PACTS
Parliamentary Advisory Council for Transport Safety

DRUG DRIVING
THE TIP OF AN ICEBERG?

Evan Webster
Policy and Research Officer, PACTS

February 2021

An independent report by PACTS

This is an independent report by PACTS. The topic was proposed, and the scope defined, by PACTS. The DfT provided the funding to enable the project and DfT staff were kept informed of the findings.

For avoidance of doubt, it was not commissioned by the DfT and DfT has not influenced or endorsed the report contents or recommendations.

Acknowledgments

This report was funded by a Road Safety Grant from the Department for Transport (DfT). PACTS is grateful for the support of the DfT, in particular the road safety statistics and drink and drug driving teams. PACTS would also like to thank the DVLA for providing data used in the project.

PACTS consulted widely in the course of researching this report. We are grateful to the many individuals and organisations who contributed their time, information, and advice to this project. PACTS would like to thank the public health teams and police officers who agreed to be interviewed for this project. PACTS is also grateful to all the members of the project advisory panel for their expert comments and advice.

Responsibility for the report's contents and conclusions lies with PACTS and the author. The report does not necessarily reflect the views of the advisory panel or others who contributed to the research.

About PACTS

The Parliamentary Advisory Council for Transport Safety (PACTS) promotes evidence-based solutions to achieve safe transport for all. Formally established in 1982, its founder members were responsible for the legislation which made it compulsory to wear seat belts in the fronts of cars in Britain.

The unique features of PACTS are that it is a multi-modal transport safety body and focuses on working with UK parliamentarians, government, professionals and other key stakeholders. It is independent and has no financial or sectoral interests.

PACTS is a charity with over 100 member organisations – our partners – who are all committed to improving safety for people on our roads, railways and when flying. Members provide PACTS with technical and business insights, advice and support. We assist them through our information, events, networking and more. If you would like information about the benefits of PACTS membership for your organisation, please visit Join Us | PACTS or contact PACTS.

Contents

Executive summary

Over the past five years, great strides have been made in tackling drug driving in the UK. Taking forward the *North Report*, scientific knowledge has been used to improve legislation and enforcement. Strict legal limits (S5a offences) for 17 drugs (legal and illegal) were introduced, akin to the long-established limits for drink driving. THINK! campaigns have sought to increase awareness of the dangers of drug driving and the serious consequences of being convicted. New equipment has been developed and type-approved, enabling the police to test drivers at the roadside for the cannabis and cocaine – the most commonly used illegal drugs. The use of these preliminary tests has increased substantially with some police forces now recording more tests for drug driving than for drink driving. The numbers vary widely across forces – which may reflect enforcement policy more than road safety risk. Significant variations also exist in relation to evidential testing – taking blood samples, laboratory costs and delays. As a result, drug driving remains a significant danger and cause of death and serious injury on UK roads.

This report by PACTS shows that we still do not have answers to many of the vital questions around the impact of drug driving, including how many people are killed as a result of drug driving, and how many roadside drug drive tests are undertaken. There are reasons to believe the problem may be far greater than current systems show and may be growing.

There are steps that the government, the police and others can take to fill these gaps. This report demonstrates the importance of doing so, in order to better prevent drug driving and reduce the number of people killed and injured on UK roads.

The report uses casualty, survey, conviction and reoffending data, along with academic literature, to investigate the profile of drug drivers in the UK. It shows that drug drivers are more likely than the general population to be younger, male, employed in the trades (e.g. carpentry, plumbing etc.) or drive for work, and more likely to have substance use or mental health issues. However, it also shows that 'drug drivers' are a varied group and that different drugs have different user profiles. For example, while those who take cocaine or cannabis and drive are more likely to be younger, those who drive under the influence of prescription drugs tend to be older.

Key statistics

- Current road safety statistics suggest 92 people were killed and 672 seriously injured in collisions where a driver was impaired by drugs in 2019. The true figure is likely to be much higher.
- 12,391 people were convicted of a drug driving offence in 2019. This number has increased significantly since 2015.
- Nearly half (44%) of drug drive offences are committed by a reoffender.

Drug driving can be reduced by better application of many conventional road safety tools. More consistent levels of enforcement of the drug driving law, backed by communications, raise the public perception of enforcement and are an effective way to reduce drug driving. Currently, the level of enforcement varies dramatically from police force to police force. This seems to reflect local enforcement practice rather than level of offending or harm. Some police forces have established better procedures, contracts and training. This should be extended across the UK.

There is evidence that drivers are less aware of the dangers or drug driving or the likelihood of being caught for it, than they are for drink driving. Education and awareness campaigns can also play a role in increasing knowledge of the dangers of drug driving while building a social consensus that drug driving is unacceptable. These education campaigns should avoid alienating those they target.

The report shows that there is also a need for new tools, including some borrowed from other fields such as public health. Not all drug drivers have drug or mental health issues, but these issues are factors for many people who drug drive. Drug drive reoffending remains very high with 44% of recorded offences being committed by reoffenders. To address these issues, a Drug Drive Rehabilitation Course and High Risk Offender Scheme should be introduced, modelled broadly on the existing drink drive programmes, but with better screening for drug and mental health problems and with clear pathways to treatment. Medical professionals can also play a role in identifying drug and mental health issues and the DVLA and relevant professional bodies should continue to raise awareness of these issues and the guidelines for medical professionals.

There is currently no additional penalty for a driver who may have consumed drink and drugs. There is therefore less incentive for the police to test or prosecute for both offences. The impairment effects of combining drink and drugs, even at low levels, are hard to calculate accurately but the risks are known to be high. A new combined drug and drink driving offence should be introduced, with lower blood alcohol limits when alcohol and drugs are combined. This would address the increased risk posed by drivers who have consumed alcohol and drugs.

The effectiveness of the current legal system is also evaluated and small and large steps identified to increase effectiveness. The current blood testing system has resulted in long backlogs and high costs for police. There is the risk that drivers charged with drug driving will avoid being banned from driving only because the blood tests results take too long to come back. The Home Office should review the blood testing process and seek out ways of increasing the efficiency of laboratory testing. They should also investigate the possibility of reclaiming blood testing costs from those who are found guilty of drug driving. The report also recommends steps that could be taken to increase the effectiveness of the system in the short term.

Above all, the report demonstrates the need for a broad strategy to tackle drug driving, which uses the knowledge of experts on drugs and drug testing. This strategy must include research to fill vital knowledge gaps and include conventional road safety interventions as well as those from the field of public health. A strategy to tackle drug driving should seek to address the underlying causes of decisions by some to drug drive, increase drivers' perception of their chance of being caught if they do so, and ensure that those who are caught receive the support they need to avoid drug driving again.

Foreword

Drug driving represents a significant challenge to modern society. Road traffic collisions (RTCs) are the ninth leading cause of death globally across all age groups and are predicted to rise to the fifth highest cause by 2030. The World Health Organisation (WHO) *Global Status Report on Road Safety* recorded that the number of fatalities per year due to RTCs was 1.35 million in 2018. It seems the problem is growing rather than receding.

We have come a long way since the North report in 2010, which recommended strengthening our drug-driving legislation. In March 2015 the Government strengthened the Road Traffic Act 1988 by introducing a new strict liability offence (Section 5a) that specified blood drug concentrations for 17 different compounds to supplement existing legislation concerned with driving under the influence of drink and drugs. This has led to a steady increase in arrests for drug driving, with 10,232 cases going to court in England and Wales in 2018 compared to 5,368 cases in 2017.

However, the playing field is not always even and there is a need to continue our journey of legal and technical progression. The evolution of the drugs themselves and our means of detecting them must be prefaced against changes in the patterns of consumption, particularly by those aged between 18 and 25 years and who are recognised as susceptible to other risky behaviours for safe driving such as speeding, seatbelt and mobile phone misuse.

Our knowledge has grown exponentially since the introduction of the strict liability offence, but it is not complete. Robust, standardised data collection and reporting would significantly help, as would support for evidence collection and sentencing. Drug driving is a multi-faceted phenomenon and requires a multi-disciplinary response.

I welcome this report which brings together some of the key issues and experience of those involved. I hope it will generate thought and debate and by so doing help take our understanding of drug-driving forward.

Professor Kim Wolff, MBE
Professor Analytical, Forensic & Addiction Science,
Director of King's Forensics and Head of the Drug Control Centre.
King's College London
Chair of the Expert Panel on Drug Driving 2013

CHAPTER 1

Introduction

1.1 Drug driving in the UK

Historically, drug driving has been seen as responsible for comparatively few road deaths and received comparatively little study. Drink driving was perceived – probably rightly – as a much bigger problem. A study by the Transport Research Laboratory of drivers involved in fatal road collision casualties between 1985 and 1987 found drugs of abuse were present in 3% of cases, compared to alcohol which was present in 35% of cases.[1] However, similar studies published in 2001 and 2012 showed that drugs were present in more than 20% of cases. These studies used data from coroners to determine the level of drug driving.[2] In 2019, Stats19 data suggests that 92 people were killed in collisions involving drivers or riders impaired by drugs. This figure has increased in recent years and is almost certainly an underestimate. All this appears to indicate not only an increased awareness of the issue but also real increases in drug driving and associated deaths over the past 20 years or so.

Our knowledge of how different drugs are associated with increased crash risk and the biochemical properties of drugs has also increased in this time, though still lags behind our knowledge of alcohol.

The first drug driving offence was introduced in the Road Traffic Act 1930 where it was made illegal to drive while 'under the influence of drink or a drug to such an extent as to be incapable of having proper control of the vehicle.'[3] Section 4 of the 1988 Road Traffic Act laid out one of the current drug driving offences 'driving/attempting to drive or being in charge of a motor vehicle whilst unfit'. To convict, a police officer would need to give evidence that the driver was unfit. This would typically require a Field Impairment Test (which consists of various physical tasks, such as walking in a straight line) at the roadside, which presented various challenges to the officer. There was no specified legal drug driving limit or equivalent of the breathalyser. Prosecutions for drug driving were relatively few.

In 2010, Sir Peter North's *Report of the Review of Drink and Drug Driving Law* was published. This, with the 2013 *Report from the Expert Panel on Drug Driving*, led to the establishment of the offence of 'driving or attempting to drive with drug level above the specified limit' in 2015. This new offence is laid out in Section 5a of the 1988 Road Traffic Act, it was inserted by the 2013 Crime and Courts Act. In Scotland, an equivalent offence was introduced in The Drug Driving (Specified Limits) (Scotland) Regulations, 2019. Northern Ireland does not have drug limits set out in law.

Legal limits were set for the levels of drugs permitted in a driver. It was no longer necessary to demonstrate impairment. Along with new devices to enable the police to conduct preliminary tests for drugs at the roadside, this new "strict offence" has led to a significant increase in the number of people convicted of drug driving in the UK.

Ten years after the *North Report*, and five years since the new offence, this report by PACTS reviews the drug driving situation in the UK, looking at the level of casualties, the profile of drug drivers, interventions that could reduce drug driving and how the current policing and justice system could be improved.

[1] Jackson, P.G. (2008) A Review of Methodologies Used in Roadside Surveys of Drinking and Driving, DfT Road User Safety Research Report No. 90, Department for Transport

[2] Tunbridge, R. et al. (2001). The incidence of drugs and alcohol in road accident fatalities. TRL. Wollf, K. et al (2013). Driving under the influence of drugs. Report from the Expert Panel on Drug Driving

[3] Road Traffic Act 1930. https://www.legislation.gov.uk/ukpga/1930/43/pdfs/ukpga_19300043_en.pdf

1.2 Drug driving limits

In Great Britain it is illegal to drive if:

- A driver is unfit to do so because they are on legal or illegal drugs; or
- A driver has certain levels of drugs in their blood.

Northern Ireland has the 'unfit' offence' but no legal limits. Legal limits are set out for 17 legal and illegal drugs in Great Britain. The government used a 'lower limit of detection' to set the limit for eight illegal drugs, a 'risk-based approach' for eight medicinal drugs, and a separate approach for amphetamine to balance its legitimate medical uses and its abuse. The limits are higher for medicinal drugs than for illegal drugs. The drug driving law also provides a medical defence if a driver is taking a medicine in accordance with instructions from a health care professional or an accompanying leaflet and is not impaired.

The respective limits are shown in Table 1.

Table 1: Legal drug limits in Great Britain

Drug	Legal limit in microgrammes per litre of blood
Illegal drugs	
Benzoylecgonine	50
Cocaine	10
Delta-9-tetrahydrocannabinol (cannabis)	2
Ketamine	20
Lysergic acid diethylamide (LSD)	1
Methylamphetamine	10
Methylenedioxymethamphetamine (MDMA)	10
6-monoacetylmorphine (Heroin)	5
Medicinal controlled drugs	
Clonazepam	50
Diazepam	550
Flunitrazepam	300
Lorazepam	100
Methadone	500
Morphine	80
Oxazepam	300
Temazepam	1,000
Amphetamine	250

The Great Britain limits are set using a 'per se' approach with risk thresholds, based on the detection of a drug in a driver's body above a defined cut-off concentration in blood that could be related to the risk of a road traffic accident. To convict someone of drug driving in Great Britain under Section 5a, a level of the drug above the specified limit must be demonstrated. The British limits for illegal drugs are low but not purely presence based (i.e.

showing the presence of any level of drugs) as they are, for example, in Australia.[4] Neither are they based purely on impairment because of the scientific and ethical difficulties of objectively measuring, trialling and defining impairment for psychoactive drugs and driving.

1.3 Drug driving policy

In 2010, *The Report of the Review of Drink and Drug Driving*, led by Sir Peter North was published. The Report had been requested by the then Secretary of State for Transport to study the legal framework governing drink and drug driving in Great Britain. The *North Report*, along with the Transport Select Committee's 2010 inquiry into drink and drug driving law, has informed much of the government's drug driving policy in the last decade.[5]

The Government's policy since 2010 has largely focused on making it easier for police to enforce the law against drug driving.

The most significant change in drug driving enforcement in the last decade was the creation of a new offence 'driving or attempting to drive with drug level above the specified limit' in 2015. Previously, drug driving offences required proof that a driver was impaired or unfit to drive, which was significantly more difficult to prove in court, in part due to the subjectivity of the roadside field impairment test. This new offence came about after the 2013 'Report from the Expert Panel on Drug Driving' led by Professor Kim Wolff which carried out a review of the scientific literature to establish which drugs should be included in regulations and what thresholds should be set.

In the last decade, preliminary drug testing devices (screeners) for use by police have also been type-approved (to Home Office standards), first for station-based use in 2012 and for mobile use in 2015, again making enforcement of drug driving laws simpler and more effective. THINK! campaigns focused on drug driving have also been run since 2010, with the 2016 'Drug Drive: More reason to be paranoid' and 'A breathalyser for drugs' campaigns highlighting the new law and technology.

The *North Report* recommended that the Government consider a wider suite of measures to better understand and reduce drug driving. For example, the Report recommended considering the creation of a drug drive rehabilitation course, including drug drivers in the High Risk Offender Scheme, collecting more accurate drug driving casualty data and commissioning research into evidential saliva testing devices. However, the government either rejected these recommendations or stated that it would consider them having first focused on making drug driving enforcement more effective.[6]

Since 2015, convictions for the new drug driving offence have increased year on year. However, they remain significantly lower than for drink driving. Convictions also vary significantly from police force to police force with some forces recording as many drug driving offences as drink drive offences, while others record less than 10% of the drug driving offences as drink drive offences (see Chapter 3.3 for more details).

It is unclear whether the relative levels of drug and drink drive prosecutions reflect levels of drug and drink driving or the practicalities and polices enforcement. Given the widespread nature of illegal drug use, it seems unlikely that the large disparities between police forces are entirely related to local risks.

[4] Quilter J and McNamara L (2017) 'Zero tolerance' drug driving laws in Australia: A gap between rationale and form? International Journal for Crime, Justice and Social Democracy 6(3): 47-71

[5] House of Commons Transport Committee. (2010) Drink and drug driving law. https://publications.parliament.uk/pa/cm201011/cmselect/cmtran/460/460.pdf

[6] North, P. (2010). Report of the Review of Drink and Drug Driving Law Wollf, K. et al (2013). Driving under the influence of drugs. Report from the Expert Panel on Drug Driving Government Response to the North Report

Efficient and effective enforcement of the drug driving law has also been hindered by issues and delays with the blood testing needed for convictions. While the UK does not have robust drug driving casualty data, the data available suggests that the current level of enforcement has not led to a decrease in drug driving. The significant percentage of drug drivers who reoffend (24%, see Chapter 3.4 for more details) also shows that there is a need to reassess the rehabilitation options available for drug drivers.[7]

1.4 Drug driving enforcement process

In Great Britain, police can conduct a preliminary drug test if a driver has committed a moving traffic offence, been involved in a road traffic collision or if an officer reasonably suspects that a person is or has been driving having consumed drugs. Preliminary drug tests in Great Britain currently detect cannabis and cocaine. If a driver fails a preliminary drug test they will be arrested and taken to a police station where a blood sample will be taken for evidential testing. This procedure may differ if, for example, a driver has been injured in a collision or is unconscious. Police may arrest a driver and take a blood sample if they believe that the driver is impaired from drugs that cannot be tested for on the preliminary drug test (such as MDMA). Police officers generally will conduct a Field Impairment Test before arresting a driver if this is the case.

After giving a blood sample the driver will be charged and, when fit, released from custody. They will be given the option to take a "B" sample from their blood test if they wish to use it in court. A driver will then await a court date. In most cases they will be free to continue to drive between being charged and appearing in court: this frequently takes several months. There are significant concerns about the amount of time taken for laboratories to process blood tests and the length of the court process in general. Most forces wait around five months for blood test results and a further three to six months for court dates. These are discussed in more detail in 'Policing and Justice.' If found guilty at court, for a first-time offence a driver will typically be banned from driving for 12 months (the legal minimum) and fined. Someone convicted of drug driving can also receive a prison sentence of up to six months.[8]

Chapter 5 'Policing and Justice' discusses the legal system, current issues and potential solutions in greater detail.

[7] Secretary of State for Transport. (2011). The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving. Cm 8050

[8] https://www.gov.uk/drug-driving-law

CHAPTER 2

Methodology

2.1 Literature review

References to research literature and other robust sources are used throughout this report to provide context and inform the discussion, particularly in relation to potential interventions.

Searches were conducted of the academic literature on drug driving, the profile of drug drivers, treatment of drug issues and interventions to reduce drug driving. This involved using Google Scholar, ProQuest and Web of Science searches and the citations and bibliographies of relevant documents. Searches of key government and parliamentary documents on drug driving at a UK, European and global level were also conducted. These included reviews of drug driving and assessments of policy options. Studies were found from the EU, Denmark, France, the Netherlands, Norway, Switzerland, Canada, the USA, Australia, and New Zealand. Only studies published in English or that provided abstracts in English were selected. Finally, members of PACTS' network and the projects advisory panel were asked to provide relevant articles and documents. Studies were screened at title, abstract and at full text.

Evidence was prioritised based on relevance to the current situation regarding drug driving in the UK. More recent research has been prioritised as has research from other countries with similar road safety records.

Information from the literature was used to provide insights into the profile of drug drivers, reasons for drug driving and how effective different interventions aimed at reducing drug driving could be.

2.2 Interviews and information requests

In-depth semi-structured interviews were conducted with road safety and drug experts as well as with roads police officers and those who work directly in drug treatment. Interviewees included people with expertise on drink driving in the UK, USA, Canada, Australia, New Zealand and Europe. These interviews were conducted in person or over the phone by at least one member of PACTS' staff and lasted between 30 and 90 minutes. Notes were made on the interviews. They were followed up with email requests for further information when necessary. Interviews provided information on best practice on reducing drug driving across the world, they also provided insight into the profile of drug drivers and the enforcement process.

An extensive appeal for information was made to local authorities. Information requests on campaigns, interventions and research on drink driving and alcohol harm reduction were sent to all local authority road safety teams listed by Road Safety GB and to all local authority public health teams. Interviews were then conducted with 7 local authorities. This provided information on campaigns being run at a local level and the profile of drug drivers across the UK.

