Protecting the public from repeat drug driving offenders

Department for Transport's Call for evidence
https://www.gov.uk/government/consultations/protecting-the-public-from-repeat-drug-driving-offenders-call-for-evidence

PACTS response

Submitted June 2022

Contact details:
David Davies, Executive Director
Parliamentary Advisory Council for Transport Safety
78 Buckingham Gate,
Westminster,
London SW1E 6PE

The Parliamentary Advisory Council for Transport Safety (PACTS) is a registered charity. Its objective is "Safe transport for all". It provides the secretariat to the All-Party Parliamentary Group for Transport Safety.

Introduction

PACTS is pleased to respond to this Call for Evidence from the DfT on drug driving.

In 2021 PACTS published *Drug driving: the tip of the iceberg?* This research was funded by the Department of Transport. We are happy to see that DfT has included some of our recommendations in this consultation.

In preparing this response, PACTS has consulted a number of its members and drawn on the information provided. We are grateful to those who have assisted, and we hope we have reproduced it accurately. The responsibility for the views stated here, however, lies with PACTS and may not necessarily reflect the views of those consulted or cited.

Question 1 - What evidence, if any, do you have that the absence of a drug-driving rehabilitation scheme is a problem? Please provide a rationale for your answer.

The number of drug driving offences detected is increasing and drug-impaired drivers are a growing road safety concern. Reoffending is a particular issue. The main prevention tool is enforcement through roads policing which has advanced considerably in the past decade. PACTS believes that education interventions also have a place. While it is impact cannot be assessed currently, the absence is of a drug-driving rehabilitation scheme is an omission that should be addressed.

In 2019, 12,391 people were convicted of drug driving offences. This is a significant increase from previous years. Comparisons to years before 2015 are not helpful because the offence ‘Drive a motor vehicle with the proportion of specified controlled drug above specified limit’ was not introduced until 2015. It is unclear if the level of drug driving is rising. It is clear, however, that the police are now better able to detect and prosecute drug driving, revealing the scale of offending and the road safety risk.[1]

Between 2010 and 2020, 24% of drug drive offenders (14,224 people) were reoffenders. These 14,224 offenders committed 34,178 offences (44% of drug drive offences).[2] This is a remarkably high level and suggests a need for rehabilitation of drug drive offenders in combination with enhanced enforcement by the police.

The road safety consequences of drug driving are being increasingly evidenced. The DfT publication Developing drug driving statistics: initial feasibility study - GOV.UK (www.gov.uk) suggests that deaths from drug driving may be as high as those from drink driving. For example, in GB in 2018, illegal levels of drugs were identified in over 200 drivers who died in road collisions.

[1] Pacts report - PACTS-Drug-Driving-The-tip-of-an-iceberg-3.0.pdf

[2] PACTS-Drug-Driving-The-tip-of-an-iceberg-3.0.pdf, p. 40.

As a UK drug drive rehabilitation scheme does not currently exist, we cannot say how effective one would be. We consider the merits of drug drive rehabilitation courses in response to Q2 below.

Question 2 - Do you agree that the Government's proposal to introduce a drug-driving rehabilitation scheme is the right approach? Please provide a rationale for your answer.

We support the introduction of a drug-driving rehabilitation scheme. Further work may be required to establish the best scheme, and more than one type of course or treatment may be necessary.

The assessment of the drink drive rehabilitation course by TRL may give some indications. TRL found that 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.[3] 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 re-offend within three years of conviction.. However, it acknowledged that course attendees contained few high-risk offenders whereas the general offending population against which they were compared included the whole population of high-risk offenders.

More generally, short course drink and drug rehabilitation programmes in a criminal justice context have a poor record in helping change drinking, drug taking or offending behaviour. In 2013 an extensive review of prison and probation accredited programmes for addressing alcohol and drug issues found that they made no difference and, in some ways, seemed to make things worse.[4]

However, a recent meta-analysis of the effectiveness of drug diversion courses (of general and not just criminal justice courses) is positive in stating that such courses reduce drug misuse.[5] It is possible to believe that a drug-driving rehabilitation course could have a similar effect.

