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COORDINATOR COMMENTS

by Sergeant Timothy Plummer

It's hard to believe that the first quarter of 2008 is quickly coming to a close and that spring is just around the corner. With the coming of spring comes the Oregon Drug Evaluation and Classification (DEC) Program, Drug Recognition Expert (DRE) School.

The DRE Pre-School will be April 29 and 30, with the DRE Full School running May 1 - 9, 2008. This portion of the training will be conducted at the Oregon Military Academy in Monmouth, Oregon. Certification Training will once again be held in the Portland area. The scheduled dates for certification training are June 4-7 and June 11-14, 2008.

Senior Trooper Mike Iwai has agreed to be this year's Course Manager. There remain teaching assignments not filled. All interested DRE Instructors should contact Senior Trooper Iwai with their available dates. Certified Instructors and DREs interested in being "trackers" during Certification Training should also contact Senior Trooper Mike Iwai for scheduling.

The Oregon DUII Multi-Disciplinary Training Task Force held their Annual Impaired Driving Training Conference March 14 & 15, 2008, at the Riverhouse Hotel and Conference Center in Bend, Oregon. As part of the conference the Task Force holds award presentations during the conference luncheons. Recognition is given to groups and individuals whose efforts have contributed to the safety of Oregon's highways and communities through impaired driving prevention, enforcement, treatment, education and adjudication.

This year the Task Force recognized several Oregon DREs for their contribution and outstanding efforts.

DUII Enforcement Officer-of-the-Year:
City Officer-Officer Darke Hull, a DRE with the Portland Police Bureau.
Sherrif's Office–Deputy Dustin Newman, a DRE with the Polk County Sheriff's Office.
State Police–Trooper James Duncan, a DRE out of the Tualatin Worksite.

DRE Officer-of-the-year:
City Officer–Officer Trevor Arnold, Medford Police Department.
Sheriff's Office–Deputy Russ Olson, Lane County Sheriff's Office.
State Police–Trooper Freddie Dunlap, Coos Bay Area Command.

DUII Trainer-of-the-Year:
Senior Trooper Mike Iwai, a DRE with the Oregon State Police, Salem Area Command.

Senior Trooper Maria Mignano Dedication to Duty Award:
Senior Trooper James Pierce, a DRE with the Oregon State Police, Astoria Area Command.

(Continued from Page 1 – Coordinator Comments)

If you have a chance to contact these individuals, be sure to offer them your congratulations. This is a continued reflection of the hard work and dedication of the men and women of the Oregon DEC Program. Congratulations to the award winners and keep up the good work.

Another opportunity for the Oregon DEC Program to lead the way in reducing impaired driving incidents and save lives is on the horizon.

The 2006 National Survey on Drug Use and Health (NSDUH) reports that the level of underage drinking, ages 12 to 20, has remained unchanged since 2002, at 28.3 percent. Approximately 7.2 million underage youth aged 12 to 20 (19 percent) were binge drinkers. Binge drinking is defined as five or more drinks on the same occasion at least 1 day in the 30 days prior to the survey. *http://oas.samhsa.gov/NSDUHLatest.htm*

As a result of this type of information there is a state and national effort going forward to reduce underage drinking. One aspect of this effort is the organization of local "Town Hall Meetings on Underage Drinking." I would encourage Oregon DREs to become involved in these discussions in your local areas to lend your expertise in formulating plans to address this issue. Listed are the areas where meetings have already been scheduled in April along with a web link to the organizations conducting town hall meetings. Talent, Condon, Gladstone, Hood River, Newport, Ontario, Pendleton, Portland, Gresham, Roseburg, The Dalles, and Tigard.

http://www.stopalcoholabuse.gov/townhall/flashmap/2008/eventlist.aspx?id=39

ALCOHOL, ENERGY DRINKS, AND YOUTH: A DANGEROUS MIX

Big Alcohol's Cross-over Brands Creating Confusion, Health Risks

Alcohol companies are finding increasingly dangerous ways to hook the nation's youth and fuel the underage drinking epidemic. That is the conclusion of a new report, *Alcohol, Energy Drinks, and Youth: A Dangerous Mix*, released by Marin Institute at the Underage Drinking Enforcement Training Center annual conference in Orlando. The report examines the alcohol industry's youth-oriented marketing tactics promoting the consumption of alcoholic energy drinks, such as Bud Extra, Tilt, Sparks, and Rockstar 21.

"The alcohol industry is irresponsibly marketing alcoholic energy drinks to youth," says Michele Simon, JD, MPH, Research and Policy Director for Marin Institute and co-author of the report with James Mosher of Pacific Institute for Research and Evaluation. "They boast that their products will enhance energy and alertness, in potential violation of federal law," says Simon.