2.3 Data

Data were obtained from a number of sources. Stats19 road casualty data were used as the primary source of casualty data, both from the *Reported Road Casualties Great Britain* annual reports, published by the DfT, and from further analysis of underlying data. Stats19 data are recorded by police forces, either from having visited the scene or from reports from the public.

PACTS also obtained data on drug driving offences from the *Ministry of Justice Motoring Tool*; *Recorded Crime in Scotland*; and *Police Service of Northern Ireland Recorded Crime Statistics*. Survey data from the *Crime Survey for England and Wales, National Travel Attitudes*

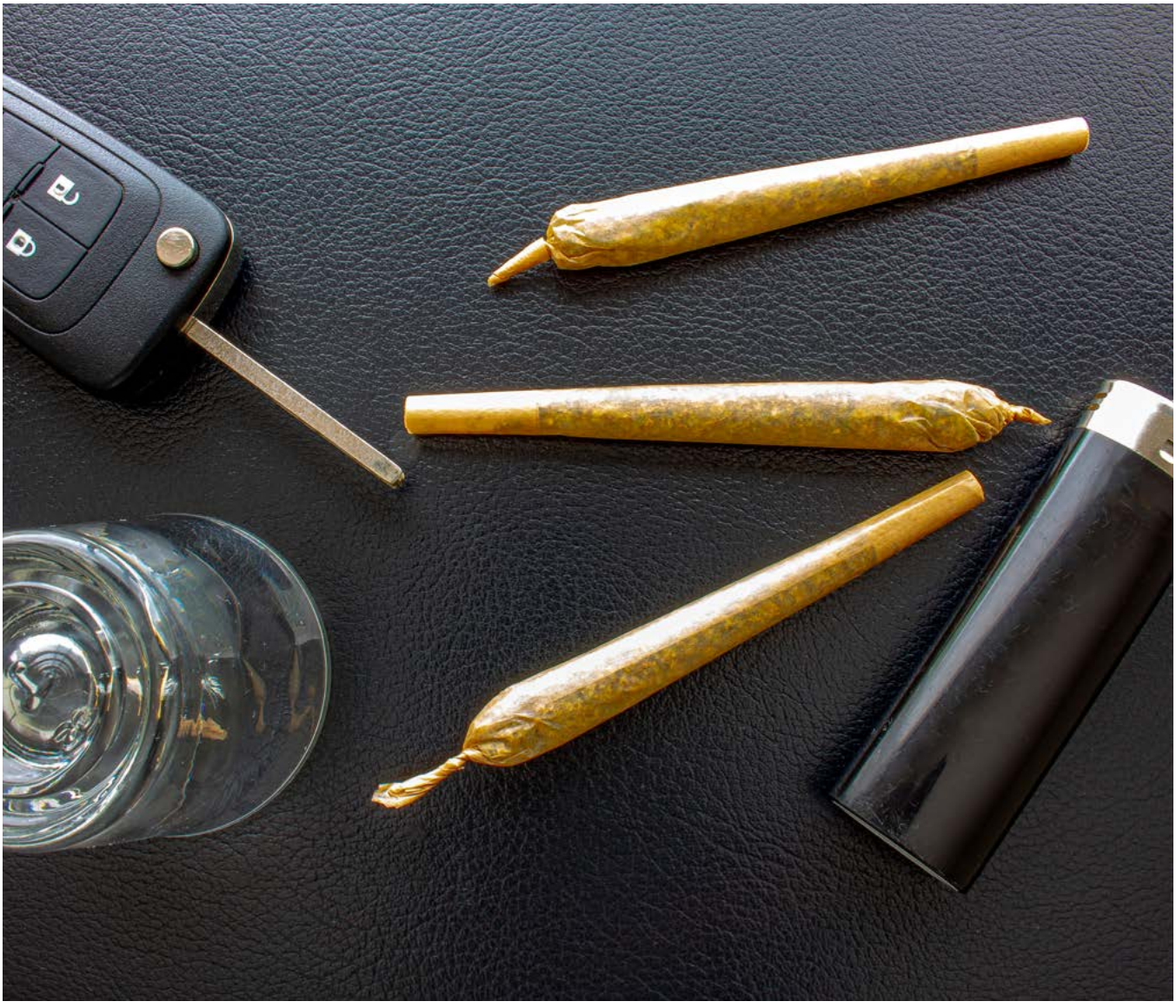
Survey and *RAC Report on Motoring* were collated. PACTS also requested and received data from the Driver and Vehicle Licensing Agency (DVLA) on drink/drug driving and reoffending and the number of people who have their licence revoked as a result of drug issues. Data were used to provide insight on the profile of drug drivers in the UK, the effectiveness of current drug driving policy, and the scope for improvement offered by different interventions.

2.4 Advisory panel

PACTS set up an advisory panel which provided input throughout the project. The panel consisted of ten experts from the fields of roads policing, road safety and drug studies. Panel members were asked to share their expertise, recommend key documents and other sources for research, and provide feedback on PACTS' project plans, findings and report drafts.

CHAPTER 3

Drug driving statistics – who, what, when, where



The DfT does not produce a robust estimate for the number of drug driving deaths in the Great Britain based on coroner data, as it does for drink driving (for more details on this see Chapter 6 'Better understanding the problem'). There is also no national data available on the number of drug tests administered and failure rates (see 'Better understanding the problem'). Again, this contrasts with drink driving, where the number of breath tests and failure rates are recorded. As a result, survey data, Stats19 data, data from police forces and conviction data must be used. Each of these data sources has their own disadvantages, though all are valuable in contributing to an understanding of drug driving in Great Britain.

3.1 Stats19 and other casualty data

Stats19 forms are generally filled out by a police officer at the scene of a collision, though occasionally they are based on reports from the public. Stats19 forms provide details about those who are involved in the collision (age, gender, severity of injuries, transport mode etc.) and the collision itself (road type, location etc.). One section of a Stats19 form is contributory factors. These allow police officers to record what they feel has contributed to collisions. One such contributory factor is 'Driver/Rider impaired by drugs (illicit or medicinal)'. Contributory factors are not a definitive guide to what contributed to a collision. Rather they represent the opinion of an officer at the scene, based on the evidence available at the time. Driver/rider impaired by drugs may be particularly challenging for a police officer to determine with little time as there may be little physical evidence of impairment (compared to, for example, 'poor or defective road surface'), particularly if the driver is killed or seriously injured. The potential inaccuracy of contributory factors for assessing the road safety impact of drug driving can be seen by comparing the number of road deaths where 'driver/rider impaired by alcohol' was noted with the more robust data published in *Reported Drinking and Driving* (based on coroner data). Contributory factors suggest that 126 people were killed in road collisions where the driver/rider was impaired by alcohol in 2018. Contrastingly, the figure based on the more in-depth coroner data is 240 deaths. It should also be noted that not all collisions have contributory factors recorded.

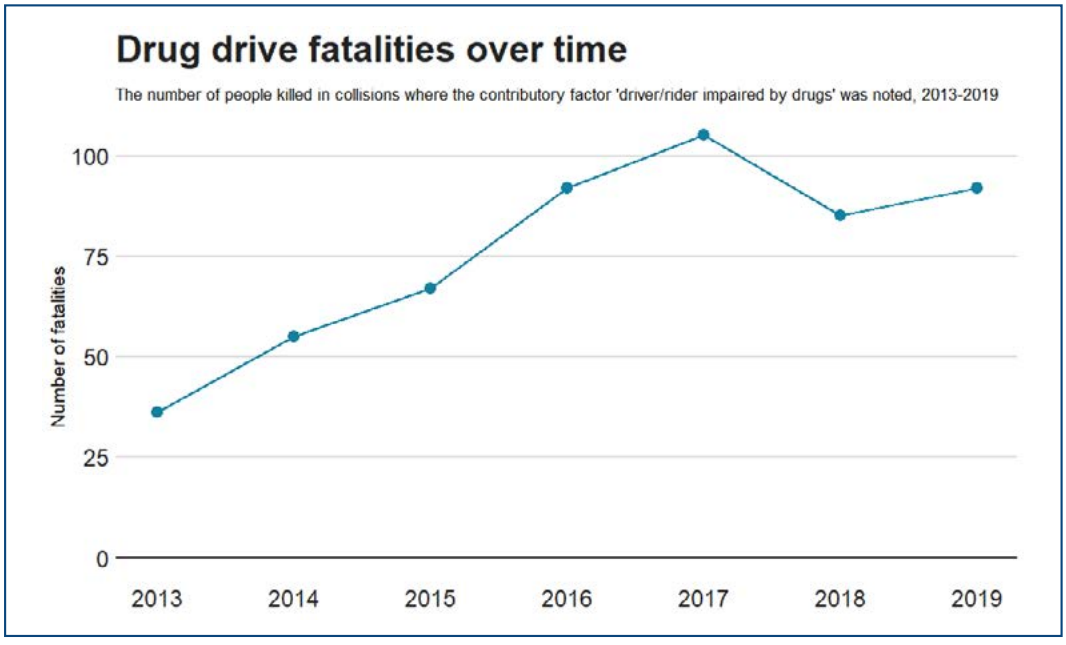


Figure 1: The number of people killed in collisions where the contributory factor 'driver/rider impaired by drugs' was noted, 2013-2019. Source Reported Road Casualties Great Britain (RRCGB)

Stats19 contributory factors suggest that, in Great Britain in 2019, there were 92 people killed and a further 672 people seriously injured where a driver/rider was impaired by drugs. These data suggest an increase in drug driving since 2013 when 36 people were killed and 241 seriously injured in such collisions. However, it is not clear if this increase is driven by an increase in drug driving or an increase in propensity of officers to record this contributory factor.

Drug driving appears to be highest for car drivers. In 2019, 82% of the collisions where the contributory factor was recorded involved a car driver being impaired by drugs (1216 collisions or 1.12% of collisions involving a car). This is also the highest percentage of any vehicle type (closely followed by van/LGV at 1.07%). This percentage is lowest for Bus or Coach drivers at 0.04%.

There is less variation in the percentage of collisions where driver/rider was impaired by drugs when split by road type. This percentage varies from 2.07% on 'other roads' to 1.63% on 'A roads.'

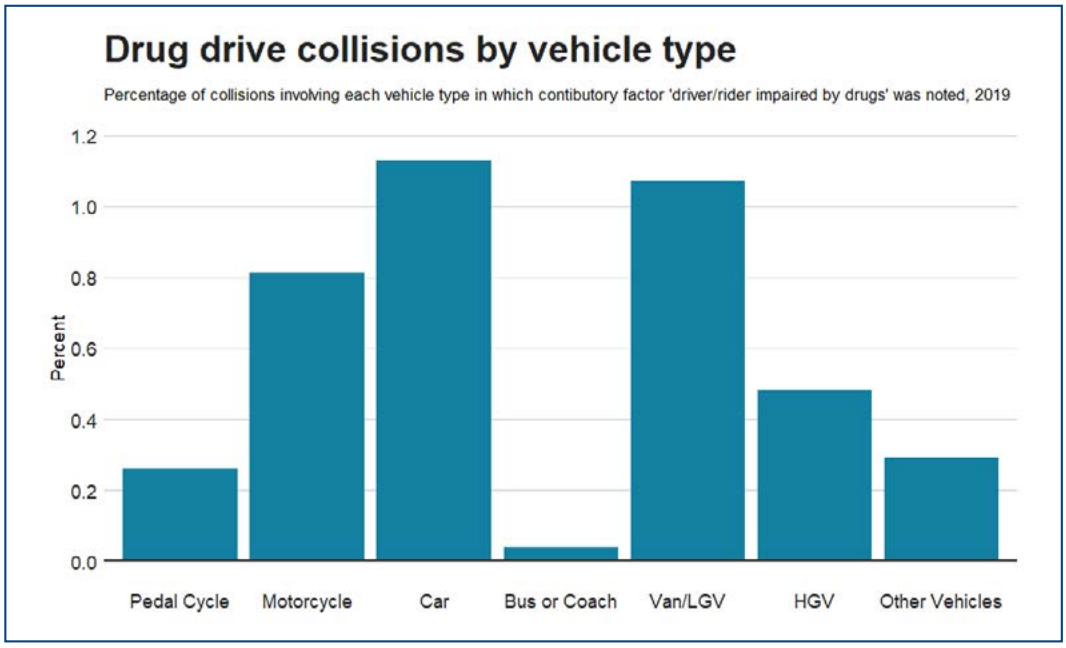


Figure 2: Percentage of collisions where a contributory factor was assigned and 'driver/rider impaired by drugs' was noted (RRCGB)

In 2019, 3.6% of collisions in the North East involved a driver/rider impaired by drugs, the highest in Great Britain. By contrast just 0.9% of collisions in London involved a driver/rider impaired by drugs. It is possible that, because Contributory Factors are officer judgement only, this may simply be a reflection of the different practices of officers completing Stats19 forms rather than the extent of drug driving. Drug driving is likely to vary both in extent and in what drugs are used across regions and even town to town in Great Britain because of the nature of the illicit drug trade and drug use.

Drug driving appears to be closely associated with other high risk driving behaviours, such as failure to wear a seat belt. An analysis by PACTS of seat belt use and contributory factors found that in 34% of KSIs where driver/rider impaired by drugs was recorded, a seat belt was not worn. The report also found that driver/rider impaired by drugs was three times as likely to be noted in a collision where the seat belt was not used than in collisions where the seat belt was worn.[9]

[9] Webster, E., and Norbury, F. (2019). Seat Belts: The Forgotten Road Safety Priority. PACTS

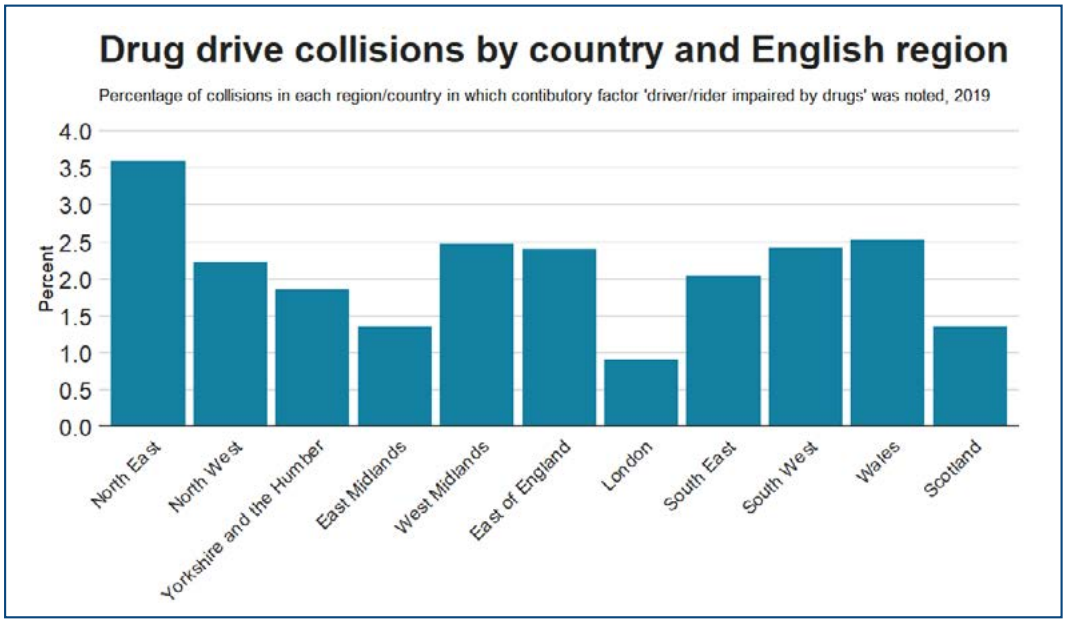


Figure 3: Percentage of collisions where a contributory factor was assigned and 'driver/rider impaired by drugs' was noted, by region/country (RRCGB)

In 2001[10] and 2012, TRL produced an analysis of the incidence of drugs and alcohol in road accident fatalities. In 2012, 231 driver fatalities had available drug data and 20% of these fatalities had an illicit drug of abuse present. 31% of these fatalities had a therapeutic drug present.[11]

The 2001 study had a sample of 1,184 fatalities and at least one medicinal or illicit drug was detected in 24% of the fatalities. The 2001 and 2012 studies do not include all fatalities in part because coroners and procurators fiscal are not required to routinely screen for drugs in road collision fatalities.[12]

More detail on how more accurate casualty data could be produced is available in Chapter 6 'Better understanding the problem.'

3.2 Self-reported levels of drug driving

The main source of survey data on drug driving comes from the *Crime Survey England and Wales* (CSEW). The *Crime Survey* is a face-to-face survey undertaken with households in England and Wales. It provides some insight into the extent of drug driving, but not the impact on road safety. Questions on driving over the legal alcohol limit and driving after taking illegal drugs have been in the CSEW since 2009/10. Questions on driving after any drinking and driving after taking legal highs and prescription medication were added to in 2019.

The *Crime Survey* found that 0.4% of drivers reported driving whilst thinking they were under the influence of illegal drugs at least once in the last 12 months (in 2019/2020). 5.4% of drivers reported that they had taken drugs at all in the last 12 months.

[10] Tunbridge, R., Keigan, M., and James, F. (2001). The incidence of drugs and alcohol in road accident fatalities. TRL.
[11] 2012 study referred to in Wolff et al. (2013). 'Driving Under the Influence of Drugs.' Report from the Expert Panel on Drug Driving.
[12] Tunbridge, R., Keigan, M., and James, F. (2001). The incidence of drugs and alcohol in road accident fatalities. TRL.

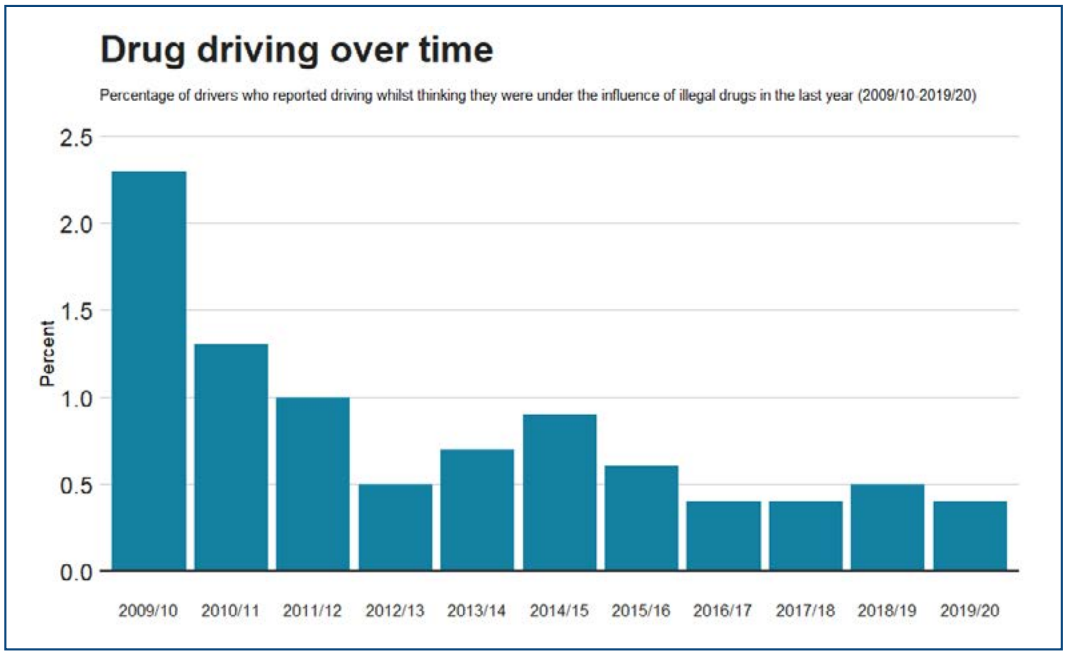


Figure 4: Percentage of divers who reported driving whilst thinking they were under the influence of illegal drugs (Crime Survey, England and Wales (CSEW))

2.5% of 16-19 year olds reported having driven whilst thinking they are under the influence of illegal drugs at least once in the last 12 months. The figure for 20-24 year olds is also high (1.1%). Self-reported drug driving is much lower amongst 25-29, 30-39, 40-49 and 50+ year olds at 0.5% 0.5%, 0.2% and 0.1% respectively. 16-19 year olds and 20-24 year olds have consistently been the most likely age groups to report drug driving, while 25-29 year olds have been near the highest percentages. The Crime Survey suggests there may have been a reduction in drug driving since 2009/10, though there is variation year on year.

