1. **Goal of the Workshop**

To obtain input on the draft Drugs and Driving Framework.

**Specific Objectives**

1. To identify priorities for action in the DDF and discuss how these priorities can be addressed;

2. To identify how to move forward on these priority activities, including who might contribute to their achievement.

2. **Agenda**

I. **Opening**

1. Welcome and Introduction (Allison Rougeau, CCMTA Executive Director)
2. Purpose of this Workshop (Ward Keith, CCMTA Chair)
3. Review of the Agenda and Process (Lise Pigeon, Facilitator)
4. Participant Introductions

II. Setting the Stage for Working on the Priorities of the DDF

1. **Overview of the DDF**

   a) Presentation: (Brian Jonah, CCMTA, Senior Researcher)

   b) Questions of clarification

2. **First reactions**

   (Short discussion to allow participants to share (a) what they like most about the draft DDF, (b) what concerns they have at this stage about the DDF, and (c) how — once finalized and priorities set — they see the framework being used.

III. Identifying the Priorities

**Part 1:** Small group work to identify priorities on each of the program elements, i.e.

   a. Policy and legislation
   b. Enforcement and adjudication
   c. Education and awareness
   d. Health promotion
   e. Technology, research and evaluation
   f. Other – if any identified during the earlier discussion
Part 2: Presentation in plenary of small groups’ recommended priorities within program elements

Part 3: Small group work to reduce 25 priorities to a maximum of 12 across program elements

Part 4: Presentation in plenary of small groups’ recommended top 5 to 8 priorities across program elements

Part 5: “Sober second thoughts” to validate and confirm the top 5-8 priorities.

IV. Moving Forward on the Top Priorities

Discussion of each priority along the following questions:

i) What major outputs or results are we seeking? (What would success look like?)

ii) Has any work already been done or is being planned in any jurisdiction or by any NGO on this?

iii) Considering what has already been done (if anything) what kind of work (big steps) is required to make significant progress on this priority?

iv) What would be the ideal timeframe for moving on this priority?

v) What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?

vi) What can you (your jurisdiction, your organization) contribute to moving forward on this priority?

V. Wrap Up

1) Immediate Next Steps (Allison Rougeau)

2) Closing comments (Ward Keith)

3. Attendance

1 Neil Arason British Columbia Ministry of Justice
2 Mark Asbridge Dalhousie University
3 Doug Beirness Consultant
4 Paul Boase Transport Canada
5 Steve Brown Traffic Injury Research Foundation
6 Jeff Brubacher Vancouver General Hospital
7 Deborah Cummings Canadian Centre on Substance Abuse
8 Mike Diack RCMP
9 Heidi Francis Ontario Ministry of Transportation
10 Ryan Freeston Ontario Ministry of Transportation
11 Heather Gorman New Brunswick Department of Public Safety
12 Evan Graham RCMP
13 Brian Jonah CCMTA
14 Joanne Keeping RCMP
15 Ward Keith Manitoba Public Insurance
16 Deb Kelly MADD Canada
4. Key Messages

I. Opening

Ms. Rougeau welcomed the group noting the broad range of disciplines represented at the workshop. She also thanked everyone for attending and suggested the workshop will be beneficial not just to CCMTA but to all participants as the process will be collaborative and recognizes each participant brings a particular expertise and knowledge to the table.

Mr. Keith introduced himself as Chair of the CCMTA Board of Directors and Registrar of Motor Vehicles at Manitoba Public Insurance. He noted CCMTA sent a draft of the Drugs and Driving Framework (DDF) to participants in December 2011 for comments. The document had been revised and the workshop is the next critical phase in obtaining additional input from government and non-government organizations, researchers and industry stakeholders. Some of the issues that are to be discussed at the workshop are “do we have it right, is there something missing from the framework, is the timing right for this initiative, what are the priorities, what type of resources may be required to move forward and how participants/organization can help to achieve reductions in drug impaired driving”. He also noted this issue has been indentified within the Road Safety
Strategy (RSS) 2015 as a contributing factor to fatalities and serious injuries in Canada. Ultimately the expertise and experience provided by those at the workshop will aid in setting a path forward so that new initiatives and strategies and be developed and potentially be added to the RSS 2015 for consideration by the jurisdictions when developing their own road safety plans.

II. Setting the Stage for Working on the DDF

1.) Overview of the Principles of the DDF

Mr. Jonah presented an overview of the DDF (see Appendix A) which included possible short term priorities under the categories of policy and legislation, enforcement and adjudication, education and awareness, health promotion and technology, research and evaluation.