The consumption of drugs leaves long-lasting traces in the hair and nails of those who take them. It may be advantageous and feasible to screen drug drivers for dependence issues, using a tool such as DAST, in the court process. [6] A requirement for the attendee to provide an analysed hair/fingernail sample demonstrating their abstinence from drugs for three months might be a precondition of joining a drug-driving rehabilitation course. Those who cannot might be offered alternative treatment which can more effectively address the underlying cause of their drug driving.

---

[3] TRL | The drink/drive rehabilitation scheme: evaluation and monitoring. Final Report

[4] MoJ 2013) Table A 4.3 The factors associated with proven re-offending following release from prison: findings from Waves 1 to 3 of SPCR; Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners);

[5] https://www.tandfonline.com/doi/abs/10.1080/09687637.2017.1398715

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

The possibility of including drug driving education in drink drive rehabilitation courses was also considered in a 2019 evaluation of the drink drive rehabilitation course, conducted by Ipsos MORI.[7] 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.

Behaviour change experts and course providers interviewed by PACTS for *Drug Driving: The tip of an iceberg* 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 change course. The evaluation concluded that more research is required to determine the impacts of mixing drink and drug drivers on a combined course.

Ideally, 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. Rehabilitation interventions in other parts of the world include a range of programmes ranging from classroom courses similar to the current drink-drive rehabilitation course through to regular therapy and drug testing. A Behaviour Change Program in Victoria, Australia, provides referrals for further support to help attendees address the underlying reason for drink and drug driving offences.[8] Referrals of support and /or therapy being included as part of sentencing are believed to be more effective than signposting support as is currently done in the UK drink drive rehabilitation course.

Question 3 - If a HRO drug-driver scheme is introduced, and with reference to the Expert Panel report, what criteria should be set for inclusion on the scheme? Please provide a rationale for your answer.

We support the introduction of a High Risk Offender Scheme for drug drivers and support the criteria proposed by the Expert Panel. We recommend that flexibility be included in the criteria so that issues such as wider medical conditions, other road traffic offences and the consequences of drug driving can be taken into account.

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 ten years,

• were driving with an alcohol reading of at least 87.5 micrograms of alcohol per 100 millilitres (ml) of breath (the legal limit in England and Wales is 35), 200 milligrams (mg) of alcohol per 100 ml of blood, or 267.5 mg of alcohol per 100 ml of urine,

[7] Ipsos MORI (2019) *Review of the Drink Drive Rehabilitation Course* (publishing.service.gov.uk)

[8] Behaviour Change Program : VicRoads

• 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.

The HRO scheme is seen as 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. PACTS report recommended that the High Risk Offender Scheme be improved by broadening the criteria, for example, more accurately identify high-risk offenders and offer support for offenders.

Question 4 - Should consideration be given to creating an offence of causing death by dangerous driving whilst under the influence of drink and/or drugs? Please provide a rationale for your answer.

We support the creation of a new offence of causing death by dangerous driving under the influence of drink and drugs with a lower blood alcohol limit. This would help the emphasise the particular dangers involved.

The offence of causing death by dangerous driving whilst under the influence of drink or drugs already exists (Section 3A Road Traffic Act 1988). However, there is no specific offence for driving under the influence of both. Even at “low” levels, combining drink and drugs can be unpredictable and particularly impairing. The Government should introduce a new combined drink and drug driving offence, with a lower blood alcohol limit (50mg/100ml). This was one of the recommendations in the PACTS 2021 report.

Driving having consumed both alcohol and other drugs is significantly more dangerous than driving with an equivalent amount of alcohol or drugs.[9] This is because the interaction of alcohol and other drugs can be significantly more impairing than in isolation.[10] This can be true for both illicit and medicinal drugs. Drivers could also have low levels of drugs and

[9] 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

[10] 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.

alcohol in their system, possibly below the legal drink and drug driving limits, but still, be significantly impaired.