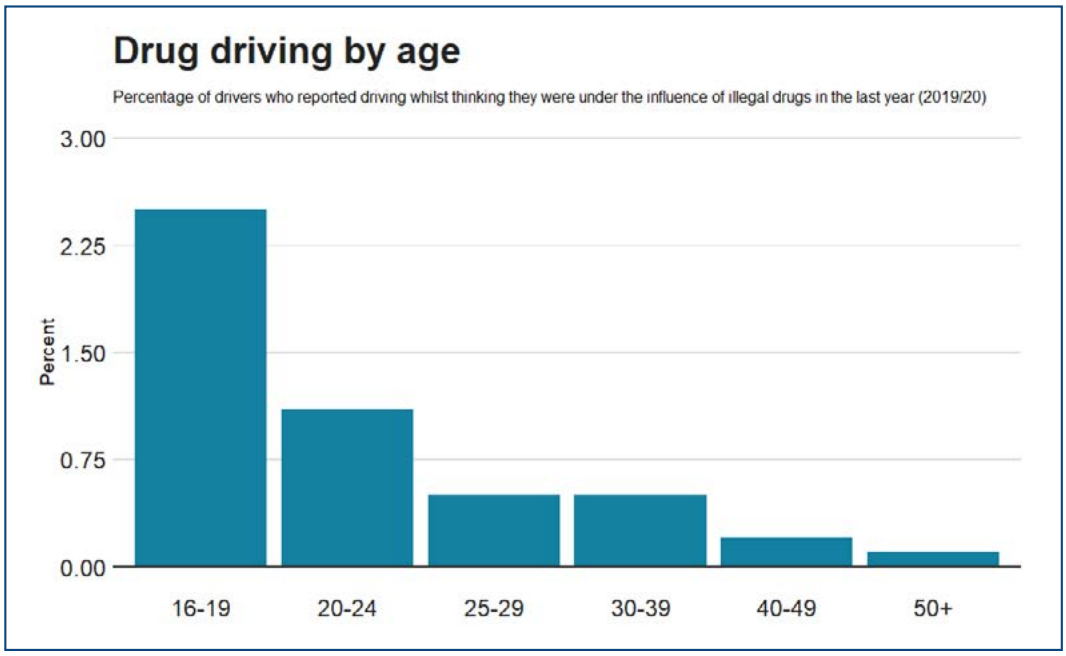


Figure 5: Percentage of divers who reported driving whilst thinking they were under the influence of illegal drugs, by age (CSEW)

The *Crime Survey* also provides data on the drug driving amongst drivers who have taken drugs in the past twelve months. As a proportion of all drivers who have taken drugs in the

last 12 months, 6.2% had driven whilst thinking they are under the influence of illegal drugs at least once. This was highest amongst 16-19 year olds at 10.8%. Drug driving was also comparatively high amongst drivers who had taken drugs in the last 12 months amongst 20-24 year olds (5.9%), 30-39 year olds (7.8%) and 50+ year olds (7.7%).

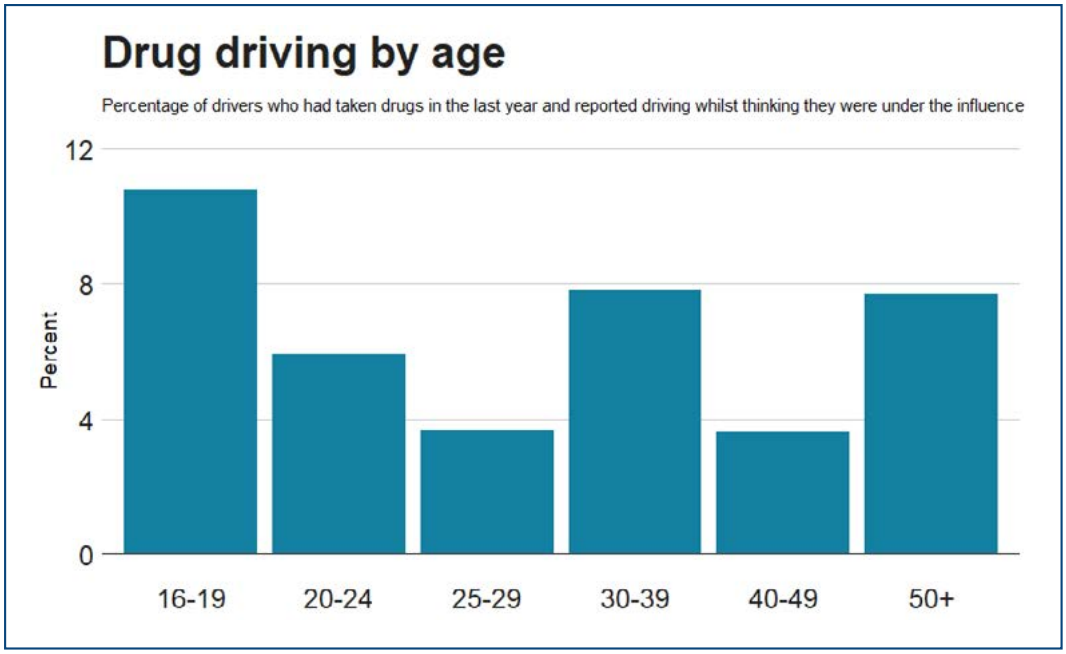


Figure 6: Percentage of divers who had taken drugs in the past year and reported driving whilst thinking they were under the influence of illegal drugs, by age (CSEW)

The *Crime Survey* suggests that drug driving amongst drivers who have taken drugs in the last 12 months has fallen significantly since it was 19.5% in 2010/11, though it may have risen slightly since 2015/16 (where it was 5.0%). Of all drivers who have taken drugs in the last 12 months, 0.6% had driven when they thought they may have been affected by or under the influence of illegal drugs a few times a week. 93.8% of drivers who had taken drugs in the past 12 months had not driven at all when they thought they may have been affected by or under the influence of illegal drugs compared to 80.5% in 2010/11.

The *Crime Survey* also shows that in 2019/20 3.8% of drivers reported that they had driven after taking medication with advice not to drive after taking. 0.6% of drivers reported that they did this every day/almost every day. 6.6% of those aged 16-19 reported driving after taking medication. This was the highest figure, followed by 25-29 year olds (5.4%), 20-24 year olds (4.8%), 30-39 year olds (3.9%), 40-49 year olds (3.8%) and 50+ year olds (3.2%).

How much faith can be placed in self-reporting?

There will be doubts about the extent to which people will accurately report having broken the law. Studies which compare confidential surveys with roadside observations of behaviour such as seat belt use suggests that robust confidential surveys, such as the CSEW, have validity and reflect behaviour on the roads.[1]

[1] Holló, P., Henézi, D., & Berta, T. (2018). Comparison of self-reported and observed road safety performance indicators. Periodica Polytechnica Transportation Engineering, 46(3), 117-121.

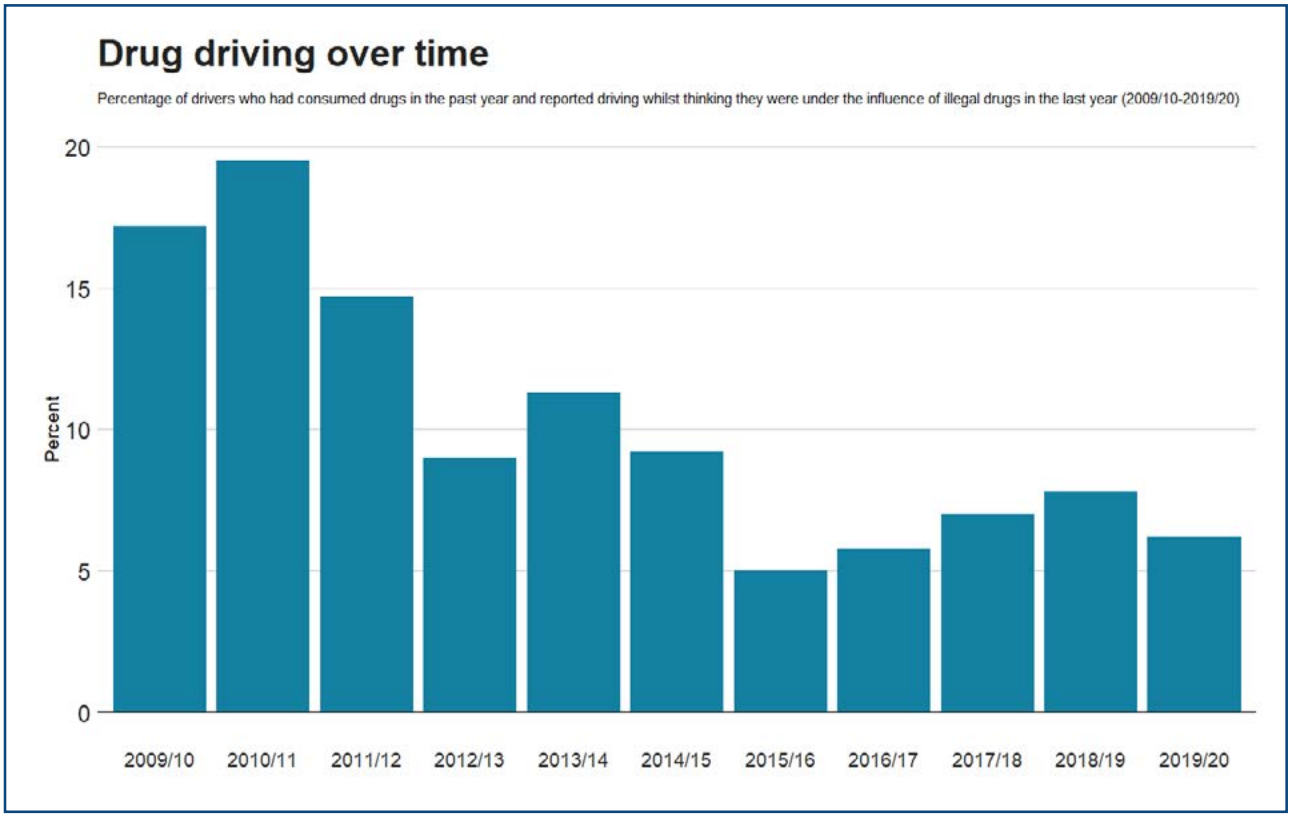


Figure 7: Percentage of divers who had consumed drugs in the past year and reported driving whilst thinking they were under the influence of illegal drugs, by year (CSEW)

0.3% of drivers reported driving after taking legal highs, or drugs formerly known as legal highs in 2019/20. 16-19 year olds were the most likely to report driving after taking legal highs (0.7%) followed by those aged 30-30 and 25-29 (0.5% respectively), 20-24 year olds (0.4%), 50+ year olds (0.2%) and 40-49 year olds (0%).

Data is also available on attitudes towards drug driving from the *National Travel Attitudes Survey* from 2020.[13] NTAS is commissioned by the Department for Transport and surveys public opinion on a wide variety of travel and transport related issues. 96% of those surveyed in Wave 2 (fieldwork August to September 2019) agreed that if someone has taken illegal drugs, they should not drive any distance, and just 2% disagreed. 50% agreed that if someone has taken legal drugs, they should not drive any distances (20% disagreed and 29% neither agreed or disagree, considerably higher than neither agree nor disagree for illegal drugs). Interestingly, 65% agreed that the laws on driving whilst impaired by illegal or legal drugs are not properly enforced and 62% agreed that the number of people driving whilst impaired by illegal or legal drugs has increased in the last five years (just 10% and 43% disagreed with these statements).

ESRA survey

An alternative source of survey data on drug driving is the *E-Survey of Road Users' Attitudes* (ESRA) an international research project which conducts surveys of road user attitudes in 38 countries.[14] ESRA is conducted by the Belgian Vias Institute and takes the form of an online survey of a representative sample of around 1,000 members of the national adult population.

[13] Department for Transport. (2020). National Travel Attitudes Study: Wave 2. Department for Transport. https://www.gov.uk/government/statistics/national-travel-attitudes-study-wave-2

[14] ESRA (2018). Driving under the influence f alcohol and drugs. ESRA. https://www.esranet.eu/en/publications/

ESRA suggests significantly higher levels of self-reported drug driving than the *Crime Survey*. 7.5% of car drivers surveyed in the UK had driven 1 hour after using drugs (other than medication) over the last 30 days in the UK (the highest of countries with a similar road safety record, the average across the European countries was 5%). ESRA also found that 13% of car drivers had driven after taking medication with a warning that it may influence driving ability.

ESRA also surveyed attitudes towards drug driving. 2.6% of drivers surveyed in the UK felt it was acceptable to drive 1 hour after using drugs other than medication (compared to 1.4% on average in Europe) and 4% in the UK felt that where they live, most other people would say it is acceptable for a car driver to drive 1 hour after using drugs (compared to 3.1% on average in Europe).

The figure for self-reported drug driving from ESRA may be higher than the Crime Survey for several reasons. Firstly, while ESRA specifies 'not medicinal' drugs it does not specify 'illegal' like CSEW. Secondly, ESRA is conducted online while CSEW is conducted in person. Thirdly, the surveys use different sampling techniques. ESRA is a quota sample using a panel while CSEW uses a more robust random probability sample. 20,233 people answered the CSEW drug driving question while just 963 answered the ESRA drug driving question. Finally, responses in ESRA are on a scale from 1-5 where 1 is 'never', 5 is '(almost) always' and the numbers in between have no set value, rather they 'can be used to define your response' whereas in the crime survey respondents state 'every day' 'once a week' etc.

3.3 Conviction and arrest data

Data on court proceedings and convictions is available from *Criminal Justice System Statistics*, published by the Ministry of Justice. Court data has the obvious limitation that it records actions by the police and courts rather than driver behaviour itself. As such, trends may reflect changes in policing and the justice system rather than in drug driving. 12,391 people were convicted of drug driving offences in 2019. This is a significant increase on previous years (Figure 8). Comparison to years before 2015 are not useful because the offence 'Drive a motor vehicle with the proportion of specified controlled drug above specified limit' was not introduced until 2015.

Initial data from police forces suggest that the number of drug driving arrests has increased during the coronavirus pandemic. This could be due to increases in drug driving, or it being easier to identify those in the drug trade during lockdown, or in some cases increased time being available to police the roads as other demands on their time were reduced. The offences counted as 'drug driving' in this report include:

- Causing death by driving without due care / consideration while over prescribed limit – specified controlled drug
- Drive a motor vehicle with the proportion of specified controlled drug above specified limit
- Attempt to drive a motor vehicle with the proportion of specified controlled drug above specified limit
- In charge of a motor vehicle with the proportion of specified controlled drug above specified limit
- In charge of a vehicle whilst unfit to drive through drink or drugs (impairment)– Drugs
- Driving or attempting to drive a vehicle whilst unfit to drive through drink or drugs (impairment) – Drugs

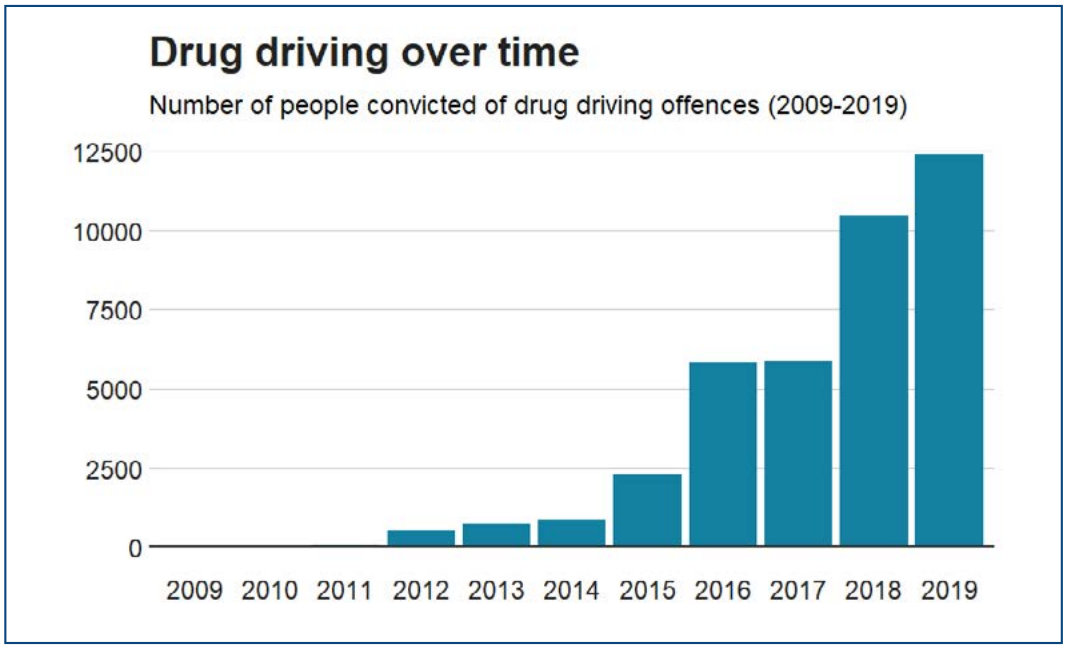


Figure 8: Number of drug drive convictions over time (Criminal Justice System Statistics (CJSS))

Court data also provides information on the age, ethnicity and gender of those convicted of drug driving. This can offer insight into the profile of drug drivers in the UK, though it should be remembered that this data shows who has been arrested and convicted for drug driving, which may not be an accurate picture of the drug driving population. Unfortunately, court data is not published with equal age intervals, though this can be controlled for by calculating the number of arrests per person in each age group. A measure such as per thousand driving licences held would be more useful but the DVLA does not publish driving license by age using the same age groups as court data. Drug driving convictions per thousand population is highest amongst 18-24 year olds and 25-29 year olds (0.65). Convictions per thousand population then decreases with age. There are the highest number of drug driving convictions in 2018 amongst 18-24 year olds (3,734), followed by 30-39 year olds (3,662) and 25-29 year olds (2,921).