2.) First Reactions

Ms. Pigeon instructed breakout groups to provide first reactions to the DDF. Below are the reactions to a set of questions provided to participants. During the discussion, it was suggested the DDF include an additional approach under the legislation section such a hybrid approach that includes both behavioural and per se legislation which is used in some European countries. It was also noted that the CCC has had criminal sanctions for alcohol impaired driving since the 1920’s and the legislation was updated in 2008 to include drug impaired driving under Bill C-32.

What did you like most about the draft DD?

- The report provided a multi-faceted approach.
- It provides the basis for making an informed assumption.
- The structure of the report is systematic.
- The report is understandable.

What concerns do you have at this stage about the DDF?

- Funding and resourcing for future activities.
- Accountability (who will do what).
- Evidence is limited on collision risk (some believe there is evidence-based information available on crash risk for marijuana use).
- What can be done that is affordable and a priority (what comes first, the chicken or the egg).
- Emphasis on DRE and its role (i.e. oral fluids), a per se limit would simplify this.
- The DRE process requires recognition of suspicion of impairment.
- We must be cognizant that this issue is being pursued in support of road safety and not to control drug use.
- We need a focus on the combination of prescription drugs.
There is a challenge for messaging because so much research is still required.
Data issues – we need more linkages.
Timing of addressing the priorities.
The challenge is in articulating a message of what is safe.

**Once the DDF is finalized and the priorities set, how do you see the framework being used?**

- It could be used as an educational tool (within all types of organizations).
- Since the report includes some best practices, it could be framed/transformed into a best practices report.
- It is an organic living document that can grow.
- It is a tool for government to use, it has multiple uses.
- It could be used to lobby government for change and funding.
- It could have broader appeal if it were framed with mental health or addiction aspects (i.e. user characteristics).
- It is general enough that it could be used by many organizations.
- It could be used to coordinate work for groups and organizations to work together.
- It includes an inventory/language lexicon pertaining to drugs and driving.
- It could be used to communicate, coordinate and reach consensus.

**III. Identifying the Priorities**

**Part One: Small group work to identify priorities on each of the program elements**

Ms. Pigeon introduced the breakout groups’ task. She indicated the questions to be discussed would set aside cost for now as well as who would lead or contribute to the activity. The groups were to focus on what are the most important/critical things that need to be done in the next 3-4 years if significant progress is to be achieved on the issue of drugs and driving? Breakout groups were asked to identify their top 3 to 5 priorities and indicate the target group (e.g., youth, health care professionals, and police), where appropriate.

Mr. Jonah clarified the scope and parameters of the exercise. He noted participants should not also concern themselves whether priorities would be national, provincial or federal in scope and that while we are focussing on short-term priorities (i.e. 3-5 years in support of the RSS 2015), this does not eliminate identifying long-term priorities if a group feels strongly about them. Participants were provided a list of short-term priorities to jump start the initial discussions.
The breakout groups were divided into the following program elements as follows: (1) policy and legislation; (2) enforcement and adjudication; (3) health promotion/education and awareness; and (4) Technology, research and evaluation.

Note, many participants were interested in the technology, research and evaluation issues, so two groups were formed for this program element. As a result, education and awareness and health promotion was combined in order to keep the breakout groups to a maximum of five.

**Part Two: presentation in plenary of breakout groups’ recommended priorities within program elements**

In plenary session each of the breakout groups presented their recommended 3-5 priorities within the program elements. The group output is presented below.

**Policy and Legislation**
1. Develop evidence-based model administrative legislation (i.e. similar to the STRID model to address lower BAC drinking drivers)
2. Develop a template for GDL (good evidence focused on illicit drugs)
3. Develop standard content for provincial/territorial drivers’ handbook
4. Amend the Criminal Code of Canada to include drug per se laws
5. Monitor and leverage best practices in other jurisdictions and countries (continually)

**Enforcement & Adjudication**
1. Develop subject matter expert groups to support prosecutions
2. Complete research into the validity of divided attention test on the SFST
   *(Note: Joined to #3 and reformulated as follows: Enhance DRE and SFST funding for training and for research, including on the validity of divided attention test on the SFST)*
3. Maintain and enhance DRE and SFST training
   *(Note: Joined to #2 and reformulated, see above)*
4. Enhance crown prosecution training at provincial level
5. Increase engagement and communication at senior levels of internal and external industry partners to create champions in these organizations