We acknowledge the practical difficulties for the police and courts with prosecuting for drink and drug driving together. There are differing methods, timeframes and costs for obtaining the evidence for each intoxicant. Generally, the police and prosecutors, through an intoximeter reading, have instant access to the level of alcohol in the accused's system. With drugs, there are at least eight illegal substances and many other legal drugs that can cause intoxication. It is a much longer and more complicated process to develop evidence of drug related intoxication or impairment. When the prosecutors have evidence of alcohol derived intoxication it may not be practical or cost effective to seek to find evidence of drug related intoxication as well.

Combination offences (covering driving with both alcohol and other drugs in the system) exist in Victoria, Australia, with similar penalties as for drink and drug driving.[11]

Question 5 - Should consideration be given to creating an offence of causing serious injury by driving whilst under the influence of drink or drugs, or failing to provide a specimen? Please provide a rationale for your answer.

We agree that the government should consider creating an offence of causing serious injury by driving whilst under the influence of drink or drugs.

There is currently an offence of causing serious injury while driving while disqualified (Section ZD Road Traffic Act 1988). It is rational to have a coherent set of laws which treat all acts of egregious law breaking proportionately.

Causing serious injury while driving in a highly risky way should always be punished severely; therefore, we support the introduction of this offence.

Question 6 - Should consideration be given to amending the HRO drink-driver scheme to include offences of dangerous and careless driving, together with any offences involving death and serious injury? Please provide a rationale for your answer.

Yes, consideration should be given to amending the HRO drink-driver scheme to include offences of dangerous and careless driving, together with any offences involving death and serious injury.

Doing so would require the law to be changed. As noted above, we support greater flexibility in the drink driving HRO scheme. The HRO Scheme is an administrative system and not one that is subject to court supervision; an offender who currently meets the criteria is

[11] 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.

automatically and administratively required to have a medical examination before the reissue of a licence. Although it deals with some of our riskiest offenders, the law treats those people as if they had a medical condition.

The HRO scheme should be augmented to include those who have committed the offences described in the question. We recommend that the law concerning the scheme be removed from the Motor Vehicles (Driving Licence) Regulations 1999 as it is surely not tenable to place such offenders on the same footing as those with a disability.

The requirements of the HRO scheme should be considered in the same way as the requirement for a driving licence retest.[12] [13] It should be a function of court sentencing; it should be incorporated into the Road Traffic Offenders' Act and should be subject to court oversight.

Causing death by dangerous driving whilst under the influence of drugs (drugs as an aggravating factor) is a growing category in Great Britain. It is recommended that the Department for Transport and the Ministry of Justice review the offences in Section 1 and 1A and Section 2 and 2B of the Road Traffic Act 1988 to allow for drug driving to be recognised as a specific offence in relation to dangerous driving.

Question 7 - Should consideration be given to ensuring a HRO drug-driver scheme includes offences of dangerous and careless driving, together with any offences involving death and serious injury? Please provide a rationale for your answer.

Yes, consideration be given to ensuring a HRO drug-driver scheme includes offences of dangerous and careless driving. The PACTS response to this question would be along similar lines to that for Question 6.

The HRO schemes for drugs and drink driving should be similar to each other for simplicity. The pattern of offence and the type and quantity of drugs found could also be an indicator for admission into the HRO scheme for drug drivers.

[12] **The following convicted offenders must take an extended retest before recommencing driving**. Motor manslaughter, Causing death by dangerous driving , Causing serious injury by dangerous driving, Dangerous driving, Causing death by careless driving under the influence of drink or drugs

[13] **The following convicted offenders may be required to take an extended retest before recommencing driving,** Unlawful vehicle taking, Aggravated vehicle taking, Making-off after a personal injury or other accident, Racing on the highway, Driving while disqualified

Question 8 - In order to comply with current medical practices, should the admissibility requirements in respect of a “specimen”, set out in section 15(5) and (5A) of the Road Traffic Offenders Act 1988 be amended to enable vacuum blood extraction? Please provide a rationale for your answer.

PACTS supports this proposal to enable vacuum blood extraction.

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.