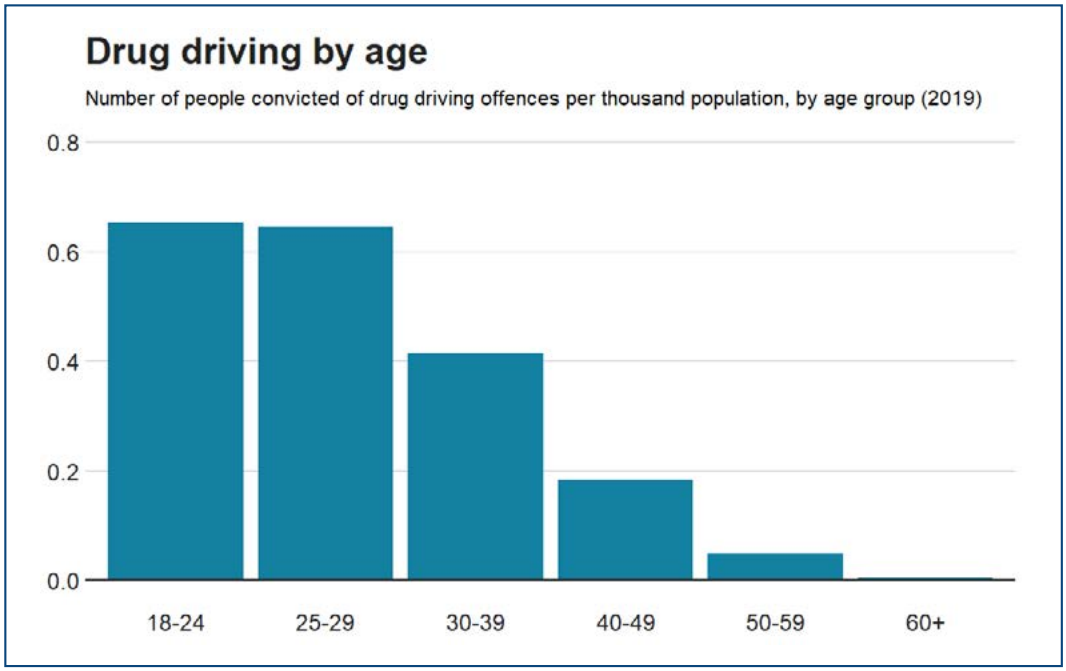


Figure 9: Number of drug drive convictions by age (CJSS)

Conviction data suggests that drug drivers are significantly more likely to be male than female. There were 1,017 women convicted of drug driving in 2019 compared to 12,245 men. The vast majority of people convicted for drug driving were white (8,040, 83% of those convicted). 737 (8%) Asian people, 663 (7%) black people, 264 (3%) mixed ethnicity people and 108 (1%) Chinese and other people were convicted of drug driving. A comparison with ONS population statistics (based on the 2011 census) suggests that black and mixed-race people are overrepresented in these statistics while white and Asian people are underrepresented. However, this could reflect policing behaviour, changing population demographics since 2011 or the driving population having different demographics to the general population rather than the likelihood of people from different ethnic backgrounds drug driving.

Finally, conviction data can be separated by police force area. There were more convictions for drug driving per 1,000 population in Merseyside (0.71) than in any other police force area. There were also more than 0.5 convictions per 1,000 population in North Wales, Dorset, Cleveland, and Norfolk. There were significantly fewer convictions per 1,000 population in the West Midlands (0.06). Northumbria, Northamptonshire, Hertfordshire, Nottinghamshire, Leicestershire and Avon and Somerset also had less than 0.1 conviction per 1,000 population. The highest number of convictions were in the Metropolitan police area (1,093), followed by Merseyside (991) and Essex (784). The lowest numbers were in Warwickshire (56), Northamptonshire (61) and Bedfordshire (63). Conviction data also allows us to compare drink and drug driving convictions. In Merseyside there were more drug convictions than drink convictions (108 drug convictions for every 100 drink convictions) while in Northamptonshire there were only 10 drug convictions for every 100 drink driving convictions. While there may be geographical variations in drug driving, this data likely reflects differing enforcement priorities and resources in different forces.

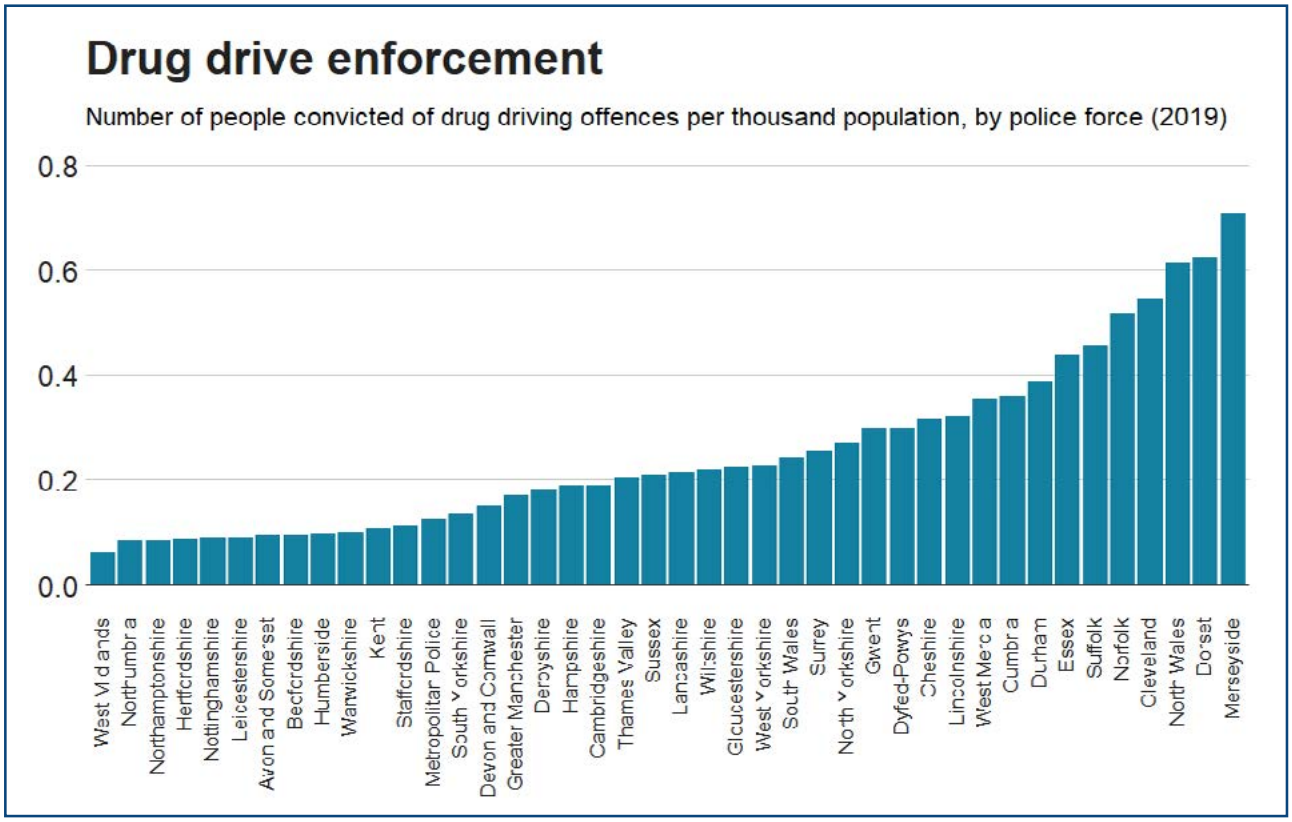


Figure 10: Number of drug drive convictions by police force (CJSS)

3.4 Reoffending

Data provided to PACTS from the DVLA shows that 58,108 *people* committed a drug driving offence between 2010 and 2019. Of these 14,224 had a previous drink/drug driving offence on their record. This means 24% of drug driving offenders were reoffending.

The same data shows that 78,062 drug driving *offences* were committed since 2010. Of these, 34,178 were not a first drink/drug driving offence. This means 44% of offences were committed by drivers who were reoffending.

By comparison, 7% of people who had a drink drive offence were reoffending and reoffenders committed 17% of drink drive offences.

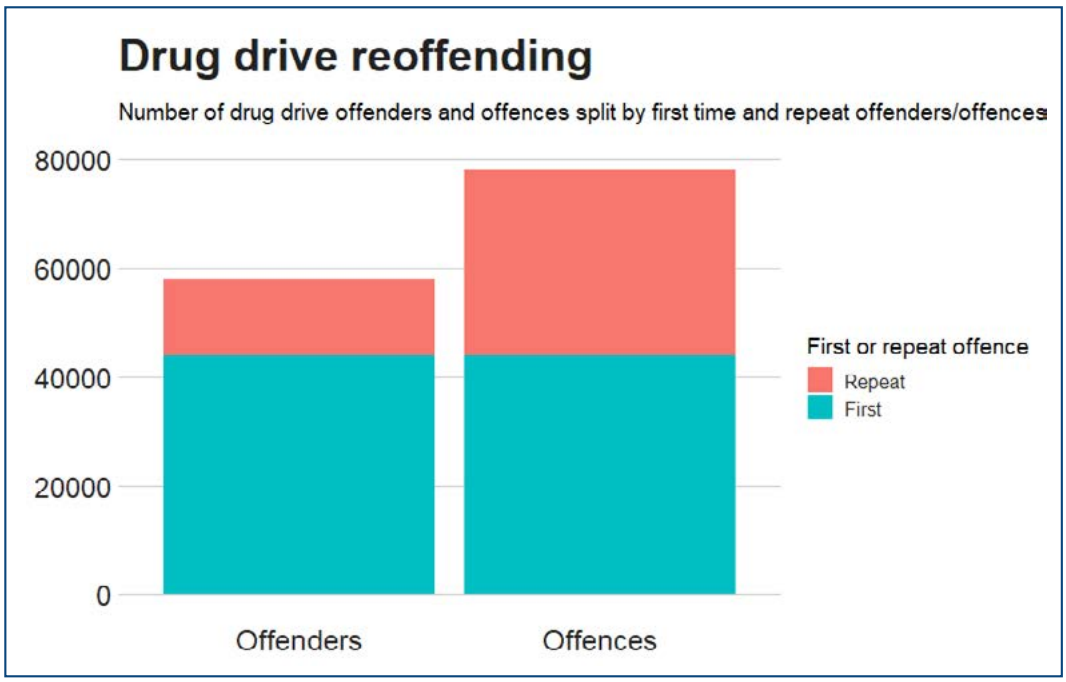


Figure 11: Number of drug drive offenders and offences, split by first time and repeat offenders/offences (CJSS)

Six people were convicted of 'causing death by careless driving when unfit through drugs' with a previous drink or drug offence on their record and a further four people were convicted of 'causing death by careless driving with drug level above the limit' with a previous drink or drug offence on their record.

One person was convicted of 'driving or attempting to drive with drug level above the specified limit' when they had 18 previous drink/drug driving offences on their record. 15 people were convicted of a drug driving offence with more than 10 previous drink/drug driving offences on their record. 425 people were convicted of a drug driving offence with more than five previous drink/drug driving offences on their record.

The overwhelming majority of those who reoffended do so within the first year of their previous offence. The data supplied to PACTS by DVLA shows the time between drug offences for 13,146 reoffenders. Of these reoffenders, 11,402 committed an offence in the year after their previous offence. (Note, data on reoffending were not supplied to PACTS in event time periods.) 1,045 people committed an offence one or two years after their previous offence, 554 two or three years after, 112 four of five years after, 29 six or seven years after and four eight or nine years after. These data do not include those who drug drove but were not caught; this figure is likely to be substantially higher. This pattern is broadly similar to, though

more pronounced than, reoffending by drink drivers. 6,164 people committed a subsequent drink drive offence in the year after their first offence. 9,733 committed an offence one or two years after their first offence, 8,550 reoffended three or four years after, 5,482 five or six years after, 2,954 seven or eight years after and 904 nine or ten years after.

This dataset only shows offences back to 2010 e.g. someone who committed a drug driving offence in 2011 with a previous offence in 2009 would not be counted as reoffending. This is because of the data supplied to PACTS by DVLA from the Impala database. It is therefore likely that these data on reoffending are an underestimate. Furthermore, these data do not include those who drug drove but were not caught, meaning that this picture of reoffending is not a true picture of the extent of repeat drug driving behaviours figure is likely to be substantially higher.

An unknown piece of data on the effectiveness of the legal system is how many people drive having been disqualified. 8,445 people were found guilty of driving while disqualified in 2019. However, the data do not show why these drivers were disqualified. To be included in this dataset a disqualified driver would also have had to be caught by the police. As such, it is likely to be a significant underestimate. Police officers, those involved in the legal system and academics interviewed for this report, expressed concerns over how many people likely drive while disqualified and how unlikely they are to be caught doing so, in part because of significant cuts to roads policing.

3.5 Academic literature on the profile of drug drivers

There is an academic literature on the profile of drug drivers in Europe, Australasia, and North America. However, fewer studies exist on the profile of drug drivers in the UK specifically. This Chapter presents the academic evidence on the profile of drug drivers; when the study is not based on the UK this is noted.

3.5.1 Criminal history

The literature suggests that drug drivers are more likely to have a criminal history than the general public. Typically, these criminal histories are drug related. An analysis of the criminal histories of those convicted of drug driving, undertaken in the 2017 assessment of the changes to drug legislation, found that 67% of those convicted of drug driving offences had one or more previous conviction. 28% of those convicted had 10 or more previous offences. Typically, these offences were for theft/burglary or drug-related.[15] An analysis of those arrested for drug driving by the Metropolitan Police between March 2015 and 2016 found that 82% had a prior criminal record and on average had 14 previous offences. 89% of those had been arrested for drugs offences. 57% of those arrested had a criminal record that met the definition of a persistent offender.[16] By comparison, 53% of those arrested for other recordable motoring offences had a criminal record. Similarly, studies of drug driving amongst young adults in New Zealand have also found that juvenile arrests is a predictor of drug driving as well as previous traffic convictions and collisions.[17] Several police officers interviewed for this project suggested that drug driving laws are a useful tool for disrupting major crime and arresting serious criminals, particularly those involved with county lines drug dealing.

It should be noted that the UK studies of drug driving are based on arrest data, so the profile may reflect the profile of those who are convicted of drug driving rather than the general

[15] Risk Solutions. (2017). Evaluation of the new drug driving legislation, one year after its introduction. Risk Solutions

[16] Nunn, J. (2018) The Criminal Histories of Drug-Drive Offenders. Policing: A Journal of Policy and Practice. 14(2), pp.456-468.

[17] Holmes, E., Vanlaar, W., and Robertson, R. (2014). The Problem of Youth Drugged Driving and Approaches to Prevention: A Systematic Literature Review. Canadian Centre on Substance Abuse

drug driving population. Even when considering this, it seems clear that drug drivers are significantly more likely to have a criminal history than the general population and other motoring offenders. This is unsurprising, as possession of a controlled drug is in itself against the law. Furthermore, people who take drugs or have substance use issues are also more likely to have criminal histories than the general population.

Police officers interviewed for this project reported that the offence 'Driving or attempting to drive with drug level above the specified limit' is often used against those involved in the county lines drug trade, and drug dealing more generally. Stops and arrests for drug driving, based on specific intelligence, disrupt the drugs trade and can enable searches to stop drugs being moved across the UK. This police activity where drivers are targeted because of their involvement in other criminal activities may help explain the extensive criminal histories of some drug drivers. This activity also demonstrates the links between road traffic offences and wider crime and it shows the value of roads policing in preventing serious crime.

3.5.2 Age

The 2017 assessment of changes to drug driving legislation found that more than half of those screened for drug driving were under 30. Furthermore, the highest percentage of tests that were positive were those in the 20-25 age group.[18] An evaluation of those arrested for drug driving in Merseyside found that 25% were 17-25, while an analysis in Essex found that 62% of those arrested are 21-34.[19] Similarly, roadside studies of Spanish drivers found that the likelihood of drug driving decreases with age.[20] These findings have also been echoed by studies across Europe, in the Netherlands and in Australian Capital Territory.[21,22,23] A systematic review of studies of drug driving amongst HGV drivers (with most studies coming from the Americas and Australia) also found that drug driving was associated with younger drivers.[24] One evaluation of the Queensland 2007-2012 roadside drug testing programme found that those aged 30-39 year olds were the most likely to drug drive. However, the age profile did vary by drug, with younger drivers being more likely to test positive for cannabis while those aged over 30 were more likely to test positive for methamphetamine (the study found particularly high usage of methamphetamine, which is not commonly used in the UK).[25]

Some studies of the age profile of drug drivers have found that young people are more likely to drug drive because they are more likely to believe that drugs do not impair driving. Young people may also feel they are less likely to be caught and punished for drug driving.[26] The age profile of drug driving is similar to other driving offences.

3.5.3 Gender

An analysis of those tested for drug driving in 2017 found that 94% of tests were conducted on men. Men were also more likely to test positive than women (61% of test on men were positive compared to 51% of tests on women).[27] There is near consensus that men are more

[18] Risk Solutions. (2017). Evaluation of the new drug driving legislation, one year after its introduction. Risk Solutions

[19] Merseyside Police (2020). Drug20 presentation. Pers. Comms.

[20] Gomez-Talegon, T. et al. (2012). Prevalence of psychoactive substances, alcohol, illicit drugs, and medicines, in Spanish drivers: a roadside study. Forensic Science International, 233(1), 106-113.

[21] SWOV (2018). SWOV Fact Sheet: The use of drugs and medicines behind the wheel.

[22] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

[23] Armstrong, K., Watling, C., and Davey, J. (2018). Deterrence of drug driving: The impact of the ACT drug driving legislation and detection techniques. Transportation Research Part F: Traffic Psychology and Behaviour, 54(1), 138-147.

[24] Girotto, E., Mesas, A., de Andrade, S., and Birolim, M. (2013). Psychoactive substance use by truck drivers: a systematic review. Occupational Environmental Medicine, 71(1), 71-76.

[25] Davey, J., Armstrong, K., Martin, P. (2014). Results of the Queensland 2007-2012 roadside drug testing program: The prevalence of three illicit drugs. Accident Analysis and Prevention. 65(1), 11-17.

[26] Holmes, E., Vanlaar, W., and Robertson, R. (2014). The Problem of Youth Drugged Driving and Approaches to Prevention: A Systematic Literature Review. Canadian Centre on Substance Abuse

[27] Risk Solutions. (2017). Evaluation of the new drug driving legislation, one year after its introduction. Risk Solutions

likely to drug drive than women. This includes evidence from surveys, testing, arrests and collision data and from studies conducted across the world.[28] One notable exception is a recent study of the drug driving programme in Australian Capital Territory, which found that gender was not predictive of drug driving. The gender profile of drug driving is similar to other driving offences.

3.5.4 Ethnicity

Though there were small sample sizes, the 2017 assessment of changes to drug driving legislation found no significant differences in the likelihood of a positive drug test by ethnicity.[29] Other than this study, the ethnicity of drug drivers has not been studied

3.5.5 Drug profile

The 2017 evaluation of drug driving laws in the England and Wales found that blood tests for those arrested for drug driving showed that THC (the substance tested for to detect cannabis use) was found in 84% of samples and exceeded the legal limit in 62% of samples. Cocaine and its main metabolite BZE was found in 48% of samples and exceeded the legal limit in 34% of cases. Morphine (3.6% of samples, over the legal limit in 0.3% of samples) was the next most common drug followed by diazepam (2.3% and 0.2%), amphetamine (1.8% and 0%), MDMA (1.5% and 1.3%), methadone (1.3% and 0.2%) and oxazepam (1.3% and 0%).[30] It is not surprising that cocaine and cannabis are the drugs most commonly associated with drug driving. As well as being the most commonly used illicit drugs in the UK, they are screened for in roadside saliva tests. Drivers can still be arrested and asked to take a blood test if they are suspected of driving when under the influence of another drug though they generally will have failed a field impairment test and the opinion of a healthcare professional is required. This is far less common than a driver being blood tested having failed a roadside saliva screening test.

There is international evidence that controlled prescription drugs may be more common than cannabis and cocaine in drivers. In particular, evidence suggests that benzodiazepines and opioids may be in a comparatively high percentage of drivers and at levels which may impair driving.[31,32] A study of drug driving across Europe also found that licit drugs, in particular benzodiazepines, were more common in the general driving population than illicit drugs. This study also noted amphetamines, cocaine, cannabis and opiates as high-risk drugs which are comparatively common in the general driving population.[33] Similarly, a study of drug driving across Europe found that THC (the active substance in cannabis) was the most commonly found illicit drug in drivers killed or seriously injured followed by cocaine and amphetamines. This study also found that benzodiazepines and medicinal opioids were the most commonly used medicines amongst drivers who were killed and seriously injured in Europe.[34]

Roadside studies of the prevalence of drugs in Spanish drivers have been conducted in 2012 and 2015. The studies carried out testing of a representative sample of around 3000 drivers, both saliva analysis and alcohol breath testing was conducted. Interestingly both

[28] Davey, J., Armstrong, K., Martin, P. (2014). Results of the Queensland 2007-2012 roadside drug testing program: The prevalence of three illicit drugs. Accident Analysis and Prevention. 65(1), 11-17.