**Education, Awareness and Health Promotion**
1. Develop user research and information to generate multiple messages (for students, police, doctors, pharmacists as well as high risk people.)
   *(Note: reformulated as follows: Develop awareness and education programs for specific groups, e.g., students, police, doctors, pharmacists, as well as for high risk groups and the general public)*
2. Generate and provide general knowledge about drugs and driving to all drivers, e.g., handbook
3. Review existing international drugged driving education campaigns for both prescription and illicit drugs
4. Develop a health promotion strategy for drugs and driving or be part of a national health strategy than includes drugs and driving

**Research, Evaluation and Technology**

1. Increase testing of fatally injured drivers; goal: 100% and use standard protocols
2. Implement protocol for drug testing of injured drivers
3. Implement more roadside surveys
4. Where technically feasible, link data bases (police, justice, and health care)
5. Support the development and implementation of a point of contact immunoassay
6. Evaluate effectiveness of interventions to reduce drug impaired driving (both current and future)
7. Undertake more extensive review of literature on what we know and what we need to know about drug impaired driving
8. Undertake driving simulators studies

**Part Three: Breakout group work to reduce 22 priorities to a maximum of 12 across program elements**

The next exercise for participants was to have the participants evaluate the aforementioned 22 priorities so that consensus is reached on those top priorities that are most critical in the next 3-4 years within each of the program elements. Discussion took place on possible criteria for selecting the priorities. The following criteria were agreed to:

1. Will it have a high impact (will it make a real difference)?
2. Is it feasible/doable/resourceable?
3. Are the timelines realistic for 3-5 years?
4. Is the priority politically appealing?
5. Will implementing the priority be a burden on the justice system or forensic laboratories?
6. Is the priority socially acceptable?
7. Is the priority enabling (allows for others strategies or activities to be implemented)?
8. Is it sustainable?
9. Does it present opportunities for further collaboration?
10. Does it need support from forensic services (this is critical to some of the priorities)?
11. Is there a ripple effect that needs to be considered (impact on different parties)?
12. How do we ensure we don’t detract from alcohol impaired driving initiatives?

There was no discussion at this stage; participants used dots to identify priorities. The detailed points awarded to each of the priorities listed under each of the program elements are provided in Appendix B.
Part Four: Presentation in plenary of breakout groups’ recommended top 5-8 priorities across program elements

Ms. Pigeon, along with participants, calculated and identified the results of voting on the priorities as discussed under Part 3. She created new breakout groups comprised of representatives from each of the previous breakout groups; (this means the new groups were diverse in expertise and interest) and instructed participants to identify and rank their recommended top 3-5 priorities from the remaining 12 across program elements.

In plenary the participants agreed to a list of top priorities. The result of the exercise was as follows:

1. **Enforcement & Adjudication:** Enhance DRE and SFST funding for training and research, including assessment of the validity of divided attention test of the SFST.

2. **Policy & Legislation:** Develop evidence-based model administrative legislation.

3. **Research:** Increase testing of fatally injured drivers; goal: 100%; use standard protocols.

4. **Evaluation:** Evaluate effectiveness of interventions to reduce drug impaired driving (both current and future).

5. **Research:** Implement protocol for drug testing of injured drivers.

6. **Technology:** Support the development and implementation of a point of contact immunoassay test devices.

7. **Education, Awareness and Health Promotion:**
   Based on social research, develop awareness and education programs for specific groups, e.g., students, police, doctors, pharmacists, as well as for high risk groups and the general public.

We don’t want to have unintentional consequences from some of the priorities such as funding drug impaired driving activities at the expense of alcohol impaired driving.

Part Five: “Sober second thoughts” to validate and confirm the top 5-8 priorities

Ms. Pigeon led the group through sober second thoughts to validate and confirm the top 7 priorities that were agreed to the previous day. She queried if anything is missing from the list of priorities.
It was noted roadside drug surveys and self-report surveys to collect information on drivers who haven’t interacted with the system would be useful in providing prevalence data. Also, before priority #6 can be tackled, legislators need to determine how they wish to use such a device (immunoassay test device) under the law.

Concluding the discussion it was agreed to combine priorities 1 and 5.

IV. Moving Forward on the Top Priorities

Ms. Pigeon divided participants into small groups with each being assigned one of the final 6 priorities listed below. The groups were instructed to consider the following questions for their assigned priority and report back to the group in plenary session.

i) What major outputs or results are we seeking on this priority? (What would success look like?)
ii) What might be some of the major systemic impacts of moving forward on this priority? Can you think of any unintended consequences?
iii) Considering what has already been done (if anything) what kind of work (big steps) are required – and by whom - to make significant progress on this priority?
iv) What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?
v) What would be the ideal timeframe for moving on this priority?
vi) What can your organization contribute to moving forward on this priority?