Alcoholic energy drink producers have built on the popularity of non-alcoholic energy drinks by promoting the mixing of energy drink products with alcohol and by marketing premixed alcoholic energy drinks in cans that look virtually identical to their non-alcoholic cousins.

"Alcohol producers are taking advantage of the popularity of non-alcoholic energy drinks to sell their products to youth," added Mosher. "They package their products so that they are indistinguishable from non-alcoholic energy drinks, confusing consumers, retailers, parents, law enforcement officers, and others who can't tell which drinks contain alcohol and which do not."

Mixing alcohol with energy drinks presents several potential health and safety risks. While young people may think that caffeine, a stimulant, masks the intoxicating effects of alcohol, research shows this is not the case. As a result, people drinking these products may mistakenly think they are less drunk than they are, and engage in dangerous activities. Youth are especially vulnerable to health and safety problems from consuming alcoholic energy drinks because they are more likely to take risks and suffer from higher rates of alcohol problems, including traffic accidents, violence, sexual assault, and suicide.

In April, 29 state attorneys general sent a letter to Anheuser-Busch expressing their concern over Spykes, an alcoholic energy drink packaged in colorful 2-ounce plastic bottles with obvious appeal to youth. The objections of law enforcement officials as well as parents, leading public health organizations and alcohol advocacy groups caused Anheuser-Busch to pull Spykes, but numerous similar products remain on the market, with more in the pipeline.

"We call upon makers of alcoholic energy drinks, including Miller Brewing Company and Anheuser-Busch, to stop selling these products." Simon said.

(Continued from Page 2 – Alcohol Energy Drinks)

"Our report also recommends that the federal government and state attorneys general investigate potentially deceptive marketing, particularly aimed at youth. In the meantime, local communities and state legislatures should consider banning these products to protect our youth from being targeted by Big Alcohol."

Information obtained from Join Together, August 3, 2007

CHALLENGES AND DEFENSES IN DUII-DRUG CASES

By Deena Ryerson
Oregon Impaired Driving Resource Prosecutor

Part I: Attacks on the Drug Recognition Expert

The Drug Recognition Expert (DRE) is an integral part of any DUII case in which the driver's impairment was caused, in whole or in part, by drugs. The DRE receives extensive training in order to detect whether a person is under the influence of drugs or, just as importantly, whether drugs can be ruled out as the cause of impairment. Because of the scientific nature of the drug recognition evaluation, the DRE's qualifications for determining whether a driver is under the influence of a drug (other than, or in addition to, alcohol) is at issue and can be attacked in any number of ways.

One of the challenges that DREs face most commonly is convincing the judge or jury that DREs are not "just cops." The defense will argue that DREs do not have any medical expertise, or that they do not receive any training that qualifies them to perform the medical components of the drug evaluation, let alone to determine whether a person is under the influence of drugs. To meet this type of challenge, it is crucial to emphasize the basis of the DRE's expertise, including the DRE's training, knowledge and experience.

First, DREs undergo a rigorous training course that is based on a nationally-accepted curriculum and is taught by both medical personnel and qualified DREs. Even though a DRE is not a doctor, illicit through your DRE on direct examination that the medical components of the DRE evaluation – *i.e.* taking pulse, blood pressure and body temperature – are not difficult. Parents take their children's temperatures all the time and many people monitor their own blood pressure. DREs also receive hands-on training by conducting drug evaluations on 12 people who are under the influence of drugs. The DRE's opinions are then confirmed by toxicology tests performed on samples drawn from the 12 subjects. To become certified, a DRE must pass several written tests and achieve a high level of accuracy in toxicology confirmations.

Second, other than emergency room physicians, jail doctors or DREs themselves, very few people experience regular opportunities to observe persons who are under the influence of drugs, specifically illegal drugs. Just as a lay person is able to give an opinion as to alcohol impairment, someone who is constantly exposed to persons who are under the influence of a particular drug or drug category can identify the impairment caused by the substance because of the common signs and symptoms unique to the drug category. In fact, DREs in Oregon have been called upon to instruct emergency room doctors and technicians and nursing school students on these common signs and symptoms.

Third, DREs do not need to understand exactly how a drug works in order to recognize its effects. The defense may argue that the DRE's opinion is unreliable because the DRE does not know how a drug causes a certain sign or symptom (*i.e.*, "Officer, how does that drug elevate the heart rate?"). In reality, even medical researchers do not know the mechanisms by which each drug (even a prescription drug) causes every sign or symptom. The effects of a particular drug become known through observation, trial and error. If this argument is raised, illicit from your DRE on re-direct (or while cross examining the defense expert) the following statement found frequently in Physician's Desk Reference: "The exact mechanism of action of this drug remains unknown."