[29] Risk Solutions. (2017). Evaluation of the new drug driving legislation, one year after its introduction. Risk Solutions

[30] Risk Solutions. (2017). Evaluation of the new drug driving legislation, one year after its introduction. Risk Solutions

[31] Raes, E., Van den Deste, T., and Verstraete, A.G. (2008). EMCDDA Insights: Drug use, impaired driving and traffic accidents. ECDDA.

[32] Smith, R.C., Turturici, M., & Camden, M.C. (2018). Countermeasures Against Prescription and Over-the-Counter Drug-Impaired Driving. AAA.

[33] Lillsunde, P., and Gunnar, T. (2005). Drugs and driving: the Finnish perspective. Bulletin on Narcotics, 57(1-2), 213-229.

[34] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

studies found more cannabis use than alcohol use. The 2015 study also found that cocaine was present in the systems of Spanish drivers more frequently than alcohol. Unsurprisingly, prescribed drugs were found to be more prevalent in older drivers, and benzodiazepines were again identified as the most common medicine.[35,36]

Data on the drug profile of drug drivers is heavily biased by regulation and what drugs are tested for by police. For example, so called 'designer drugs' or new psychoactive substances such as synthetic cannabinoids will not be detected by standard roadside saliva tests because of their novel chemical structures. This may pose a significant road safety risk as these drugs tend to be used in combination with alcohol, increasing how much they impair drivers and are generally stronger than older drugs.[37] Both coroners and experts on drug use highlighted the potential risk posed by new psychoactive substances in discussions with PACTS, because of their increasing use and effects on users.

A systematic global review of drug use by HGV drivers found that amphetamine use was particularly high amongst this groups (compared to other studies) particularly amongst drivers who work longer hours or through the night. Cocaine and cannabis use was also high amongst this group.[38]

It has been suggested that drivers who test positive for drugs may also have alcohol in their system and vice versa. However, there is no available data on this in the UK. This may be in part because being convicted of drug driving alongside drink driving carries no additional penalty so police officers may not conduct a drug test if someone fails a breathalyser. There is some evidence of an overlap between drink and drug driving from Europe. For example, a study of drivers who tested positive for drugs after being involved in a fatal collision in France in 2017 found that half also had a blood alcohol level above the legal limit in France.[39] There is the need for better data to understand this issue in the UK, particularly as drugs and alcohol in combination can have a significantly greater impairing effect than either taken in isolation.

3.5.6 Drug driving and HGVs

A systematic review of substance use by truck drivers found that certain truck drivers were more likely to use drugs. The review found that younger drivers, those working night shifts, employees of small and medium sized companies, those with prior involvement in collisions and those with productivity-based earnings were more likely to use drugs and drive. This study was based on international research with most studies reviewed taking place in Brazil, the USA and Australia.[40] Interviews with police officers and drug driving experts also suggest that drug driving may be comparatively high in those who drive for work, but who may not hold HGV licenses, such as delivery drivers. This is perceived to be particularly amongst those working long hours and night shifts.

3.5.7 Employment

An analysis of those arrested for drug driving in Merseyside found that 50% were from professions such as: the trades, factory workers and delivery drivers. This study also found

[35] Domingo-Salvany, A. et al. (2015). Prevalence of psychoactive substances, alcohol and illicit drugs, in Spanish drivers: A roadside study in 2015. Forensic Science International, 278(1), 253-259.

[36] Gomez-Talegon, T. et al. (2012). Prevalence of psychoactive substances, alcohol, illicit drugs, and medicines, in Spanish drivers: a roadside study. Forensic Science International, 233(1), 106-113.

[37] Frith, W.J. (2020). Risks of driving when affected by cannabis, MDMA (ecstasy) and methamphetamine and the deterrence of such behaviour: a literature review. NZ Transport Agency research report 664.

[38] Girotto, E., Mesas, A., de Andrade, S., and Birolim, M. (2013). Psychoactive substance use by truck drivers: a systematic review. Occupational Environmental Medicine, 71(1), 71-76.

[39] ETSC. (2019). Half of drug drivers involved in fatal collisions in France were also over the drink drive limit. 2019.

[40] Girotto, E., Mesas, A., de Andrade, S., and Birolim, M. (2013). Psychoactive substance use by truck drivers: a systematic review. Occupational Environmental Medicine, 71(1), 71-76.

that more than 150 taxi drivers had been arrested for drink and drug driving in the last 2 years.[41] A study of drug drivers in West Mercia found that those who were unemployed or who worked in construction were significantly more likely to be arrested for drink driving. Interviews with representatives from other police forces suggest a similar situation across the rest of the UK, with those working in the trades and taxi drivers more likely to be drug driving than the rest of the population.

3.5.8 Drug issues and mental health

The profile of drug drivers has significant overlaps with the profile of people with drug use disorders. Younger people and men are particularly likely to have substance use issues and to be drug drivers.[42] The DRUID project suggested that chronic drug users are more likely to drug drive than moderate drug users.[43] Similarly, many experts in addiction suggested that drug drivers may be particularly likely to have substance use issues as they are unable to separate their drug taking from their other behaviour. As such, their drug driving is a manifestation of their substance use issue. This has implications for both interventions aimed at preventing drug driving and sentencing and treatment options for drug drivers. Alongside issues around problematic substance use, mental health experts, police officers and those involved in the legal process suggested that many drug drivers are likely to have mental health issues such as depression and anxiety. Drug dependence and misuse is significantly more prevalent in adults with various psychiatric problems, including common mental disorders, personality disorders and severe psychotic illness.[44] More than a third of adults with current signs of dependence on drugs other than cannabis have received treatment, help or advice specifically because of their drug use at some point. Only 14.6% of those with signs of cannabis dependence have received treatment, help or support specifically because of their drug use.[45] This shows both the high levels of mental health issues amongst those with dependence issues and the significant proportion of those with drug dependency who have not received help.

There is more evidence on the relationship between alcohol issues, mental health and drink driving than there is for drug driving. Drink drivers are significantly more likely to have alcohol and mental health issues than the general population.[46]

More research on the level and impact of drug dependence and poor mental health on drug driving in the UK would be useful. Drug drivers are more likely to have mental health issues and use drugs in a problematic way than the general population. Drug dependence and mental health issues are also likely to contribute to drug driving.

[41] Pers.Comms

[42] Roberts, C., Lepps, H., Strang, J., and Singleton, N. (2014). Chapter 11, Adult Psychiatric Morbidity Survey 2014 in Drug use and dependence. NHS.

[43] EMCDDA 2012, Driving Under the Influence of Drugs, Alcohol and Medicines in Europe: Findings from the DRUID Project

[44] Roberts, C., Lepps, H., Strang, J., and Singleton, N. (2014). Chapter 11, Adult Psychiatric Morbidity Survey 2014 in Drug use and dependence. NHS.

[45] Roberts, C., Lepps, H., Strang, J., and Singleton, N. (2014). Chapter 11, Adult Psychiatric Morbidity Survey 2014 in Drug use and dependence. NHS.

[46] Webster, E. (2020). Drink Driving: Taking Stock, Moving Forward. PACTS

3.6 Summary

While certain groups are more likely to drug drive, such as younger men, 'drug drivers' are a varied group. Different drugs have different user profiles, for example while those who take cocaine or cannabis and drive are more likely to be younger, those who drive under the influence of prescription drugs tend to be older. Even amongst those who drive after taking recreational drugs there will be a different user and journey profile. For example, those who drug drive having taken cannabis will likely have a different profile to those who drive after taking MDMA and other amphetamines. Even amongst those who are taking cannabis, significant differences will exist between heavy habitual users who are likely to regularly be over the drug driving limit and occasional users as well as between those who self-medicate with cannabis and those who use it purely for recreational purposes. It is important to remember this diversity when designing interventions.

CHAPTER 4

Prevention and interventions

4.1 Introduction

A variety of interventions have been suggested and implemented with the aim of reducing drink driving across the world. This includes but is not limited to enforcement campaigns, education and prevention programmes, and rehabilitation and treatment courses. Unfortunately, there has been comparatively little assessment of drug driving interventions compared to other aspects of the Fatal 4/5 (speeding, seat belt non-use, distraction/mobile phone use, drink driving), particularly drink driving and speeding. This is in part because drug driving has only received significant attention relatively recently and because drug driving offences have generally only been introduced in the past twenty years. There is clearly a need for further assessment, particularly in the UK, when interventions are run. However, there is sufficient evidence of the effectiveness of many interventions to evaluate whether they are likely to be effective in reducing drug driving in the UK.

4.2 Enforcement

Enforcement of drug driving aims to increase road safety by removing drug drivers from the roads and increasing general deterrence. The aim of the 2015 and 2019 drug driving laws in Great Britain was to reduce the number of people killed and seriously injured as a result of drug driving by:

1. Deterring people from taking illegal drugs in the first place and deterring those who abuse their medication.
2. Enabling more effective enforcement against those who persist in taking illegal drugs and those who abuse their medication and continue to drive.
3. Increasing the efficiency of enforcement activity against drug drivers.[47]

The changes led to an immediate and dramatic increase in drug driving enforcement which has continued to 2020 (though significant variation remains between different police forces). A 2017 assessment of these changes also found that the increase in enforcement had led to a rise in awareness surrounding drug driving and a small decrease in the percentage of individuals who reported driving under the influence of drugs.[48] Self-reported drug driving (as reported in the Crime Survey for England and Wales) has remained lower than it was before enforcement increased after 2015 (though the difference remains small - 0.9% of adults in 2014/15 and 0.4% in 2019/20). However, there has been an increase in self-reported drug driving amongst drivers who have taken drugs in the past twelve months (6.2% in 2019/20 compared to 5.0% in 2015/16). This data should be treated with caution because of year-on-year variation in the data and because they are relatively small changes. Unfortunately, the data on drug driving injuries is not robust enough to be used to evaluate the impact of UK enforcement on drug driving deaths and serious injuries. It should also be noted that there is still a relatively low level of drug driving enforcement in the UK. Drug driving enforcement remains significantly lower than drink drive enforcement (10,477 drug driving convictions compared to 35,580 drink driving convictions, though some forces do on occasion record more arrests for drug driving than drink driving) and drink driving enforcement itself is significantly lower than it was before cuts to roads policing began in 2010 (there were 61,437 drink drive convictions in 2009). The decrease in drink drive convictions while drug driving convictions have increased is likely because of the new drug driving offence and the relatively high level of drink drive convictions in 2010. It is possible that we would not expect drug

[47] Risk Solutions and CPH (2017). Evaluation of the new drug driving legislation, one year after its introduction. DfT
[48] Risk Solutions and CPH (2017). Evaluation of the new drug driving legislation, one year after its introduction. DfT

driving enforcement to have a significant impact on road safety currently because of its low level. Indeed the HMICFRS report *Roads Policing Not an Option: An inspection of Roads Policing in England and Wales* concluded that because of the cuts to roads policing, as well as the costs and delays associated with drug driving prosecutions 'offenders who are suspected of driving while under the influence of drugs are being tolerated and allowed to present a continuing threat to communities.'[49]

Using conviction data as a proxy for enforcement activity suggests that drug driving enforcement varies immensely by police force area in England and Wales. In 2019, there were more than ten times more convictions for drug driving (per thousand population) in the Merseyside Police Force Area (0.71) than in the West Midlands (0.06). Seven police forces had less than 0.1 convictions for drink driving per thousand population while seven police forces had a figure four times higher than that. A similar story can be seen when comparing the relative number of drink and drug driving convictions. In Merseyside there were more drug driving convictions than drink driving convictions (108 drug driving convictions for every 100 drink drive convictions), while in Northamptonshire, West Midlands and Nottinghamshire there were ten times as many drink drive as drug driving convictions (ten, eleven and eleven drug driving convictions for every 100 drink drive convictions respectively). Currently, there is a geographical lottery, where in large swathes of the country the drug driving laws are not being effectively enforced. This is often due to resourcing issues and competing priorities for the limited resources already in place.

There is some international evidence that drug driving enforcement is effective. For example, a cost study of tripling drug driving enforcement in three European countries found that the increase reduced drug driving deaths, with more significant effects in countries that originally had lower levels of enforcement. The authors estimated that this enforcement cost around €4000 per conviction and between €1.5m and €13m per prevented fatality (with the lower costs occurring in countries with a lower baseline of enforcement.[50] Other studies have also found that increasing drug driving enforcement is effective at reducing casualties, particularly when there were already low levels of enforcement, though not when conducted at the cost of lower drink drive enforcement.[51] That finding was echoed by another evaluation of drug driving enforcement which found it would not have a positive road safety impact if it was conducted at the expense of drink drive enforcement.[52] An evaluation of which enforcement model would be most effective at reducing drug driving in Canada recommended using the model of Victoria, Australia, with a high level of random roadside oral fluid/saliva testing.[53] Earlier evaluations of drug driving and drug driving enforcement in Australia had also found that enforcement needed to be at a high level with sustained publicity to be an effective deterrent.[54]

Drug driving enforcement in Victoria, Australia between 2005 and 2009 is the example of drug driving enforcement that has been most studied. The number of drivers screened for drug driving in Victoria increased from 13,158 in 2005 to 27,883 in 2009 with positive rates falling from 2.3% to 1.0% in this period having previously been increasing. Cameron (2013),

[49] HMICFRS (2020). Roads Policing: Not optional. HMICFRS

[50] Veisten, K. et al. (2013). Is law enforcement of drug-impaired driving cost-efficient? An explorative study of a methodology for cost–benefit analysis. International Journal of Drug Policy, 24(2), 122-134.

[51] Schulze, H. et al. (2012). Findings from the DRUID Project. European Commission.

[52] SWOV. (2017). SWOV Fact Sheet: The use of drugs and medicines behind the wheel. https://s3-ap-southeast-2.amazonaws.com/cdn-nrspp/wp-content/uploads/sites/4/2017/03/19220428/FS-Drugs-and-medicines.pdf

[53] Solomon, R., and Chamberlain, E. (2014). Canada's new drug-impaired driving law: the need to consider other approaches. Traffic Injury Prevention, 15(7), 685-693.

[54] Watling, C., et al. (2010). Applying Stafford and Warr's reconceptualization of deterrence theory to drug driving: Can it predict those likely to offend? Accident Analysis and Prevention, 42(2), 452-458.

produced a model based on the impacts of this increase and found that by testing 1.24% of licensed drivers per year, 15.2% of driver deaths could be avoided. It should be noted that this relationship is based on casualty numbers and roads policing procedures in Victoria so it would not be directly applicable to the UK. Moreover, Cameron assumes that all drug driver deaths would have been avoided if they had not consumed drugs.[55] Nevertheless, the study provides further evidence that drug driving enforcement reduces road casualties. Victoria also continues to see the value of high levels of drug driving enforcement and conducts around 150,000 tests per year.[56]

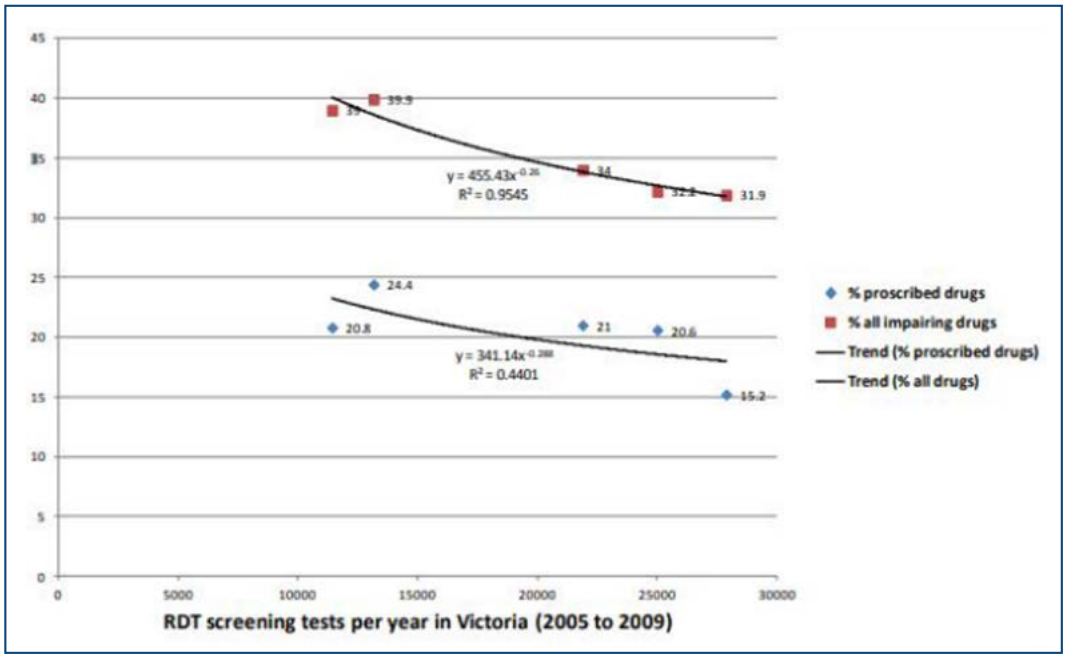


Figure 12: Relationships between percentage of killed drivers with proscribed drugs, or any impairing drug, versus number of drivers screened by ROFTs at RDT in Victoria. Cameron (2013).

Experts on behaviour change and drug use in the UK interviewed for this project suggested that drug driving enforcement may need to be different to other forms of enforcement within roads policing to be effective. This is because, unlike other motorists who commit road traffic offences, a proportion of drug drivers will have committed other criminal offences before drug driving. As such, they may have higher personal risk thresholds or believe that they are more likely to avoid arrest and punishment. Some published literature has also found that 'punishment avoidance' is a predictor of future drug driving.[57] It is possible that because drug drivers may have higher personal risk thresholds, or may be more likely to attempt to avoid enforcement, the level of drug driving enforcement may have to be higher than for other driving offences such as drink driving to provide an effective deterrent.

The literature is less clear on the effectiveness of drug driving enforcement than other road traffic enforcement, such as speeding or drink driving enforcement. In part, this is due to comparatively few assessments of drug driving enforcement being conducted. However, the evidence suggests that increasing and further publicising drug driving enforcement would

[55] Cameron, M (2013) Random drug testing in Australia, analogies with RBT, and likely effects with increased intensity levels. 20th International Conference on Alcohol, Drugs and Traffic Safety Conference Proceedings, Brisbane, Australia

[56] Frith, WJ (2020) Risks of driving when affected by cannabis, MDMA (ecstasy) and methamphetamine and the deterrence of such behaviour: a literature review. NZ Transport Agency research report 644

[57] Watling, C., et al. (2010). Applying Stafford and Warr's reconceptualization of deterrence theory to drug driving: Can it predict those likely to offend? Accident Analysis and Prevention, 42(2), 452-458.

have a positive road safety impact, particularly if it is not increased at the expense of drink drive enforcement.

Levels of drug driving enforcement should be increased in the UK, particularly in those police force areas where levels are low. The impact of increases on road casualties should closely monitored. This would provide useful evidence both for future British drug driving programmes and for the international road safety community. Enforcement could be increased more efficiently if the recommendations in Chapter 5. Policing and Justice of this report are implemented.

4.3 Education and prevention

Experts on drug driving interviewed for this project stated that there is a real need for greater education around drug driving, which was specifically created to reduce drug driving. Experts suggested that key differences between drink and drug driving were not well understood. For example, while people who regularly consume alcohol may be able to drive and be below the legal blood alcohol limit at certain times, people who regularly consume drugs are less likely to be able to drive when below the legal blood drug limit. For example, a person who has consumed cannabis in the evening is much more likely be over the limit the morning after than someone who consumed alcohol the evening before. Indeed, one expert stated that 'a habitual cannabis user is probably never below the drug drive limit,' because of the lower drug drive limits. Prevention programmes, education and communications can play a role in strengthening the social norm that driving under the influence of drugs is not acceptable.[58]

However, designing education campaigns which are effective at reducing drug driving may be more challenging than designing other road safety education interventions. Education campaigns are also vital because fear is less likely to be effective for drug drivers. Behaviour change experts, including those who specialise in changing the behaviour of people who use drugs, interviewed for this project suggested that drug drivers may have higher personal risk thresholds than other road traffic offenders, such as drink drivers. As such conventional road safety messaging such as the THINK! 'Drug Driving: more reason to be paranoid' are unlikely to significantly impact behaviour. Experts also stated that messaging should not be judgemental or highlight the illegality or negative effects of drug taking generally or this may alienate drug users. Messaging campaigns should not be seen to shame drug users. It was also suggested that messaging around the broader negative impacts of drug use or which sought to address drug use would be more appropriate in clinical settings and where more time was available.