Top Priorities

1. **Enforcement & Adjudication**
   Enhance DRE and SFST funding for training and research, including assessment of the validity of divided attention test of the SFST.

2. **Policy & Legislation**
   Develop evidence-based model administrative legislation.

3. **Research**
   Increase testing of fatally and injured drivers; goal: 100%; use standard protocols.

4. **Evaluation**
   Evaluate effectiveness of interventions to reduce drug impaired driving (both current and future).
5. **Technology**  
Support the development and implementation of a point of contact immunoassay test devices.

6. **Education, Awareness and Health Promotion**  
Based on social research, develop awareness and education programs for specific groups, e.g., students, police, doctors, pharmacists, as well as for high risk groups and the general public.

The detailed breakout groups’ output regarding the questions for each of the priorities is provided in Appendix C.

V. Wrap Up

Ms. Rougeau thanked everyone for their participation. She noted that drugs and driving is a complex issue and the discussion that took place at the workshop was very useful to CCMTA. The organization will be able to bring a more fulsome picture of the priority activities and the related issues back to the CCMTA Board for their consideration. She noted a report will be provided summarizing the outcomes of the workshop and providing a list of attendees. It will be shared with all participants and other organizations that are interested in the results of the DDF Workshop.

Mr. Keith also thanked attendees for their contributions to the workshop. He noted the CCMTA Board will be very pleased to learn of the multidisciplinary participation and how committed everyone was to the process. The workshop results will also make the Board aware of how complex the issue of drugs and driving can be whether the issue is the types of drugs being examined, the degree of impairment of a driver, challenges with the DRE program, acceptability of the evidence to the courts, the evolution of science and technology and being cognizant of any unintended consequences resulting from a variety of approaches.

What is important is determining the scope of the drugs and driving issue in Canada so that CCMTA can develop a final DDF framework that jurisdictions and other organizations can use to develop their own policies and programs to tackle the issue of drugs and driving.
Drugs and Driving Framework

Presented at the CCMTA Workshop
February 22-23, 2012

Brian Jonah
CCMTA

Purpose of Framework

• Provide environmental scan on drugs and driving by:
  – Reviewing effects of drugs on driving,
  – Reviewing recent Canadian and international research on drugs and driving,
  – Reviewing current activities in Canada and several other countries to deal with drugs and driving,
• Offer future optional activities that jurisdictions may want to adopt to address drugs and driving over next 5-10 years.
• Serve as consultative document to obtain input from stakeholders about gaps in information and actions that could be taken.
Drugs and Driving is More Complex than Drinking and Driving

- There are so many different kinds of psychoactive drugs,
- Drugs are harder to detect in the body,
- There is a lack of standardized testing for drugs,
- Different drugs have different effects on driving performance,
- Absorption, action, and elimination of psychoactive drugs are difficult to predict given individual differences among users.

Classes of Psychoactive Drugs

- Drug Classification and Evaluation Classes:
  - Cannabis (e.g., marijuana),
  - Central Nervous System Depressants (e.g., benzodiazepines),
  - Central Nervous System Stimulants (e.g., cocaine),
  - Hallucinogens (e.g., LSD),
  - Dissociative Anesthetics (e.g., ketamine),
  - Narcotic Analgesics (e.g., heroin),
  - Inhalants (e.g., gasoline).
Canadian Fatality Data

- Beasley et al. (2011) analyzed coroner data on fatally injured drivers in Canada for 2000-2008,
- Only 47% of drivers were tested for drugs (ranged from 23-88%) compared to 83% for alcohol,
- 41% of drivers tested had been drinking and 37% had one or more psychoactive drugs in body (ranged from 25-42%),
- Prevalence of drugs has increased by 24% since 2000,
- Most common drugs detected were:
  - Depressants (36%),
  - Cannabis (26%),
  - Stimulants (19%),
  - Both alcohol and other drugs (14%)

Drug Use Among Injured Drivers

- Brubacher (2010) conducted pilot study at Vancouver General Hospital in 2008-2009 taking blood samples from 100 injured drivers and found:
  - 38% were positive for alcohol,
  - 28% were positive for cannabis or cannabis metabolites,
  - 18% had cocaine present or cocaine metabolites,
- Larger study now being conducted in five BC hospitals.
Roadside Survey in BC- 2010

- Beirness and Beasley (2011) conducted night time (21:00 and 03:00) roadside survey at 16 sites in each of five BC communities Wed to Sat.,
- 86 % of drivers voluntarily provided breath sample and 71% provided oral fluid sample,
- 9.9% of drivers had been drinking,
- 7.2% had consumed psychoactive drug mainly:
  - Cannabis (4.5%),
  - Cocaine (2.3%),
  - Opiates (1.2%),
  - Both alcohol and drugs (11.0%).