Fourth, the defense often argues that the DRE does not know the particular person's normal vital signs, and therefore, is unable to determine conclusively whether the observed symptoms and behaviors are truly signs of impairment. It is important to point out that standards exist within the medical community that define the normal range for pulse, blood pressure and temperature, and the vast majority of people fit within these normal ranges. Moreover, not only is the DRE seeing vital sign levels outside the normal range, but also is observing other outward signs of impairment. Vital signs are only one factor in the DRE's opinion.

Finally, DREs are often attacked as being biased. The defense argues that a DRE is predisposed to decide that an arrested driver is under the influence of drugs, rather than admit that the arresting officer made a mistake. Have your DRE point out that it is important that the DRE confers with the arresting officer before forming an opinion. This is because the information may assist in determining whether the impairment is caused by a medical condition,

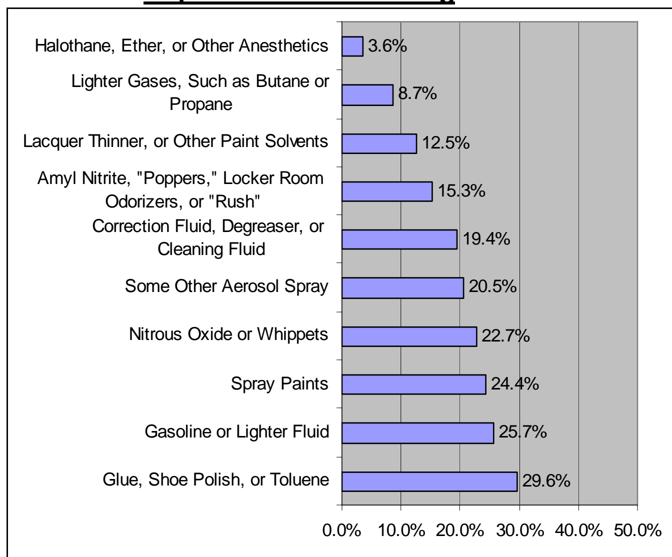
(Continued from Page 3 – Challenges and Defenses)

poly-drug use, or whether the impairment is coming from the type of drug that acts quickly and therefore impairment is less apparent at the time of the evaluation. Also, the officer can inform the DRE of any drugs found at the scene or statements of the defendant. The issue of bias becomes less significant when the DRE has a toxicology report to confirm their opinion of the cause of impairment.

If you focus on the officer's extensive training, hands-on experience and, in most cases, the confirmatory toxicology test verifying the DRE's opinion, you will be able to handle most challenges raised by the defense in this type of case.

More Than One-Half a Million Adolescents Use Inhalants for the First Time Each Year

An annual average of 593,000 adolescents ages 12 to 17 use inhalants for the first time each year, according to combined data from the 2002 to 2006 National Household Survey on Drug Use and Health. The most frequently mentioned types of inhalant used were glue, shoe polish, or toluene (29.6%); gasoline or lighter fluid (25.7%); and spray paints (24.4%)—household products that are readily accessible to many youths. Younger adolescents (ages 12 to 15) were most likely to use these three types of inhalants, while older youths (ages 16 or 17) were more likely to use nitrous oxide or whippets (43.4% and 59.3%, respectively; data not shown). For more information about inhalant use, visit the National Inhalant Prevention Coalition's website at http://www.inhalants.org.



Types of Inhalants Used by Youths Ages 12 to 17 Who Reported Using Inhalants for the First Time in the Past Year, 2002 to 2006

Information obtained from Cesar Fax
March 24, 2008, Vol. 17, Issue 12

COCAINE MAY CAUSE HEART ATTACK SYMPTOMS

DALLAS—Younger ER patients with heart attack symptoms should be asked if they've recently used cocaine, which can cause similar chest pain, the American Heart Association warns doctors. For these patients, honesty can be a matter of life or death: Some heart attack treatments can be deadly to someone using cocaine.

New guidelines published online Monday in the American Heart Association journal Circulation say that emergency room doctors need to be aware that symptoms of a heart attack in younger patients with no heart disease risk factors may be caused by cocaine use.

The drug can cause chest pain, shortness of breath, anxiety, palpitations, dizziness, nausea and heavy sweating—all symptoms of a heart attack.

"Not knowing what you are dealing with and giving the wrong therapies could mean death rather than benefit," said Dr. James Reiffel, professor of clinical medicine at Columbia University Medical Center/ New York Presbyterian Hospital.