Broadly speaking, education campaigns aimed at reducing drug driving have taken two forms. Prevention programmes which often take place in schools aimed at reducing drug driving and other anti-social behaviour amongst young people and media campaigns aimed at increasing awareness and reducing drug driving.

Most of the evaluation of prevention programmes come from Australasia and North America. These prevention programmes generally take the form of the P.A.R.T.Y programme or Life Skills Training programme. These interventions target school age children and utilise group discussion, modelling exercises and the like.[59] Some programmes also take place in hospital settings.[60] Preventions programmes generally increase knowledge and awareness of drug

[58] SWOV. (2017). SWOV The use of drugs and medicines behind the wheel. https://s3-ap-southeast-2.amazonaws.com/cdn-nrspp/wp-content/uploads/sites/4/2017/03/19220428/FS-Drugs-and-medicines.pdf

[59] Holmes, E., Vanlaar, W., and Robertson, R. (2014). The Problem of Youth Drugged Driving and Approaches to Prevention: A Systematic Literature Review. Canadian Centre on Substance Abuse

[60] Holmes, E., Vanlaar, W., and Robertson, R. (2014). The Problem of Youth Drugged Driving and Approaches to Prevention: A Systematic Literature Review. Canadian Centre on Substance Abuse

driving issues and some have also found that they play a role in strengthening social norms that drug diving is unacceptable.[61,62] Some evaluations have also found a positive impact on behaviour. An evaluation of the PARTY programme in Western Australia found that those who participated in the programme had a lower incidence of subsequent traffic or violence related offences. Similarly, students who participated in the US Life Skills Training programme have fewer violations and points on their driving license than those who did not attend.[63] Evaluations have also found that participants of similar programmes have fewer alcohol or drug related offences and traumatic injuries.[64] Unfortunately, these evaluations have not separated the impact on drug driving alone.

The evidence on media campaigns is much weaker than that for prevention campaigns. The evidence does suggest that messaging generally reaches its target audience and increases awareness. However, there is insufficient evidence to suggest that media campaigns are effective at reducing drug driving.[65]

Finally, it has been suggested that education on drug use and its impact on driving performance should be included in professional driver training.[66] This type of intervention could be particularly impactful if drug use plays a role in driving behaviour (for example to aid alertness or concentration on long-haul journeys of during shift work). Education on drug driving is an option for training as part of professionals maintaining their Driver Certificate of Professional Competence (CPC) required to drive a lorry, bus or coach. Conversations with those who provide training also suggest that it is a popular choice. Unfortunately, no evaluations of this type of programme have been found. However, as evidence suggests that drug driving may be particularly high amongst professional drivers and those driving for work (see Profile), PACTS believes providing education for professional drivers should continue to be investigated, trialled and evaluated. This could include local authorities providing information and training to private hire drivers.

Education campaigns may be effective in increasing awareness and knowledge of drug driving issues. There is also some evidence that prevention programmes may be effective, but there is not evidence of this in a UK context. In its response to the North Report, which recommended running more education campaigns on drug driving, the Government stated that its priority was to fix issues with enforcement before addressing education and publicity.[67]

Education needs to be increased to build and entrench a social norm that drug driving is unacceptable and to raise awareness of enforcement of the drug driving law. These media campaigns should take account of advice from behaviour change experts who specialise in behaviour change amongst drug users.

4.3.1 Education and medicinal drugs

Another educational intervention is based around providing information on the effects of prescription and other medicinal drugs on driving performance. A range of research suggests that those taking prescription drugs have a poor understanding of the impact of these drugs

[61] SWOV. (2017). SWOV Fact Sheet: The use of drugs and medicines behind the wheel. https://s3-ap-southeast-2.amazonaws.com/cdn-nrspp/wp-content/uploads/sites/4/2017/03/19220428/FS-Drugs-and-medicines.pdf

[62] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

[63] Botvin, G., Griffen,K. and Nichols, J. (2004). Life Skills Training: Empirical Findings and Future Directions. The Journal of Primary Prevention, Vol. 25, No. 2.

[64] Banfield, Gomez & Kiss, 2011, p.732

[65] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

[66] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

[67] Secretary of State for Transport. (2011). The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving. Cm8050

on their ability to drive safely.[68,69] For example, a study of over 55s in America found that only 1 in 5 individuals taking five or more prescription drugs had some awareness of their impairing effects.[70] Interviews with medical and pharmaceutical professionals suggests that information flow to frontline staff on the impairing effect of medicines is slow and that some staff do not feel confident to offer advice to patients. The impact of this on road safety in the UK is not clear, though the international evidence does suggest that those taking medicinal drugs do make up a significant proportion of drug drivers and may, in some settings, outnumber those driving having taken illicit drugs.

One intervention aimed at reducing impaired driving by those taking medicinal drugs is offering education and training to pharmacists and doctors. This includes training on how doctors and pharmacists can best inform patients, as well as training on the effects of the drugs themselves.[71,72] The research suggests that these schemes are most effective at increasing awareness amongst pharmacists when warnings are integrated into existing computing software for dispensing medications.[73,74] Road safety experts have also suggested that doctors should discuss possible alternatives with patients during consultations.[75] Although these studies have found increased awareness amongst doctors and pharmacists, the impact on patient understanding and behaviour and road safety has not yet been assessed.

Improved labelling on medicines has also been implemented. For example, France employs a three-category labelling system, using yellow, amber, and red warning symbols to advise users about the risk of impaired driving with each drug.[76] However, studies with patients have found very low awareness and understanding of warning labels on medication. For example, a 2013 study of labelling on US medicine found that half of patients did not recall seeing warning labels on medication. Studies have also found that patients frequently fail to understand what labels convey and misjudge how dangerous driving would be when taking their medication.[77]

There are other issues with interventions aimed at providing more information to those taking potentially impairing medicines. Firstly, there is very little research on the impact of many drugs (and their potential alternatives) on driving performance.[78] Secondly, there is even less research on the effect of different drugs in combination on driving performance.[79]

---

[68] Smith, R.C., Turturici, M., & Camden, M.C. (2018). Countermeasures Against Prescription and Over-the-Counter Drug-Impaired Driving. AAA.

[69] Richard, C. M., Magee, K., Bacon-Abdelmoteleb, P., & Brown, J. L. (2018, April). Countermeasures that work: A highway safety countermeasure guide for State Highway Safety Offices, Ninth edition (Report No. DOT HS 812 478). Washington, DC: National Highway Traffic Safety Administration.

[70] Smith, R.C., Turturici, M., & Camden, M.C. (2018). Countermeasures Against Prescription and Over-the-Counter Drug-Impaired Driving. AAA.

[71] SWOV Fact Sheet: The use of drugs and medicines behind the wheel. https://s3-ap-southeast-2.amazonaws.com/cdn-nrspp/wp-content/uploads/sites/4/2017/03/19220428/FS-Drugs-and-medicines.pdf

[72] Smith, R.C., Turturici, M., & Camden, M.C. (2018). Countermeasures Against Prescription and Over-the-Counter Drug-Impaired Driving. AAA.

[3] Richard, C. M., Magee, K., Bacon-Abdelmoteleb, P., & Brown, J. L. (2018, April). Countermeasures that work: A highway safety countermeasure guide for State Highway Safety Offices, Ninth edition (Report No. DOT HS 812 478). Washington, DC: National Highway Traffic Safety Administration.

[74] Smith, R.C., Turturici, M., & Camden, M.C. (2018). Countermeasures Against Prescription and Over-the-Counter Drug-Impaired Driving. AAA.

[75] SWOV Fact Sheet: The use of drugs and medicines behind the wheel. https://s3-ap-southeast-2.amazonaws.com/cdn-nrspp/wp-content/uploads/sites/4/2017/03/19220428/FS-Drugs-and-medicines.pdf

[76] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

[77] Richard, C. M., Magee, K., Bacon-Abdelmoteleb, P., & Brown, J. L. (2018, April). Countermeasures that work: A highway safety countermeasure guide for State Highway Safety Offices, Ninth edition (Report No. DOT HS 812 478). Washington, DC: National Highway Traffic Safety Administration.

[78] Richard, C. M., Magee, K., Bacon-Abdelmoteleb, P., & Brown, J. L. (2018, April). Countermeasures that work: A highway safety countermeasure guide for State Highway Safety Offices, Ninth edition (Report No. DOT HS 812 478). Washington, DC: National Highway Traffic Safety Administration.

[79] Smith, R.C., Turturici, M., & Camden, M.C. (2018). Countermeasures Against Prescription and Over-the-Counter Drug-Impaired Driving. AAA.

These gaps in our knowledge pose a significant challenge to any programme that aims to offer comprehensive advice to those taking potentially inhibiting medicinal drugs.

In the UK both the Medicines and Healthcare Products Regulatory Agency (MHPRA) and the DVLA issues guidance to doctors to doctors, primarily through their websites though the MHPRA does issue safety notifications on specific safety issues through letters and drug safety alerts. The DVLA also issues guidance to people who are taking prescription drugs and the haulage industry.

Overall, despite seeming a common-sense solution to the issues of poor knowledge of the impacts of licit drugs on driving performance, there is little evidence that interventions which have aimed to provide further information to patients have been effective. Furthermore, it is not clear the extent to which this is a road safety issue in the United Kingdom[80]

4.3.2 Driving for work

Interviews with vehicle fleet managers and discussion with drug experts suggests that, in recent years, large fleets have developed stronger drug driving policies, many of which include regular drug testing alongside education. This appears to be expanding, though progress is not universal and still seen as lagging behind drink drive policies. Large fleet operators should still be encouraged to develop, implement and prioritise strong drug driving strategies. Drug policies are less common in smaller fleets and in the grey fleet (drivers who use their own cars for business purposes). This is concerning as there is some evidence that drug driving is high amongst those who drive as part of their work in the trades.[81] Some police forces have also found high levels of drug driving amongst taxi and private hire drivers. Smaller fleets and taxi/private hire fleets should be encouraged to develop effective drug driving policies, with regular education and testing. Local authorities should investigate making taxi and private hire licensing dependent on fleets having effective drug driving policies.

An important part of vehicle fleet safety, relevant to all companies, is having good alcohol policies and providing support for those with alcohol issues. Challenging cultures of workplace drinking has been identified as a key part in the significant progress made in reducing drink driving in Denmark. Denmark introduced no-alcohol policies in the workplace and employees were also offered leave to help support people with alcohol problems.[82] Providing support for people with drug issues is less common and should be considered.

The Government and agencies, including the Health & Safety Executive, should encourage companies, and others with responsibility for those who drive for work, to develop strong drug driving policies, including education, testing and enforcement. This should include smaller fleets, "grey fleets" and "gig" workers.

4.4 Drug drive rehabilitation course

Since 2010, 24% of drug drive offenders (14,224 people) have been reoffenders. These 14,224 offenders have committed 34,178 offences (44% of drug drive offences).[83] This suggests that there is a need for more effective rehabilitation of drug drive offenders. Rehabilitation interventions constitute a wide range of programmes ranging from classroom courses – similar to the current drink drive rehabilitation course – through to regular therapy and drug testing.

A drink drive rehabilitation course is currently offered to many of those in Great Britain who plead guilty to a drink drive offence and are banned from driving for 12 months or more.

[80] Secretary of State for Transport. (2011). The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving. Cm8050

[81] Merseyside Police. (2018). Drug20 Presentation. Pers. Comms.

[82] Calinescu, T., and Adminaite, D. (2018). *Progress in reducing drink driving in Europe*. ETSC.

[83] Data provided to PACTS by DVLA

The course can cost up to £250. Having taken a course, the offenders driving ban is usually reduced by a quarter. A similar scheme is run in Northern Ireland, though at lower cost (up to £160). The course is taken in person and in groups, though they have been completed virtually during the coronavirus pandemic. It takes places over 16 hours, typically on three days spread over three weeks. The course has two units, one on understanding the impact of alcohol use in relation to driving and one on changing alcohol use in relation to driving. The overall purpose of the course is 'to support [participants] to take responsibility for their actions, recognise where they have acted inappropriately, and recognise that they can and should behave differently in compliance with driving standards, road traffic law and for general health benefits'.[84]

The effectiveness of the drink drive rehabilitation course was first assessed by the Transport Research Laboratory (TRL) during a trial period where the course was offered in some areas of the UK, but not others. TRL found that the course successfully reduced reoffending with the reoffending rate of those who did not attend the course being almost three times higher than the reoffending rate of those who did attend it 3 years after taking the course.[85] Monitoring of the course was carried out in 2003 and 2007 and it was found to continue to be effective. Non-attendees were 2.15 times more likely to reoffend within three years of conviction.

The drink drive rehabilitation course is not perfect, for example, it may not be appropriate or as effective for offenders with alcohol or mental health issues.[86] Nevertheless, it demonstrates that a rehabilitation course, aimed at people who have driven while impaired in the UK can be effective at reducing reoffending.

In 2016 the DfT and DVSA collaborated to develop a joint alcohol and drug driving impairment course, which was trialled with drink drivers. The pilot course followed the format of the existing drink driving rehabilitation course, supplementing it with information relevant to drug driving. An evaluation was in 2017 found that the course brought about an immediate and positive change to the attitudes and behaviour of participants. A longer-term study of reoffending rates and a formal consultation on the introduction of the course was recommended. This is yet to be conducted.

The possibility of including drug driving education in drink drive rehabilitation courses was also considered in a 2020 evaluation of the drink drive rehabilitation course, conducted by Ipsos MORI.[87] This found no major concerns about the practicability of expanding the drink drive course to include drug driving. However, concerns were raised about whether including drug drivers would impact the effectiveness of the course. Course providers and behaviour change experts interviewed for the project suggested that because drink and drug drivers are two distinct groups, they may struggle to interact and cooperate.

Others suggested that the inclusion of materials not directly relevant to some offenders may reduce the impact of the course, causing attendants to switch off. Concerns were also raised about the challenge of including an additional audience when it is already challenging to cater for the different needs of those who do and do not have alcohol issues.

Behaviour change experts and course providers interviewed by PACTS for this project echoed concerns over the impact of including drink and drug drivers on the same course. Other experts interviewed by Ipsos MORI were more positive about the inclusion of drug drivers and felt the materials could be more readily adapted and presented as a generic behaviour

[84] DVSA. (Undated). Drink-drive rehabilitation scheme course syllabus. DVSA.

[85] Davies, G., Harland, G., and Broughton, J. (1999). *Drink/driver rehabilitation courses in England and Wales.* TRL Report 426.

[86] PACTS, *Drink Driving: Taking stock, moving forward*, December 2020

[87] PACTS understand that the DfT intends to publish the Ipsos MORI report in summer 2021.

change course. The evaluation concluded that more research is required to determine the impacts of mixing drink and drug drivers on a combined course. This study noted the wide support for the introduction of a rehabilitation scheme for drug-drive offenders, but the evidence was less clear whether including drug drivers in the current drink drive scheme would be appropriate.

There would need to be key differences between a drink drive and drug drive rehabilitation course (or from the current drink drive course to a combined drink/drug driving course). As noted earlier, the current drink drive rehabilitation course may not be appropriate, or as effective for people with mental health and substance use issues. A separate course for offenders with these issues, or an effective screening and referral system would need to be introduced. This is discussed in more detail in Chapter 5.3. Furthermore, while regular drinkers may not need to stop drinking to be able to drive when under the limit, it is possible that regular drug users would need to stop taking drugs, in part because of the lower legal limit for drugs. In addition, while the effects of alcohol are broadly the same regardless of the type of alcohol consumed, the effects of drugs vary significantly depending on what drug was consumed. Drug users are also often distinct in their patterns and reasons for drug usage Designing a course that speaks equally to these groups could therefore be challenging, and would require careful design.

The North Report recommended that the Government consider the case for introducing a drug drive rehabilitation course. In their response the Government noted the complexities associated with creating a drug driving rehabilitation course, such as having a suitable syllabus and links to drug treatment services. The Government also stated that it would return to this recommendation when there were sufficient numbers available to sustain a national scheme. There are now over 10,000 people convicted of a drug driving offence each year.

4.4.1 International courses

While drug drive rehabilitation courses are run internationally, there is limited evidence of their effectiveness. The DRUID project assessed the impact of drug and drink driving rehabilitation courses and found that they reduce recidivism, prevent people from impaired driving and restore mobility in a safe way.[88] Since 2018, Victoria, Australia has run a course which is mandatory for anyone who has committed a drink, drug or combined drink and drug offence. This programme is designed to help offenders identify the underlying reason for their drink or drug driving offences and identify ways to reduce the risk of reoffending.[89] Denmark has also run a joint programme since 2014, when their existing drink driving rehabilitation course was extended to include drug drivers. Similarly to the Victorian course, the course is a prerequisite for drivers to regain their license.[90] Unfortunately, PACTS is not aware of any evaluations of these courses' effectiveness.

4.4.2 Similar programmes

There are also rehabilitation schemes which are offered to drug drivers but are not specifically aimed at them. For example, the Alcohol and Other Drug Treatment Court (AODTC) programme is run in New Zealand to provide an alternative, non-adversarial approach to criminal offending when it is driven by dependency. Courses which form part of sentencing often include sections on driver safety and also seek to address alcohol and drug dependency. Graduates of this programme can now be subject to ongoing drug testing as part of their

[88] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

[89] VicRoads. (No Date). Victoria Behaviour Change Program. https://www.vicroads.vic.gov.au/licences/demerit-points-and-offences/behaviour-change-programs

[90] Atchison, L. (2017). Preventing Drug Driving in Europe. Policy measures for national and EU action. PACTS/ETSC.

sentence. Evaluations of this programme have found that they reduce reoffending, non-crime related incidents and driving offences compared with equivalent offenders who did not go through the AODTC programme.[91, 92]

4.4.3 Drug addiction, mental health and rehabilitation

An important part of the AODTC programme is that it addresses drug use disorders that may be the cause of drug driving. Experts on drug addiction and course providers interviewed by PACTS stated that without addressing any underlying dependence, drug drive rehabilitation schemes are unlikely to be effective. This echoes findings from the Ipsos MORI evaluation of the drink drive course where interviewees suggested that some individuals would have needs which were beyond a drug drive rehabilitation course and that those who had alcohol dependence were likely to need more support than the current course provided.

There is strong evidence that chronic drug users and those with dependence issues are more likely to drive under the influence than moderate drug users.[93] Those with dependence issues are unlikely to be able to separate their drug taking from the rest of their activities, leading them to drug drive. The increased likelihood of those with dependence issues drug driving is also a challenge to those planning rehabilitation measures because of the co-morbidity of drug dependence and mental health issues. Drug dependence and misuse is significantly more prevalent in adults with various psychiatric problems, including common mental disorders, personality disorders and severe psychotic illness.[94] More than a third of adults with current signs of dependence on drugs other than cannabis have received treatment, help or advice specifically because of their drug use at some point. However, only 14.6% of those with signs of cannabis dependence have received treatment, help or support specifically because of their drug use.[95] This shows both the high levels of mental health issues amongst those with dependence issues and the significant proportion of those with dependence who have not received help.

There are a range of clinically proven treatments for some drug use disorders, including talking therapies, pharmacotherapies, detoxification and self-help (groups like Narcotics anonymous).[96] There are also effective and simple screening tools such as the Drug Abuse Screening Test (DAST) as well as more drug specific screening tools.[97] Screening and referrals to support are an essential part of reducing drug driving. The Behaviour Change Program in Victoria provides referrals for further support to help attendees address the underlying reason for drink and drug driving offences.[98] Referrals of support and or therapy being included as part of sentencing is far more effective than signposting support as is currently done in the UK drink drive rehabilitation course.