Summary of Data on Drugs and Driving

- The data for Canada and elsewhere suggest that prevalence of drug impaired driving rivals alcohol impaired driving,
- OECD report concludes that prevalence of drugs in fatal or injury collisions is in 14-25% range with most common drugs being cannabis (10%) and benzodiazepines (5-9%),
- However, presence of drug in body of driver involved in collision has not yet been demonstrated to be cause of collision given difficulties in testing drivers and being able to obtain adequate control data.
Current Activities Addressing Drugs and Driving

• Legislation and policy,
• Enforcement and adjudication,
• Public awareness and education,
• Health promotion,
• Technology.

Legislation and Policy

• Three types of drugs and driving laws:
  – Per se law with legal limit,
  – Per se law without limit (zero tolerance),
  – Behavioural impairment law.
Canadian Criminal Legislation

- Canada has adopted behavioural impairment approach,
- Criminal Code of Canada permits police to request driver to take Standardized Field Sobriety Test (SFST) if there is suspicion driver is impaired,
- If there are reasonable and probable grounds of drug use based on SFST, driver is submitted to Drug Recognition Evaluator (DRE) who conducts Drug Evaluation and Classification (DEC) assessment,
- If there are signs and symptoms from this assessment that driver is impaired by drug, demand is made to provide body fluid sample, usually urine,
- Penalties for conviction of drug impaired driving same as those for alcohol impaired driving.

Canadian Administrative Laws

- Most jurisdictions have short-term licence suspension for lower levels of alcohol (.04/.05 to .08) and are moving toward longer suspensions (up to 7 days for first offence),
- Some Canadian jurisdictions (BC, AB, SK, MB, NL, NT, YK) have provisions that permit police to suspend driver’s licence for 24 hours if there are reasonable and probable grounds for suspecting drug impairment.
Laws in Other Countries

• In U.S., 22 states have some form of per se law, mostly zero tolerance, while rest have behavioural impairment laws like Canada,
• In Europe, some countries have zero tolerance per se laws (e.g., France), some have per se laws with legal limits (e.g., Norway), some have behavioural impairment laws (e.g., Netherlands), and others have both (e.g., Germany),
• Most Australian states have zero tolerance per se laws.

Enforcement and Adjudication

• Most police services conduct periodic RIDE types of programs for alcohol or drug impaired driving,
• Detection of drug impaired driving requires DREs,
• Lack of DREs in Canada particularly in rural areas,
• Difficulty getting DRE evidence perceived as scientific by Crown prosecutors and judges.
Public Awareness/Education

• Most Canadian jurisdictions are conducting some kind of awareness/educational activity but it is generally based on pamphlets, bus shelter ads, websites,
• There is little widespread educational activity using mass media or social media,
• Some countries (e.g., Australia, UK, Poland) have conducted nation-wide television ad campaigns on drugs and driving.

Health Promotion

• Many jurisdictions in Canada have assessment and treatment programs for impaired drivers but they do not distinguish between alcohol and drug impaired drivers,
• It is not known whether these programs are effective in reducing recidivism among drug impaired drivers,
• DRUID project in Europe noted that best rehab programs are tailored to individual and use combination of treatment strategies,
• Some European countries are using labeling of drug packages to alert consumers about risks of driving.
**Optional Future Activities**

- Some of following activities to address drugs and driving could be pursued over the next 3-4 years (i.e., during Road Safety Strategy 2015),
- There are other longer-term activities presented in the Drugs and Driving Framework.

**Legislation/Policy**

- Develop model legislation for drugs and driving that could be adopted by jurisdictions,
- Require new drivers who are in Graduated Driver Licensing programs to have no psychoactive drugs in their body while driving,
- Include information about effects of drugs on driving and legislation on drugs and driving in driver’s handbook and test new drivers for their knowledge of drug impaired driving as part of licensing process.
Enforcement and Adjudication

- Conduct more frequent RIDE type programs that seek both alcohol and drug impaired drivers,
- Discuss with the Canadian Association of Chiefs of Police (CACP) how more DREs can be trained, their skills can be maintained and upgraded, and how DREs can be retained longer,
- Provide more DREs in rural areas or set up “flying squads” of DREs which could travel from one area to another to support local police services when they conduct RIDE programs,
- Conduct training workshops for prosecutors and judges regarding drugs and driving and DEC program,
- Separate alcohol and drug impaired driving convictions in police and driver records.