The number of cocaine-related users visiting ERs rose 47 percent from 1995 to 2002, increasing from 135,711 to 199,198, according to the government's Substance Abuse and Mental Health Services Administration. (That's a tiny percentage of the more than 100 million patient visits to emergency rooms each year.)

"The symptoms that they get with the cocaine are very similar to a heart attack," said Dr. James McCord, who chaired the statement writing committee.

Cocaine can cause a heart attack, but only about 1 percent to 6 percent of patients with cocaine-associated chest pain actually have a heart attack, the statement says. Still, doctors say it's important for anyone with chest pain to get it checked out.

Cocaine increases blood pressure and the heart rate, constricting arteries into the heart, said McCord, cardiology director of the chest pain unit for the Henry Ford Health System in Detroit.

"Your heart rate goes up because your heart needs more oxygen, then it shrinks the arteries to the heart," McCord said.

The statement says that since most cocaine-associated chest pain isn't a heart attack, such patients should be monitored instead of being admitted to the hospital. They would have an electrocardiogram and other tests to rule out a heart attack.

(Continued from Page 4 – Cocaine may cause heart attack symptoms)

"If you admit everyone to hospital with chest pain, you use valuable resources," said Reiffel.

Two typical heart attack treatments can be dangerous to those using cocaine:

— Clot-busting drugs carry an extra risk of bleeding into the brain in patients whose blood pressure is high due to cocaine use.

— Betablockers that can lower blood pressure without constricting arteries in typical heart attack patients have the opposite effect in cocaine users, raising blood pressure and squeezing cocaine-narrowed arteries.

Information obtained from ContraCostaTimes.com
By Jamie Stengle Associated Press Writer
3/18/2008

PRESCRIPTION DRUG ABUSE

What's the issue?

Misuse, abuse and diversion of prescription drugs are a threat to public health and safety.

Many people believe prescription drugs are safer than illicit drugs. While prescription medications are legal and important resources, data indicate prescription drug abuse is the most rapidly increasing form of substance abuse.

Nationally more persons initiated nonmedical use of narcotic pain relievers in the past year than initiated use of marijuana or cocaine.

Abuse of prescription medications can be a gateway to further illicit drug use, such as methamphetamine, heroin and crack cocaine. National data show many persons abuse pail relievers before using other drugs.

What does it mean for Oregon?

The National Survey on Drug Use and Health asked individuals if they used prescription drugs for nonmedical purposes.

Results for Oregon show:

- One out of every four adults in Oregon will abuse prescription drugs in their lifetime.
- The rate of nonmedical use of pain relievers in Oregon is higher than that of the nation.

Compared to the rest of the nation, Oregon ranks among the top ten states for:

- Annual abuse of prescription drugs for all ages (228,000 persons per year)
- Past year abuse of prescription drugs by youth 12 to 17 (34,000 persons per year)
- Past year abuse of prescription pain relievers (177,000 persons per year)
- Past year abuse of prescription stimulants (55,000 persons per year)

How does it affect health care?

Based on national data from the Drug Abuse Warning Network, of those hospital emergency room visits involving drug misuse or abuse:

- 25% involved pharmaceuticals alone,
- 8% involved illicit drugs with pharmaceuticals, and
- 14% involved illicit drugs with pharmaceuticals and alcohol.

In a study by the National Center on Addiction and Substance Abuse, physicians and pharmacists identified the three most common methods of prescription drug diversion:

- Doctor shopping,
- Forged or altered prescriptions, and
- Patient deception or manipulation of doctors.

In the same study, 28.9% of the pharmacists indicated they had experienced theft or robbery of controlled drugs with the last five years.

Successful Approaches

The National Center on Addiction and Substance Abuse recommends comprehensive and collaborative efforts that:

Train health care professionals,
Safeguard controlled prescription drugs from children,
Educated the public on the dangers of prescription drug abuse, and
Strengthen monitoring and enforcement to prevent and detect diversion through Prescription Drug Monitoring Programs (PDMPs).

PDMPs focus on identifying patterns of controlled substance prescription drug dispensing in the state. An important aim of these programs is to use the data collected to promote appropriate drug use in a manner that is most efficient and useful for medical and pharmacy practice.

Information obtained from Oregon DHS – January 2007

Oregon Drug Evaluation Classification Program
Oregon State Police
255 Capitol Street NE 4th Floor
Salem, Oregon 97310

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14TH ANNUAL IACP
"Drugs, Alcohol, &
Impaired Driving Conference"

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Indianapolis, Indiana
For more information, visit the conference website at www.decp.org