A drug drive rehabilitation course be introduced in the UK. This course should be based on the UK drink drive rehabilitation course, though run separately for drink and drug drivers if possible. Drug drivers should be screened for dependence issues, using

[91] Ministry of Justice (New Zealand). (2019). Alcohol and Other Drug Treatment Court Outcomes Evaluation 2018-19. Ministry of Justice.

[92] Katey, T. (2017). Exploring te whare whakapiki/The alcohol and other drug treatment court pilot: Theory, practice and known outcomes. New Zealand Criminal Law Review, 11(1), 180-

[93] EMCDDA 2012, Driving Under the Influence of Drugs, Alcohol and Medicines in Europe: Findings from the DRUID Project

[94] Roberts, C., Lepps, H., Strang, J., and Singleton, N. (2014). Chapter 11, Adult Psychiatric Morbidity Survey 2014 in Drug use and dependence. NHS.

[95] Roberts, C., Lepps, H., Strang, J., and Singleton, N. (2014). Chapter 11, Adult Psychiatric Morbidity Survey 2014 in Drug use and dependence. NHS.

[96] NHS. (No Date). Drug Addiction: getting help. https://www.nhs.uk/live-well/healthy-body/drug-addiction-getting-help/

[97] SmartCJS. (No Date). Drug Screening Questionnarie (DAST). https://www.smartcjs.org.uk/wp-content/uploads/2015/07/DAST.pdf

[98] NHS. (No Date). Drug Addiction: getting help. https://www.nhs.uk/live-well/healthy-body/drug-addiction-getting-help/

a tool such as DAST, in the court process and offered alternative treatment which can more effectively address the underlying cause of their drug driving.

4.5 High Risk Offender Scheme

Currently, a High Risk Offender Scheme is run for drink driving where people convicted of drink driving are placed in the scheme if they have:

- been convicted of two drink driving offences within 10 years,
- were driving with an alcohol reading of at least 87.5 microgrammes of alcohol per 100 millilitres (ml) of breath, 200 milligrammes (mg) of alcohol per 100 ml of blood, or 267.5 mg of alcohol per 100 ml of urine,
- refused to give the police a sample of breath, blood or urine to test for alcohol, or
- refused to allow a sample of blood to be analysed for alcohol (for example, if the sample had been taken when they were incapable of giving consent).

Having been placed on the scheme an offender must reapply for their licence and pass a medical examination, which includes an examination with a doctor and a blood test. A DVLA doctor can then decide to accept or refuse the application or, if alcohol dependency or misuse is uncertain can issue a medically restricted driving licence for up to three years, after which the offender will have to submit to another medical examination.

While the High Risk Offender Scheme has issues, it could for example more accurately identify high risk offenders and should offer support for offenders, it is a useful and practical scheme which enables some dangerous drivers to be prevented from regaining their licence until it is safe to do so. The North Report recommended including drug driving offenders who met certain criteria in the High Risk Offender Scheme. In 2019, the DfT commissioned an Expert Panel to make recommendations for a High Risk Offender scheme, based on the existing drink drive scheme

A separate High Risk Offender Scheme, with evidence-based criteria for inclusion, such as being a repeat offender or Drug Abuse Screening Test scores, could be a useful tool for identifying dangerous drivers and preventing them from regaining their licences until the underlying cause of their drug driving was addressed. A drug drive High Risk Offender Scheme should also include referrals to treatment.

The Department for Transport should develop a High Risk Offender Scheme for drug drivers, with evidenced based criteria for inclusion and clear pathways to treatment.

CHAPTER 5

Policing and justice

5.1 Blood sample and testing procedures

One of the main sources of frustration, delays and legal challenges when moving from initial drug test to convictions is procedures around blood tests. Currently, blood samples must be taken by a healthcare practitioner and a healthcare practitioner in charge of the case must approve the specimen being taken.

However, police officers reported to PACTS that this can requires taking people arrested on suspicion of drug driving to A & E where, under the triage systems most hospitals operate, they will be allocated a doctor but it can be some time before the doctor is able to see the patient. Defence solicitors have also asked these A & E doctors to attend court to confirm they were consulted. This system creates unnecessary delays and is an inefficient use of both hospital and police resources. While many stations have force healthcare professionals in attendance, this is by no means universal and discussions with police officers suggest it can be a significant challenge, particularly on busy evenings such as Friday and Saturday nights. Furthermore, even where healthcare practitioners are present at stations, the range of contracts, often negotiated without input from roads police units, can mean they are unable to take blood.

Two possible solutions have been identified for this. In the early 2000s nurses were based in, or made available to attend all stations. These nurses were able to take blood samples and reduced the strain on often over stretched force medical examiners. However, due to funding cuts, this is no longer the case. **Onsite medical personnel should be readily available to all roads police officers to take blood samples.** This would significantly increase the efficiency of taking blood samples, reduce the number of people who may have the amount of drugs in their blood fall below the legal limit when waiting for a blood sample to be taken and be a more efficient use of police and hospital resources.

Currently, defendants can take a blood sample (a "B" sample) with them from the police station when they are released from custody. However, an emerging legal defence is that defendants were not offered this opportunity, or were unable to collect their sample after being released. As a result, some police forces now have different procedures and keep defendant samples after they have been released. This is an issue because of forces then requiring the facilities to store samples and the fact that B samples tested months after the police sample may have deteriorated (this is particularly the case for THC) and provide different results than the original sample. **The Home Office and NPCC should remind police forces and those in the legal system that the police have no obligation to keep B samples. Officers should also ensure that Custody Records record when offenders are given the opportunity to keep their B samples.**

The 2017 assessment of the 2015 drug driving law found that in approximately 1 in 8 arrests, no blood sample was taken. In more than half of cases, this was because of medical issues, typically poor veins. In just under a third of cases suspects refused to provide a sample (and then will likely have been charged with failing to provide a sample), in around 5% of cases needle phobia was the cause and in around 10% of cases other reasons such as religious beliefs or the lack of availability of a healthcare professional were the reason. One simple change that could enable blood to be taken in more cases would be the use of vacuum tube blood extraction, which is currently not permissible under drug driving legislation. Vacuum tube blood extraction is used the vast majority of the time by health professionals in the UK (e.g. for taking blood for medical testing). It is a more efficient method of taking a blood sample and safer for healthcare professionals and patients. **Vacuum tube blood extraction should be legalised in drug driving cases.**

While needle phobia was noted in only 5% of cases where a blood sample could not be taken in the 2017 evaluation, it has emerged as one of the main defences in court from a defendant having been charged with failing to provide a sample. Police officers also suggest it has become a more common reason for not providing a blood sample. Some people arrested for drug driving also refuse to provide a blood sample for religious reasons, though this defence is often not successful as it is not a medical reason to not provide blood. One way to enable more testing is for police to arrest people for being unfit to drive (Section 4) as well as drug driving (Section 5) as this would give police the option of a urine test (though driving while unfit does not have legal drug limits like Section 5a drug driving). Evidential tests with legally set levels in mediums other than blood would be highly beneficial; however, as discussed in Section 6.1, this is not likely to be possible in the UK based on the current system. **Police should be encouraged to consider all options (Section 4, 5 and 5a) when they have stopped a driver they suspect has consumed drugs.** This would help reduce the number of people who avoid prosecution for drug driving.

A related issue is that some medical professionals find they are unable to take blood because of constricted blood vessels. This is often occurs because cocaine can elevate blood pressure and constrict blood vessels. In this situation, officers and medical professionals should be encouraged to wait a short period of time – around 15 minutes as the effects of cocaine lessen and blood pressure falls.

It is also worth reiterating the importance of taking blood samples as quickly as possible. West Yorkshire Police highlight a 'golden hour' for a blood sample to be taken post roadside drug test and do not train Police Officers to use roadside drug tests unless they themselves can transport those who test positive to have a blood test. Speed is particularly important as the defence of passive inhalation of cannabis has increasingly been used by defendants, and accurate blood sampling is a key tool in assessing the validity of this defence.

5.2. Blood testing delays

Interviewees also raised concerns about the current laboratory test turnaround time. Test results generally take at least four to five months to come back. Furthermore, backlogs in laboratories are not uncommon and concerns have been raised that backlogs could lead to the statutory time limit (generally six months in Magistrate's Courts) being missed for some samples. Since 2017, forensic service provider capacity has been exceeded by the number of positive roadside breath tests.[99] Backlogs in laboratories may also have contributed to some forces cancelling or delaying campaigns focused on reducing drug driving. Furthermore, some forces have encouraged officers to focus on other crimes potentially committed before drug testing a driver because of backlogs, such as encouraging officers to test for drink first. Some forces also 'ration' the number of drug test kits given to roads police officers, making officers more reluctant to drug test all but the most obvious drug drivers. Other forces have specifically asked officers to reduce their use of drug test kits.

At the least, delayed test results mean that many drug drivers will stay on the road for several months while awaiting trial. Recent delays due to Covid-19, on top of an existing backlog, has also raised the possibility that some samples will not be tested in the statutory time period. While the impacts of coronavirus may seem an exceptional circumstance, a succession of exceptional circumstances at laboratories has led to testing capacity being reduced since 2018. The continued delays with drug testing, and risk of samples not being tested in the

[99] HMICFRS. (2020). Roads Policing: Not optional. HMICFRS https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/roads-policing-not-optional-an-inspection-of-roads-policing-in-england-and-wales.pdf

statutory time limit has created a need for a detailed assessment of the issue. Merseyside Police have publicly tendered for the creation of a regional laboratory for Section 5a drug driving cases. The impact of this should be carefully observed by other police forces and the Home Office. **The Home Office should review the blood testing process and seek ways to reduce costs and increase the efficiency of laboratory testing by increasing capacity, improved procurement, or other means. This review should also evaluate the possibility of seeking to reclaim blood testing costs from those who are found guilty.**

5.3. Costs

One issue frequently raised in discussion with police and those involved in drug driving prosecutions is the cost of blood tests. Each police force has its own commissioned testing service and costs vary from around £60 to over £400 from force to force and depending on which tests are conducted. The UK is unusual internationally for requiring police forces to pay for the cost of laboratory testing. More often, laboratory costs are paid by central governments, or in some cases reclaimed from those convicted. The high costs of more detailed testing may also lead to some offences being missed. For example, a driver who had taken cannabis and MDMA could fail a roadside blood test for cocaine, pass the blood test for cocaine because their body had further metabolised the cannabis but not be prosecuted for drug driving under the influence of MDMA because the full range of blood tests were not requested. Not conducting complete blood tests for all samples also reduces the amount of knowledge the police and the road safety community have about drugs in the body of drivers.

A similar concern that has been raised is the cost of drug test kits. Conducting a drug testtest is significantly more expensive than conducting a breath test because a drug test kit costs around £16 compared to a few pence for the cost of a new breath tube for a breathalyser. The cost of drug test kits contributes to some forces equipping a roads policing officer with a only single drug test kit when they leave stations. As a result, officers are less likely to use the wipe unless there is clear evidence of drug use. Indeed, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) stated that reductions in roadside drugs tests were due to falling police numbers, the capacity of forensic service providers, and the cost. HMICFRS also reported frustration from both officers and supervisors that screening and forensic analysis was being effectively rationed, preventing them from using a powerful and effective tool.[100]

The increase in drug driving enforcement, in some forces has significantly increased costs for some. The cost of drug driving enforcement represents a significant challenge to increasing drug driving enforcement in the UK.

The cost of drug tests for police forces could be reduced if courts sought to recover the costs of blood tests from those found guilty. This is currently the case in prosecutions involving alcohol. This change would also encourage police forces to request a broader range of drugs to be tested for in blood, leading to more successful convictions for drug driving and giving police and the road safety community a better understanding of drug driving.

The combination of delays and high costs led HMICFRS to 'the inescapable conclusion is that offenders who are suspected of driving while under the influence of drugs are being tolerated and allowed to present a continuing threat to communities.'[101] In 2020, the Forensic

[100] HMICFRS. (2020). Roads Policing: Not optional. HMICFRS https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/roads-policing-not-optional-an-inspection-of-roads-policing-in-england-and-wales.pdf

[101] HMICFRS. (2020). Roads Policing: Not optional. HMICFRS https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/roads-policing-not-optional-an-inspection-of-roads-policing-in-england-and-wales.pdf

Science Regulator also stated that there is a need to 'ensure that a longer-term strategy for sustainable provision of high-quality forensic science is developed as a matter of urgency'. There is an urgent need to address the high costs and laboratory delays which are preventing police officers from being able to effectively enforce drug driving laws. **The Home Office should review the blood testing process and seek ways to increase the efficiency of laboratory testing by increasing capacity or through other means. This review should also evaluate the possibility of seeking to reclaim blood testing costs from those who are found guilty.**

5.4. Blood test results and saliva tests

One concern raised by police, which echoes concerns raised in the 2017 assessment of the drug driving law, is that a significant proportion of offenders test positive for cocaine or cannabis on roadside drug tests but their blood tests show levels of drugs below the legal limit. For example, in 2017, 30% of blood tests were at or below the legal limit for THC amongst drivers who had tested positive for cannabis on the saliva test. Similarly, 17% of those who tested positive for cocaine on saliva tests were below the specified limit for cocaine and BZE.[102] Overall, in 2017, 61% of those who tested positive on roadside saliva tests were charged with a Section 5a offence. Around 10% were charged for another offence (such as failure to provide a sample) and in 30% of cases no further action was taken, mainly because the blood analysis results did not support a conviction or a blood sample could not be taken.

Officers also expressed frustration about the number of blood tests that they see as showing no drugs present despite the driver having tested positive at the roadside, and in some cases, this has led to scepticism about the effectiveness of road side drug tests in all situations. The failures in blood tests having tested positive in saliva tests is likely as a result of the body continuing to metabolise the drug in the time between the saliva and blood test. Blood tests may also be reported to the police as a zero level when in fact there were very low levels of drugs found if:

a) there were drugs present but the test was for a Section 5a offence and the level of drugs is below the laboratories limit of quantification (though this could plausibly be used as evidence in a Section 4 test), or

b) there were drugs but the level was below the level of detection.

It is worth reiterating that in both cases this would be an accurate result for courts and legal process – the offender did not have drugs above the legal limit in their blood. However, it can cause frustration and confusion for police officers.

Clearer communication from laboratories to police forces, and blood samples routinely being tested for both Section 4 and 5a offences may help avoid frustration amongst officers. A more efficient, quicker process of taking a blood sample would also reduce the number of people who test positive on saliva tests before testing negative on a blood test.

5.5. Bodycams

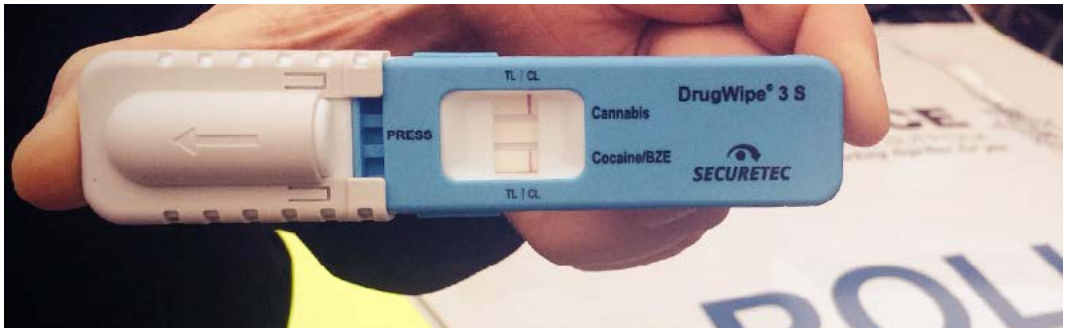
An increasingly used defence in drug driving cases is drivers not disputing blood tests but claiming that they have taken drugs after driving. This issue can be overcome by ensuring all police officers are wearing body worn video cameras and that they monitor any suspect

[102] Risk Solutions and CPH (2017). Evaluation of the new drug driving legislation, one year after its introduction. DfT

arrested on the suspicion of driving under the influence of drugs until after a blood sample is taken. This will provide a clear process from which to abate any challenges in a court of law.

5.6. Adding drugs to the preliminary test

Several interviewees suggested that it would be valuable if additional drugs could be tested for using a preliminary (roadside) test. DrugWipe 3S, the device most commonly used by police in the UK, currently tests for cannabis and cocaine but has the capacity to test for additional drugs. This would require Home Office type approval. Ideally, decisions on what drugs should be included would be made based on road casualty data. However, these data are not presently available in the UK. While drug use varies across the UK and there may be some value in having different tests in different force areas, MDMA was most commonly identified as the additional drug most useful to test for. Heroin, amphetamine and ketamine were also suggested, though it was noted that field impairment testing is likely to be quite effective if a driver has taken particularly impairing drugs such as LSD or ketamine. It is also worth noting that a roadside saliva test for amphetamine would likely also pick up MDMA and methamphetamine. While consultation with all UK police forces would be useful, there would be clear value in expanding the number of drugs which can be tested for at the roadside. This change would require police demonstrating the demand for this feature to manufacturers, given the cost of passing type approval for additional testing strips.



The number of drugs which roadside preliminary drug tests detect should be increased, starting with amphetamine (including MDMA and methamphetamine). Senior police officers and Police and Crime Commissioners should clearly communicate their need for this feature to the Home Office, Department for Transport and manufacturers.

5.7. Court procedures

Those involved in the justice system raised concerns about an emerging trend of defence lawyers submitting requests for Streamline Forensics Report 2 (SFR2) late in the legal process. SFR2s are intended for use only if the defence disagrees with the initial streamline forensics report (SRF1). (The SRF1 procedure was introduced to keep cases on track and avoid delays at court). This causes issues as the tight time margins to get SRF2s from forensic service providers have led to cases being discontinued. The time that it can take to go back to laboratories to get SRF2s, particularly when the CPS is already overstretched, makes this an increasingly concerning issue. Furthermore, toxicologists having to take the time to complete SRF2s or appear in court means they have less time to conduct blood tests in the laboratory. One reform which could help to ensure SRF2 requests are only used legitimately would be to place the cost and timescales of providing SRF2s on defendants rather than the police. Clarity and consistency from magistrates on when SFR1s can be challenged would be useful for the CPS, police forces and laboratories.

5.8. Operation Revoke

There are concerns about people drug driving in the sometimes lengthy period between arrest and conviction. One police campaign which aims to reduce this risk is Operation Revoke. It is now run by several police forces across the UK. It aims to:

- Reduce and prevent organised crime by removing the ability of prolific offenders to drive a vehicle lawfully.
- Reduce the risk of serious collisions through drivers having medical episodes and posing risks to themselves and others thereby increasing community confidence.

'Medical conditions' include substance use issues – typically drugs, though on occasion Operation Revoke has targeted drivers who have alcohol problems. Operation Revoke is often used to prevent people from driving after they have been arrested, but before they appear in court. This is in part because of the time taken to receive laboratory results for drug driving. When someone has their licence revoked, they need to undergo a medical investigation by the DVLA to regain it (as they would if they had informed the DVLA themselves of a medical condition which made them unfit to drive). Operation Revoke has also been used where a person's mental health issues have made them unfit to drive.

Operation Revoke has been successfully used to revoke the licence of drivers who have been frequently arrested for drug driving, admit to consuming large amounts of drugs, and are involved in serious crime.