Public Awareness and Education

- Develop and implement national drugs and driving awareness campaign based on social research, targeting general population using mass media (e.g., newspapers, radio, electronic billboards, bus shelter ads) and social media (e.g., Facebook, Twitter, websites),
- Develop and implement more focused awareness and education campaigns based on social research targeting young drivers who are more likely to drive while impaired by illicit drugs (e.g., cannabis) and older drivers who are more likely to be impaired by some prescription medications.
Health Promotion

• Work with drug addiction agencies to develop best practice for the assessment and treatment of drivers convicted of drug impaired driving,
• Meet with healthcare professional groups (e.g., physicians, nurses, pharmacists) to discuss how their members can become more engaged in raising awareness about effects of drugs on driving,
• Encourage physicians to use Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure to detect alcohol and drug abuse problems in their patients.

Technology

• Support the development of more accurate point-of-contact immunoassay tests of oral fluid for detection of specific drugs (e.g., cannabis, methamphetamines, cocaine) that could be used at roadside by police officers,
• Support creation of scientific committee of forensic toxicologists to develop guidelines for testing bodily fluid of suspected drug impaired drivers that would be followed by all labs.
Research

• Encourage increased testing of fatally injured drivers by coroners so that at least 70% of drivers are tested for drugs in each jurisdiction or random sample of driver fatalities of sufficient size for analysis is tested,
• Conduct roadside surveys of alcohol and drug use by drivers in each region of Canada including some daytime testing,
• Support experimental research using driving simulators and closed driving courses to test drivers under influence of commonly used drugs (e.g., cannabis) at dosage levels higher than those that have been used in previous research.

Research (Cont’d)

• Conduct public opinion survey to determine Canadians’ knowledge, perceptions, attitudes, and experiences with respect to drugs and driving,
• Conduct focus groups with younger and older drivers about drugs and driving,
• Evaluate drugs and driving interventions for their effectiveness.
Next Steps

• Conduct workshop over next 2 days,
• Revise DDF based on what we heard,
• Return to Board with revised DDF including:
  – top five priority activities identified,
  – resources needed to carry out these activities,
  – timeframes for conducting them,
  – partners that could provide resources,
  – who could lead priority activities.
## Prioritizing the List of Priorities by Program Element

<table>
<thead>
<tr>
<th>Program Element</th>
<th>Dots</th>
<th>Points</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy and Legislation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Develop evidence-based model administrative legislation</td>
<td>18</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>2. Develop template for GDL (good evidence focused on illicit drugs)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. Develop standard content for federal/provincial drivers’ handbook</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4. Amend the Criminal Code of Canada to mirror alcohol per se laws</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>5. Monitor and leverage best practices in other jurisdictions and countries (continually)</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td><strong>Enforcement &amp; Adjudication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Develop subject matter expert groups to support prosecutions;</td>
<td>4</td>
<td>8*</td>
<td>12*</td>
</tr>
<tr>
<td>2. Complete research into the validity of divided attention test</td>
<td>13</td>
<td>17*</td>
<td>30*</td>
</tr>
<tr>
<td>(Note: Joined to #3 and reformulated as follows: Enhance DRE and SFST funding for funding and training and research, including on the validity of the divided attention test of the SFST.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Maintain &amp; enhance DRE and SFST training</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>(Note: Joined to #2 and reformulated, see above)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Enhance crown training at provincial level</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Education, Awareness and Health Promotion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Develop user research and information to generate multiple messages (for students, police, doctors, pharmacists as well as high risk people.)</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Program Element</td>
<td>Dots</td>
<td>Points</td>
<td>Total</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Note:</strong> reformulated as follows: Develop awareness and education programs for specific groups, e.g., students, police, doctors, pharmacists, as well as for high risk groups and the general public</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Generate and provide general knowledge about drugs and driving to all drivers, e.g., handbook</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>3. Review existing international /source drugged driving education campaigns for both prescription and illicit drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Develop a health promotion strategy for drugs and driving or be part of a national health strategy than includes drugs and driving</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Research, Evaluation and Technology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Increase testing of fatally injured drivers; goal:100%; use standard protocols</td>
<td>15</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>2. Implement protocol for drug testing of injured drivers</td>
<td>8</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>3. Implement more roadside surveys</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>4. Where technically feasible, link data bases (police, justice, health care)</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>5. Support the development of a better point of contact immunoassay</td>
<td>8</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>6. Evaluate effectiveness of interventions to reduce drug impaired driving (both current and future)</td>
<td>17</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>7. Undertake more extensive review of literature on what we know and what we need to know about drug impaired driving</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>8. Undertake driving simulators studies</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. **Policy and Legislation:** Develop evidence-based model administrative legislation (i.e. similar to STRID Strategy to Address Lower BAC Drinking Drivers).

