of drugged driving.

CONCLUSION

In conclusion it is not easy to find a single factor within the Norwegian system that explains why this country has a high rate of detection of drugged driving. The most important point might be what can be summarized as the experience factor. Through its operation on the existing legal background, the system has given the police the experience that people apprehended under the suspicion of drugged driving very often have drugs in their blood samples, and that they often are impaired by these drugs. Furthermore the courts appear to react to the cases brought to the courtrooms to the general satisfaction of the police. This can be seen as a learning process. The police learn that if cases fulfilling certain criteria during the process are taken to court, the police succeeds. Thus even a rather complicated and individually impairment based system like the Norwegian, might through the way is has established its function, act to lower the threshold for the police to investigate suspected drugged driving. It is quite possible that other systems e.g., based on per se laws might be effective too, to increase the drug detection rate . The critical factor is probably not the law system, but the results the police observe they can obtain through the system in operation.

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