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Driving Under the Influence of Drugs

Most people associate DUI charges with alcohol, but any substance or combination of substances that impair a person's ability to drive can lead to a DUI charge.

In most states, a driver can be convicted of drugged driving for being in "actual physical control" of a vehicle while under the influence of "harmful chemicals" or "controlled substances."

According to the National Survey on Drug Use and Health, people who report very frequent cocaine or methamphetamine use are substantially more likely to report driving under the influence of these stimulants. This also holds true for driving under the influence of cannabis and hallucinogens.

Because there are such high levels of risk to self and others with DUI, it is illegal in all U.S. states to drive under the influence of methamphetamine, opioids, marijuana, or any potentially impairing drug, even if prescribed or purchased over the counter.

Drugs can impair one's ability to drive because—depending on the drug—they can slow judgment, coordination and reaction time, or make a driver more aggressive and reckless. Mixing multiple drugs and drinking alcohol of course intensifies the impairing effects of each drug and increases the chances of an accident.

Those who drive under the influence of drugs, whether obtained legally or illegally, pose a danger to themselves, their passengers, and other road users.

DUI at Work

Employers have a vested interest in preventing driving under the influence by employees. If an employee is involved in a DUI accident that injures or kills another person, the company the employee works for could in some cases be held liable under a legal doctrine known as *respondeat superior*. If it can be shown that the accident occurred within the employee's *scope of employment*, the company could be held vicariously responsible.

In the past, courts based their opinions on a narrow definition of scope of employment, but today, courts almost always hold employers liable for accidents that occur while an employee is working, even if the employer did not condone the action that caused the accident.

If an employee is found guilty of DUI (outside of work), and the employer becomes aware of it, the company may now be in a greater position of legal liability if the employee is allowed to continue to drive company vehicles. This is why some businesses have a policy in place that requires dismissal of an employee convicted of DUI, or at the very least the transfer of the employee to a non-driving position.

Be a Responsible Driver

The following recommendations on how to be a more responsible driver are from the National Highway Traffic Safety Association:

- Plan ahead for a sober driver, if you plan to use an impairing drug.
- Don't let friends get behind the wheel if they're under the influence of drugs.
- If you're hosting a party where alcohol or other substances will be used, it's your job to make sure all guests leave with a sober driver.
- Always wear your seat belt—it's your best defense against impaired drivers.

In addition to the dangers of driving under the influence, drug use and drug withdrawal can cause depression. Depression is the number one risk factor for suicide, and intentional car crashes are sometimes the result of a suicidal driver suffering from severe depression. According to a study on driver behavior published in *Science Serving Society*, the percentage of suicides that are traffic fatalities has been increasing over time.

The following suicide prevention information, while provided by the Georgia Department of Behavioral Health and Developmental Disabilities, will also be helpful to those in states other than Georgia. Online resources listed are available to users nationwide.

September was 2022's National Suicide Prevention Month and marked what many of us consider the beginning of the holiday season. On the topic of suicide and the holidays, there is a prevailing misconception that suicide rates are highest during the fall and winter months, but research indicates that this is not the case. As most instances of individuals experiencing seasonal affective disorder (SAD) begin to feel depressed and lethargic during the fall and throughout the winter, then begin to feel better by spring, it would make sense if suicide rates correlated with these months. However, it is the spring months (April, May, and June) when suicide rates are greatest, and the winter months (especially December) when rates are the lowest. At face value this seems counterintuitive, especially when also considering that alcohol abuse and binge drinking increases exponentially between Thanksgiving and New Year's, as alcohol abuse is a major contributing factor in many suicide deaths.

So why do suicide rates increase so greatly during the spring months? Before we address that question, it is worth noting that causes of suicide are complex and varied. Most individuals that consider suicide are ambivalent, hoping for some other solution to the various stressors that make it seem like an option in the first place. In fact, 85-90% of individuals who survive a suicide attempt go on to never die by suicide.

While though it is true for many that the holidays are a time when stressors such as depression, financial, social and familial anxiety, lethargy, and substance abuse become exacerbated, that doesn't mean that those individuals will carry out a suicide attempt. For individuals who experience clinical depression year-round, the winter months can be a time when staying indoors and laying low is more socially acceptable. Though the term "misery loves company" misses the mark, continuing to feel depressed during a time when many other people are beginning to feel happier and reenergized during those warmer months can increase feelings of loneliness, depression, and isolation. Another emerging theory is that one of the greatest contributing factors to an increase in suicide deaths in the spring is allergies. Yep. Allergies. Autoimmune responses have been proven to increase depression, and there is a direct correlation between inflammation and depression. Locations farther from the equator with more extreme seasonal variations also show a greater increase in suicide deaths during this changing of the seasons.

Looking at the past few years of suicide data specific to the state of Georgia, it is harder to see as clear of a pattern as it is when looking at national data. In 2016 for instance, the months with the highest number of suicide deaths were: April, August, and July. Even among those months, there was a very small difference separating them (i.e., 132 deaths in April, 131 deaths in August, 130 deaths in July). For 2017, those months were: August (137 deaths), June (135), and July/October (134). Overall, the months with the most deaths were April and/or August. Despite not being as clear cut as the national data, one thing that the Georgia data does show is that November and December have the lowest numbers of suicide deaths each year, mirroring the national data.

If this data proves anything, it is that our mental and physical health are much more linked than we tend to think of them as in our current society. Though social factors are certainly at play, physiological factors are also important to consider. This research also makes a strong case for changing the way that we talk about suicide. Removing terms like "committed" suicide from our vocabulary and speaking about suicide as the result of an untreated medical condition than a crime or a mortal sin could help reduce stigma and assist individuals who are at an increased risk of suicide get the help that they need.

To learn more about suicide prevention, visit the DBHDD website at: https://dbhdd.georgia.gov/suicide-prevention.

Or contact the Suicide Prevention Director, Rachael Holloman, at: rachael.holloman@dbhdd.ga.gov.

National Suicide Prevention Lifeline:
1-800-273-TALK (8255).