   a) *What major outputs or results are we seeking on this priority? (What would success look like?)*

   - Fewer casualties
   - Easy to enforce
   - Withstand challenges in court
   - Decrease in drug impaired driving incidence
   - Buy in at the provincial level
   - More uniformity across jurisdictions
   - Public support (more of it)
   - Less pressure on court system
   - Evaluation to confirm
   - Government cannot pay lip services (must fund program and oversight)

   b) *What might be some of the major systemic impacts of moving forward on this priority? Can you think of any unintended consequences?*

   - Perception that we are decriminalizing drugs and driving
   - Still can face legal challenges
   - Doctors prescribing medication to patients will not discourage the patient from driving
   - Drivers could see the policies as a “judge and jury” situation
   - Is political will available to support initiative
   - Perceived conflict between new federal crime bill C-10
   - More treatment facilities may be required
   - Can change attitudes and behaviours
   - Education strategy needed
   - Tendency to proceed administratively rather than criminally
   - Police DRE skills could decline with fewer CCC cases
   - Administrative sanctions do not replace CCC but compliment it
   - Proceeding with administrative sanctions provides benefit over CCC charges

   c) *Considering what has already been done (if anything) what kind of work (big steps) are required – and by whom - to make significant progress on this priority?*

   - Governments cannot provide lip service and must provide oversight on how it the legislation will operate
   - More research is needed (i.e. what to put in legislation)
   - Ensure continuity
   - Establish fines that are based on cost-recovery and act as a deterrent
   - Consultation process needed with Pharmacists

   d) *What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?*

   - Making enough resources and people available
   - Political will
   - Communication and consultation
   - Must decide what type of research is needed (consultation with F/P/T governments)
Must decide what are the criteria for issuing an administrative sanction (smoking and possessing drugs in the car versus being drug impaired driving).

**e) What would be the ideal timeframe for moving on this priority?**

- Should move forward now and build in short, medium and long-term processes for input

**f) What can your organization contribute to moving forward on this priority?**

### 2. Research: Increase testing of fatally and injured drivers (goal: 100%), use standard protocols.

**a) What major outputs or results are we seeking on this priority? (What would success look like?)**

- Have a better understanding of the problem
- Develop a standardized way to collect data and communicate it
- A higher testing rate will improve data accuracy

**b) What might be some of the major systemic impacts of moving forward on this priority? Can you think of any unintended consequences?**

**c) Considering what has already been done (if anything) what kind of work (big steps) are required – and by whom - to make significant progress on this priority?**

- Data collection is in various stages of development
- Fatality data
- Roadside survey data – prevalence
- Injury data – less advanced
- Injury data collection should not impede doctors and not impede alcohol data collection

**d) What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?**

- Expensive
- Coordination is needed
- There are privacy issues
- Injury data needs to defined
- Need a leader in the field of injury data to coordinate health, justice and transport
- Need to identify who will do the coordination piece to start the conversation
- Needs to be sustainable and built on things already done

**e) What would be the ideal timeframe for moving on this priority?**

**f) What can your organization contribute to moving forward on this priority?**
3. **Evaluation:** Evaluate effectiveness of interventions to reduce drug impaired driving (both current and future).

<table>
<thead>
<tr>
<th>a) What major outputs or results are we seeking on this priority? (What would success look like?)</th>
</tr>
</thead>
</table>
| • Additional data/research to use  
• Public awareness  
• Enforcement  
• Set of best practices  
• Reduced incidents of DD  
• Having data that can be used for legislative change (programs and policies)  
• Cultivate goals to reduce drugs and driving  
• Supports programs |

<table>
<thead>
<tr>
<th>b) What might be some of the major systemic impacts of moving forward on this priority? Can you think of any unintended consequences?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Put pressure on agencies to be supportive of this issue and providing additional funding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c) Considering what has already been done (if anything) what kind of work (big steps) are required – and by whom - to make significant progress on this priority?</th>
</tr>
</thead>
</table>
| • Metrics have to be in place  
• Evaluate international best practices for evaluation  
• Supports the model legislation |

<table>
<thead>
<tr>
<th>d) What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?</th>
</tr>
</thead>
</table>
| • No metric  
• No commitment  
• No funding or champion  
• Lack of training  
• Evaluation has to serve the program which leads to program improvement |

<table>
<thead>
<tr>
<th>e) What would be the ideal timeframe for moving on this priority?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>f) What can your organization contribute to moving forward on this priority?</th>
</tr>
</thead>
</table>
4. **Enforcement and Adjudication:** Enhance DRE and SFST funding for training and research including assessment of the validity of the divided attention test on the SFST.