Currently, a significant proportion of drivers who test positive for cocaine or cannabis in roadside drug tests are not prosecuted because their blood tests show levels of drugs below the legal limit. This may be due at least partly to delays in taking the blood sample. Vacuum blood extraction would enable faster sampling and avoid the objection of needle phobia.

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. Some people arrested for drug driving also refuse to provide a blood sample for religious reasons. However, 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.

Retrieving samples from offenders using new medically approved and reliable techniques should be a matter for secondary legislation. The question refers to vacuum blood extraction, but there are other ways of getting reliable forensic samples of an offender’s drug metabolites without using blood, let alone requiring needles. (see the work of Intelligent Fingerprinting[14]) Methods of capturing these data will change over time, and it should not require primary legislation to enable those methods to become accredited. We

[14] https://www.intelligentfingerprinting.com

support the proposition implicit in this question but ask that the changes are contained in regulations produced by the Secretary of State.

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.

The PACTS report also recommended that the Home Office 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.

Question 9 - Are there any comments on the relationship of medicinal cannabis to road safety that you would like to raise?

There is little specific evidence on the effects of medicinal cannabis on road safety.

Cannabis has a wide range of effects, and individual responses to the drug are subjective. Drowsiness and sedation, impaired judgement, slower reaction time, poorer control of motor skills, lack of concentration, confusion, and blurred vision were all effects that could have an impact on driving safety. The typical duration of neurocognitive impairment associated with the use of THC-containing medical cannabis is four hours or less (the evidence reviewed did not include comparable estimates for recreational cannabis use). Even in the absence of acute intoxication, chronic recreational cannabis use has been linked to mild to moderate cognitive loss and impaired driving performance. However, understanding the levels and durations of THC concentrations in medical users would be needed to assess how relevant this is for the medical cannabis user population. [15]

Literature on cannabis use and risks to road safety (which mostly relates to recreational use) generally suggests a low-to-moderate increase in crash risk compared to driving sober. The increased risk may vary by type of collision, with lower additional risk for fatal crashes and more additional risk for less serious collisions as cannabis use may be more likely to cause crashes due to inattention than to aggressive driving. The evidence base has some limitations in how consistently studies measure the frequency and quantity of cannabis used and how cannabis use is isolated from use of alcohol. Within cannabis-impaired driving, it is likely that medical cannabis users pose less of a risk than recreational users. Evidence from the USA where states have different legal regimes around cannabis legalisation suggests differences in risk according to legal and policy frameworks (and how these are interpreted and implemented). This suggests that increased population-level risk from medical legalisation may be much lower than for decriminalisation or general legalisation. Literature on adherence to safe driving guidelines mostly relates to recreational cannabis use but suggests that adherence may be higher among users with medical needs as their main aim is

---

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

to alleviate symptoms rather than to get high. The risk of accidents increases substantially when cannabis is mixed with alcohol, this generally results in a greater degree of impairment.[16]

The issue of medicinal cannabis is complex and centres largely around the relative ratios of cannabinoids in any given sample. Whilst there are a number of psychoactive and non-psychoactive cannabinoids in any given cannabis sample, the main issue concerns the ratio of tetra hydro cannabinol (THC), which is highly active and impairing, to that of cannabidiol (CBD) which is non-psychoactive. Medicinal cannabis which has been prescribed to treat, in particular, symptoms of epilepsy and chronic low-level pain has a high concentration of CBD, but also a lesser amount of THC. The latter, although present in relatively low quantities, seems essential to its therapeutic quality. CBD, on its own, is now readily available over the counter and provides no impairment risk. In medically prescribed cannabis the THC level is relatively low (< 5%) and the number of studies relatively small. The impairing effects are likely to be low compared to recreational cannabis where THC levels can be as high as 25% in samples of unregulated cannabis.[17]

[16] Cameron, M., Newstead, S., Clark, B. and Thompson, L. (2022). "Evaluation of an Increase in Roadside Drug Testing in Victoria Based on Models of the Crash Effects of Random and Targeted Roadside Tests". Journal of Road Safety, 33(2), p 31. https://doi.org/10.33492/JRS-D-20-00272

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