Operation Revoke may also be relevant for drug driving because of the high levels of mental health issues amongst drug drivers. Interviews with police officers who have been involved with Operation Revoke across the country suggest it has been an effective way of preventing dangerous drivers from using the roads. Police forces have also been able to work effectively with courts and the DVLA on Operation Revoke. While it does not address the underlying issue of long periods between arrest and conviction for drug driving, Operation Revoke has proven to be an effective way of preventing dangerous, and often vulnerable drivers, from using the roads. **All UK police forces should be encouraged to use Operation Revoke, or similar means of preventing dangerous drivers from driving between arrest and conviction, where appropriate.**

5.9. Alternative metrics to blood

The North Report recommended that after roadside screening tests had been developed, research should focus on developing evidential saliva tests.[103] In 2013, *The Drug Driving Expert Panel Report* considered whether equivalent thresholds to the blood drug limit could be set in other metrics such as saliva or urine.[104] There would be considerable advantages to evidential saliva testing in particular: in theory it could be conducted without the need for a medical professional, it could reduce the amount of time needed for evidential results in court and would be less invasive than blood tests. The Drug Driving Expert Panel, however, stated that oral fluid tests could not at the time be used to give a precise prediction of the concentration of a drug in blood. The Expert Panel also found that other fluids such as urine could not be used.

According to the experts on drug testing interviewed for this project, the evidence has not significantly changed since 2013 and it would still not be possible to calculate equivalent drug thresholds in blood and saliva. While confirmatory saliva testing is more likely to be

[103] North, P. (2010). Report of the Review of Drink and Drug Driving Law.
[104] Wolff, K. et al (2013). Driving under the influence of drugs. Report from the Expert Panel on Drug Driving.

technically possible for illicit drugs with their lower limits, the legal process focuses on how the amount of drug present related to impairment and this relationships cannot be quantified in saliva. A move towards saliva testing, if the science develops, would require a law change and laboratories applying for Home Office approval to test saliva.

Countries where evidential saliva testing is used, such as in Australia, have presence-based drug driving laws rather than 'per-se' risk threshold-based limits in the UK. As such evidential saliva testing (or testing of any other metric) is more challenging in the UK because a test needs to show the level of a drug in the body, and this level must relate to how much it would impair a driver. By contrast, with presence-based laws tests just need to show the presence of a drug.

While evidential saliva (and other metrics) testing is not currently possible in the UK, research should continue to seek methods that might prove sufficiently reliable. The Government should encourage innovation in this field.

5.10. Drug misuse/dependence and the DVLA

Drivers who have drug misuse or dependence can have their licence refused or revoked by the DVLA. The DVLA guidance *Assessing Fitness to Drive, a guide for medical practitioners* offers several factors which can be considered as associated with drug misuse or dependence. The World Health Organisation's classifications of F11 to F19 (these mental and behavioural disorders due to use of various drugs) are also used by the DVLA in relation to these conditions.

The DVLA groups misuse and dependence by the drug involved. The first group includes cannabis, amphetamines (excluding methamphetamine), ecstasy/MDMA, ketamine and 'other psychoactive substances, including LSD and hallucinogens. Someone who is persistently misusing or dependent on these drugs must not drive and must notify the DVLA. If a medical enquiry confirms this, their licence will be revoked for a minimum of six months, which must be free of misuse or dependence. Relicensing may also require an independent medical assessment and urine screen, arranged by the DVLA. The second group includes heroin, morphine, methadone, cocaine, methamphetamine and benzodiazepines. The same criteria apply for this group except a licence will be revoked for a minimum of one year. Lorry and bus drivers in the first group have their licence revoked for a minimum of one year and in the second group for a minimum of three years.

As well as self-reporting, a driver can be reported to the DVLA by others, such as medical professionals. The General Medical Council (GMC) advises that doctors should ask for the patient's consent to disclose information for the protection of others unless the information is required by law or it is not safe, appropriate or practicable to do so. Where it is not practicable or appropriate to seek consent and in exceptional cases where a patient refuses consent, the GMC states that disclosing personal information may be justified in the public interest, if failure to do so may expose others to a risk of death or serious harm. Unless it is not safe or practicable to do so, a doctor should inform the patient of their intention to disclose personal information. The GMC advises that when deciding whether the public interest in disclosing information outweighs the patient's and public interests in keeping information confidential doctors should consider:

- the potential harm or distress to the patient arising from the disclosure;
- the potential harm to trust in doctors generally;
- the potential harm to others;
- the potential benefits to an individual or to society arising from the release of the information;
- the nature of the information to be disclosed; and

- whether the harms can be avoided or benefits gained without breaching the patient's privacy or what the minimum intrusion is.[105]

The GMC summary on the process of dealing with a patient who may not be fit to drive is 'if you become aware that a patient is continuing to drive when they may not be fit to do so, you should make every reasonable effort to persuade them to stop. If you do not manage to persuade the patient to stop driving, or you discover that they are continuing to drive against your advice, you should consider whether the patient's refusal to stop driving leaves others exposed to a risk of death or serious harm. If you believe that it does, you should contact the DVLA or DVA promptly and disclose any relevant medical information, in confidence, to the medical adviser.'[106]

3,629 people had their licence revoked or refused on drug misuse grounds in 2019. It is not known if these people self-reported or were reported. By comparison, in 2019, 2,354 people had their licence revoked or refused due to alcohol misuse and a further 5,354 had it revoked/refused for alcohol dependency.[107] There is no available information on how often medical professionals inform the DVLA about drug dependence, or their knowledge of these issues. There is some evidence that doctors have a poor understanding of DVLA guidance on alcohol dependence, though it is not clear if this is also the case for drug misuse and dependence

The DVLA and the relevant professional bodies should continue to raise awareness of the guidance for medical professionals and others regarding informing the DVLA of a patient's drug issues.

5.11. Combination offences

Driving having consumed both alcohol and other drugs is significantly more dangerous than driving with an equivalent amount of alcohol or drugs.[108] This is because the interaction of alcohol and other drugs can be significantly more impairing than in isolation.[109] This can be true for both illicit and medicinal drugs. Drivers could also have low levels of drugs and alcohol in their system and therefore be below the drink and drug driving limit, but still be significantly impaired. Furthermore, while the courts could consider this to be an aggravating circumstance, drivers generally do not receive more severe sentences for driving with both alcohol and drugs in their system and are usually prosecuted, and convicted, for one offence only. As a result, police officers will often not conduct a breath test or roadside drug test if a driver has tested positive for the other test. This means there are poorer data on the level of drink and drug driving in the population. Furthermore, the full danger a driver who could be possibly under the influence of both drink and drugs at the time of the offence is not considered in court and there is no additional penalty or deterrent.

Combination offences (covering driving with both alcohol and other drugs in the system) do exist in in Victoria, Australia with similar penalties as for drink and drug driving.[110]

The Government should introduce a new combined drink and drug driving offence, with a lower blood alcohol limit.

[105] General Medical Council. (Undated). *Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA*

[106] General Medical Council. (Undated). *Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA*

[107] Data supplied to PACTS by DVLA.

[108] Dubois S, Mullen N, Weaver B, Bédard M. (2015). The combined effects of alcohol and cannabis on driving: Impact on crash risk. *Forensic Sci Int.* 248(1), 94-100

[109] Australian Drug Federation (2007). *Drugs and Driving in Australia.* http://www.onlinelibraryaddictions.stir.ac.uk/files/2017/07/Drugs_and_Driving_in_Australia_fullreport.pdf
Sewell, R. A., Poling, J., & Sofuoglu, M. (2009). The effect of cannabis compared with alcohol on driving. *The American journal on addictions*, 18(3), 185–193.

[110] Moxham-Hall, V., and Hughes, C. (2020). Drug driving laws in Australia: What are they and why do they matter? Drug Policy Modelling Program, UNSW Social Policy Research Centre. Bulletin No. 29.

CHAPTER 6

Better understanding the problem

6.1. Casualty data

As discussed in Drug Driving Profile and Statistics above, there is not reliable data on the number of people who are killed or seriously injured in collisions involving drug drivers in Great Britain. Stats19 contributory factors show the number of fatal collisions where a police officer noted that a 'driver/rider impaired by drugs' contributed to the collision taking place. However, contributory factors are not a definitive guide to what contributed to a collision. Rather they represent the opinion of an officer at the scene, based on the evidence available at the time. Driver/rider impaired by drugs may be particularly challenging for a police officer to determine with little time as there may be little physical evidence of impairment (compared to for example 'poor or defective road service'), particularly if the driver is killed or seriously injured. The potential inaccuracy of contributory factors for assessing the road safety impact of drug driving can be seen by comparing the number of road deaths where 'driver/rider impaired by alcohol' was noted with the more robust data published in Reported Drinking and Driving (based on coroner data). Contributory factors suggest that 117 people were killed in road collisions where the driver/rider was impaired by alcohol. Contrastingly, the figure based on coroner data is 240 – more than double.

In 2001 and 2012, TRL produced an analysis of the incidence of drugs and alcohol in road accident fatalities based on coroners reports. In 2012, 231 driver fatalities had available drug data and 20% of these fatalities had an illicit drug of abuse present. 31% of these fatalities had a therapeutic drug present. The 2001 study had a sample of 1,184 casualties from 1996 to 2000 and at least one medicinal or illicit drug was detected in 24% of the fatalities. The relatively small sample size for both is in part because coroners and procurators fiscal are not required to routinely screen for drugs in road collision fatalities.

There would be immense value in the Department for Transport producing an accurate figure for the number of people killed or seriously injured as a result of drug driving. It would enable the road safety community to better understand the scale of the drug drive problem and the road safety impact of interventions which aim to reduce drug driving.

There are two possible ways the DfT could collect this data. The 2013 review of drug driving recommended that the Secretary of State should consider adopting a similar system to that in Norway where blood samples are routinely collected at all RTA following standardised collection procedures and analysed against a universal list of substances.[111] A similar system has also been implemented in some Australian states. This would provide the DfT with a database of the level of drug driving for serious, fatal, and slight injury collisions which would be an extremely valuable resource in understanding and reducing drug driving. This approach would require new legislation to give police the powers to routinely collect blood samples after collisions and would likely be expensive.

An alternative approach would be to produce statistics in the same way as an accurate figure for drink drive deaths and as the TRL studies in 2001 and 2012 did. TRL are contracted by the DfT to produce this data and combine coroner and Stats19 data to produce a reliable estimate of the number of road deaths involving drink drivers. Coroners and Procurators Fiscal would need to be required to routinely screen for drugs but unlike the Norwegian approach this would not require legislative change. However, it would also be expensive and calculating this figure for drug driving is more complicated than for drink driving because of the range of substances and the deterioration of drugs in the blood.

[111] Wolff, K. (2013). Driving Under the Influence of Drugs. DfT

The Department for Transport should produce and publish robust casualty data on drink driving using coroner data. Coroners and Procurators Fiscal should routinely screen for drugs in road collisions victims. The Government should consider the plausibility and practicality of following the Norwegian model, where blood samples are collected following collisions.

6.2. Roadside drug test data

While some forces choose to record and publish the number of roadside drug tests they conduct and the number of positive tests results, there is no requirement for forces to do so. In contrast, there is a requirement for forces to record the number of breath tests conducted, whether they were positive or negative, the reason that a test was conducted and some basic demographic details. This is then published by the Home Office in *Police Powers and Procedures England and Wales* and by the Scottish government and Police Service Northern Ireland in similar publications. This data gives the road safety community insight into the level of enforcement over time (as opposed to number of convictions), how effectively enforcement is targeted, and a basic profile of drink drivers.

Requiring police forces to record how many roadside drug tests were conducted would provide significant insight into drug driving and its enforcement. It would also provide further information on the large variation in the level of drug driving enforcement between police forces. In its response to the North Report, the Government stated that when drug driving enforcement was more effective, there would be an opportunity for research into drug drivers.[112] The increased number of roadside drug tests being conducted show that this opportunity has arrived. **Police forces should record the number of roadside drug tests conducted, whether they are positive and basic demographic details about those tested. This data should then be published annually by the Home Office or Department for Transport.**

6.3. Other data sources

In 1964, 1988, 1990 and 1998-99 roadside surveys were conducted to determine the level of drink driving on British roads. Around 10,000 drivers were sampled, in a mix of police force areas and urban and rural sites. Police officers worked with civilian staff to select survey sites, police officers randomly pulled over drivers and officers and civilians collected data from drivers. The Department for Transport last planned to commission a survey in 2008, and in 2007 published a review of methodologies for the survey. This review recommended that the survey should become a rolling survey that, over time, would enable the prevalence of drink driving to be determined, provide valuable data on regional, seasonal and temporal differences, and create a platform for collecting data on other issue.[113] Unfortunately, the DfT did not proceed with these plans.

[112] Secretary of State for Transport. (2011). The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving. Cm8050

[113] Jackson, P. (2008). A Review of Methodologies Employed in Roadside Surveys of Drinking and Driving

Other countries have done. For example, in 2012 and 2015, the Spanish government carried out roadside surveys to monitor psychoactive substance use amongst Spanish drivers. Around 3,000 drivers were breath tested for alcohol and saliva tested for drugs. This survey provided an outstanding resource to help understand the extent and profile of drink and drug driving in Spain.

Given the comparatively poor data on drug driving in the UK, both in terms of profile and road safety impacts, **the DfT should investigate the feasibility of conducting a roadside survey to monitor drink and drug driving in the UK, such as those conducted to monitor drink driving in the 1980s and 1990s.**

CHAPTER 7

Conclusions and Recommendations

7.1. Conclusions

Drug driving is a significant danger and cause of death and serious injury on UK roads. This report shows that we still do not have robust answers to many of the vital questions regarding drug driving particularly:

- How many people are drug driving?
- How many people are killed as a result of drug driving?
- How many people are drug tested on the roads?

This report shows the steps the government can take to fill these gaps. It also demonstrates the importance of filling these gaps if we are to address drug driving.

The report shows that we can reduce drug driving using many conventional road safety tools. Education campaigns can play a role in increasing knowledge of the dangers of drug driving while building a social consensus that drug driving is unacceptable. These education campaigns should avoid alienating those they target. High levels of enforcement of the drug driving law, which raises the public perception of enforcement is an effective way of reducing drug driving. However, currently, the level of enforcement varies dramatically from police force to police force. A more consistent approach should be taken and drug driving enforcement increased across the UK.

The report highlights issues with the current legal system and the small and large steps that should be taken to resolve them. A new combined drug and drink driving offence should be introduced, with lower blood drug and alcohol limits when alcohol and drugs are combined. The current blood testing system has resulted in long backlogs and high costs for police. There is the risk that people who have been charged with drug driving will not be banned from driving not because they are found not guilty, but because blood tests results take too long to come back. The Home Office should review the blood testing process and seek ways of increasing the efficiency of laboratory testing. They should also investigate the possibility of reclaiming blood testing costs from those who are found guilty of drug driving. In the short-term other steps should be taken to increase the efficiency of the court system.

All UK police forces should be encouraged to use Operation Revoke, where appropriate, to revoke the licences of dangerous drivers in the time between them being charged and their court date. It should be reiterated to police forces, Magistrates and others in the legal system that police forces have no obligation to keep B samples. To increase the efficiency of taking blood samples, vacuum tube blood extractions should be enabled in drug driving cases and onsite medical personnel should be reintroduced at all police stations. To help address the rising issue of needle phobia, police should also be encouraged to arrest drivers for driving when unfit if an offender is medically unable to provide a blood sample. Finally, steps should be taken to increase the number of drugs which roadside drug tests detect, starting with MDMA.

There is also a need for new tools to be utilised to reduce drug driving. Some can be borrowed from other fields such as public health. This would address the increased risk posed by drivers who have consumed alcohol and drugs. Not all drug drivers have drug or mental health issues but these issues do lead to many people drug driving. Drug drive reoffending remains very high with 44% of offences being committed by reoffenders. To address these issues, a Drug Drive Rehabilitation Course and High Risk Offenders Scheme should be introduced, modelled broadly on the existing drink drive programmes but with better screening for drug and mental health problems and with clear pathways to treatment. Medical professionals also have a significant role to play in identifying drug mental health issues and stopping people from driving before they cause harm by informing the DVLA. The DVLA and relevant professional bodies should continue to raise awareness of these issues.

Above all, the report demonstrates the need for a broad strategy to tackle drug driving which uses the knowledge of experts on drugs. This strategy must include research to fill vital knowledge gaps and include conventional road safety interventions as well as those from the field in public health. A strategy to tackle drug driving should seek to address the underlying causes of people's decision to drug drive, increase drivers' perceptions of their chance of being caught if they do drug drive and ensure that those who are caught receive the support they need to stop drug driving.

7.2. Recommendations

Wide-reaching review of policy

1. The Department for Transport, in collaboration with the Department for Health, the Home Office, the Ministry of Justice and the National Police Chiefs' Council, should undertake a review of policy on drug driving.

Education

2. Education needs to be increased to build and entrench a social norm that drug driving is unacceptable and to raise awareness of enforcement of the drug driving law. These media campaigns should take account of advice from behaviour change experts who specialise in behaviour change amongst drug users.
3. The Government and agencies, including the Health & Safety Executive, should encourage companies, and others with responsibility for those who drive for work, to develop strong drug driving policies, including education, testing and enforcement. This should include smaller fleets, "grey fleets" and "gig" workers.
4. The DVLA and the relevant professional bodies should continue to raise awareness of the guidance for medical professionals and others regarding informing the DVLA of a patient's drug issues.

Legislation: Drink and drug driving offence

5. The Government should introduce a new combined drink and drug driving offence, with a lower blood alcohol limit.

Enforcement

6. Levels of drug driving enforcement should be increased in the UK, particularly in those police force areas where levels are low. The impact of increases on road casualties should closely monitored.
7. The number of drugs which roadside preliminary drug tests detect should be increased, starting with amphetamine (including MDMA and methamphetamine). Senior police officers and Police and Crime Commissioners should clearly communicate their need for this feature to the Home Office, Department for Transport and manufacturers.
8. All UK police forces should be encouraged to use Operation Revoke, or similar means of preventing dangerous drivers from driving between arrest and conviction, where appropriate.
9. Police should be encouraged to consider all options (Section 4, 5 and 5a) when they have stopped a driver they suspect has consumed drugs.
10. Onsite medical personnel should be readily available to all roads police officers to take blood samples.

11. The Home Office and NPCC should remind police forces and those in the legal system that the police have no obligation to keep B samples. Officers should also ensure that Custody Records record when offenders are given the opportunity to keep their B samples.

12. Vacuum tube blood extraction should be legalised in drug driving cases.

Blood testing and the courts

13. The Home Office should review the blood testing process and seek ways to reduce costs and increase the efficiency of laboratory testing by increasing capacity, improved procurement, or other means. This review should also evaluate the possibility of seeking to reclaim blood testing costs from those who are found guilty.

14. While evidential saliva (and other metrics) testing is not currently possible in the UK, research should continue to seek methods that might prove sufficiently reliable. The Government should encourage innovation in this field.

Rehabilitation

15. A drug drive rehabilitation course should be introduced in the UK. This should be based on the UK drink drive rehabilitation course, though run separately for drug drivers when possible.

16. Drug drivers should be screened for drug dependence issues, using a tool such as DAST, in the court process and offered treatments which can more effectively address the underlying cause of their drug driving.

17. The Department for Transport should develop a High Risk Offender Scheme for drug drivers, with evidenced based criteria for inclusion and clear pathways to treatment.

Research and data

18. The DfT should investigate the feasibility of conducting a roadside survey to obtain data on drink and drug driving in the UK, such as those conducted for drink driving in the 1980s and 1990s.

19. Police forces should record the number of preliminary roadside drug test conducted, whether they are positive and basic demographic details about those tested. Drug and breath test data should be linked, to show the order of tests. These data should be published annually by the Home Office or Department for Transport.

20. The Department for Transport should produce and publish robust offence and casualty data on drug driving using coroner data and other sources, as for drink driving.

21. Coroners and Procurators Fiscal should routinely screen for drugs in road collision victims.

22. The Government should consider the practicality of following the Norwegian model, where blood samples are collected from drivers following serious and fatal collisions.

admin@pacts.org.uk
0207 222 7732
www.pacts.org.uk
@PACTS

Parliamentary Advisory Council for Transport Safety (PACTS)
Buckingham Court
78 Buckingham Gate
Westminster
London
SW1E 6PE

Designed by Trevor Mason, Glyme Creative Ltd.