<table>
<thead>
<tr>
<th>a) What major outputs or results are we seeking on this priority? (What would success look like?)</th>
</tr>
</thead>
</table>
| • Divided attention test  
  o Complete acceptable by the courts  
  o Success in courts  
  o Improved road safety  
| • DRE  
  o Increased number of qualified CREs to meet current and future needs  
  o Standardized reporting  
  o National standards  
  o Number of convictions based on DRE  
  o Improved management/monitoring leading to consistency of reporting |

<table>
<thead>
<tr>
<th>b) What might be some of the major systemic impacts of moving forward on this priority? Can you think of any unintended consequences?</th>
</tr>
</thead>
</table>
| • DREs  
  o Increased number of charged will produce burdens on courts and crowns if dealt through criminal process – leading to delays and charged dropped  
  o Perception that if criminal, other processes do not need to be support by authorities.  
  o Raising the profile of drug impaired driving versus other types of crimes  
  o Increased pressures on police, courts and laboratories  
| • Divided attention test  
| • Identifying cost and scope for phase II  
| • Research – support for completion of test |

<table>
<thead>
<tr>
<th>c) Considering what has already been done (if anything) what kind of work (big steps) are required – and by whom - to make significant progress on this priority?</th>
</tr>
</thead>
</table>
| • Conversations need to happen between police and provincial funders  
| • Police leadership needs to hear road safety priorities  
| • Building a business case and included health as a stakeholder |

<table>
<thead>
<tr>
<th>d) What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?</th>
</tr>
</thead>
</table>
| • Different players and they do not always control the decisions  
| • Need a champion  
| • Need to gain CACP support  
| • Set up forums in jurisdictions to create linkages and champions |

<table>
<thead>
<tr>
<th>e) What would be the ideal timeframe for moving on this priority?</th>
</tr>
</thead>
</table>

| f) What can your organization contribute to moving forward on this priority? |
5. **Technology: Support the development and implementation of a point of contact immunoassay test device.**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **a)** *What major outputs or results are we seeking on this priority? (What would success look like?)* | **b)** *What might be some of the major systemic impacts of moving forward on this priority? Can you think of any unintended consequences?*
| - Tool for pre-screening the driver | - Charter challenges  
- Public perception of use of device (false negatives)  
- Police may lose ability to do SFST  
- Manufacturer buy-in  
- What if you detect too many people – what do you do?  
- Funding required for development of the device and purchasing new devices
| **c)** *Considering what has already been done (if anything) what kind of work (big steps) are required – and by whom - to make significant progress on this priority?* |   |
| |   |
| - Need to make a determination as to what you want to utilize it for (connects to legislation)  
- Currently no legislative authority to utilize it  
- Ties into legislative issues  
- Create a demand for the tool  
- Cost/benefit analysis
| **d)** *What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?* |   |
| |   |
| - Same as above  
- A champion is needed to take ownership politically  
- New science that the US has not adopted  
- There may be opposition
| **e)** *What would be the ideal timeframe for moving on this priority?* |   |
| |   |
| |   |
| **f)** *What can your organization contribute to moving forward on this priority?* |   |


6. **Education, Awareness and Health Promotion:** Based on social research, develop awareness and education programs for specific groups, e.g., students, police, doctors, pharmacists, as well as for high risk groups and the general public.

**a) What major outputs or results are we seeking on this priority? (What would success look like?)**

- Increases knowledge of risks to drugs and driving legislation and their consequences
- Must be careful in messaging as it can be seen as supporting the use of drugs
- Need a champion
- Increased perceived likeliness of apprehension
- Greater involvement of health care
- Public support for interventions

**b) What might be some of the major systemic impacts of moving forward on this priority? Can you think of any unintended consequences?**

- May raise expectations of public that governments will do something about this issue
- Campaigns must be carefully crafted not to confuse the public (i.e. ok to do drugs but just don’t drive)

**c) Considering what has already been done (if anything) what kind of work (big steps) are required – and by whom - to make significant progress on this priority?**

- Have strategies tailored to specific target groups
- Link to enforcement campaign
- Federal government and CCMTA work together for components of a national campaign that could be adopted by the jurisdictions
- Standardized questions on common issues to have consistent reporting back on these issues
- Standardize messaging

**d) What major hurdles (e.g., resources, political commitment, linkages, etc.) need to be overcome in order to make significant progress?**

**e) What would be the ideal timeframe for moving on this priority?**

**f) What can your organization contribute to moving forward on this priority?**