

Evaluation of the new drug driving legislation, one year after its introduction

A report for Department for Transport
April 2017
Issue 1



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Executive Summary

Section 4 of the Road Traffic Act 1988 is concerned with ‘**Driving, or being in charge, when under influence of drink or drugs**’. It addresses the offence of driving a vehicle while impaired through consumption of drugs or alcohol. For drink driving, Section 5 of the Act allows for specified limits for how much alcohol can be present in a driver’s breath, blood or urine. Until recently, there was no equivalent for drug levels in drivers, with any charges brought for drug driving under Section 4 relying on evidence of impairment while driving and evidence that drugs were present in blood or urine. This changed on 2 March 2015 through implementation of new legislation (Section 5A of the Road Traffic Act 1988) which prescribed upper limits for the level of specific controlled drugs in a driver’s blood.

The overall objective of the new offence is to improve road safety by reducing the risk that drug drivers pose to themselves as well as other road users, by reducing its prevalence in the driving population¹. To achieve this the Department for Transport (DfT) aims to:

1. Deter people from taking illegal drugs in the first place and those who abuse* their medication.
2. Enable more effective enforcement against those who persist in taking illegal drugs and those who abuse their medication and continue to drive.
3. Increase the efficiency of enforcement activity against drug drivers.

**Note – ‘abuse’ here should be interpreted as taking prescribed medication other than in accordance with the directions of a healthcare professional, or taking over-the-counter medication other than in accordance with the manufacturer’s instructions.*

This report presents the results of an evaluation of the new drug driving offence. The information provided in this report aims to set out the position of a range of key indicators both prior to the introduction of the new drug driving offence, and approximately one year after its introduction, so that any changes can be identified and evaluated.

Background

The Review of Drink and Drug Driving Law by Sir Peter North² concluded that there was “a significant drug driving problem” with some research estimating as many as 200 drug driving-related deaths a year in Great Britain³. However, in 2011, around 30% of the prosecutions in magistrates’ courts for driving while impaired through drugs did not result in convictions⁴. This improved to around 20% in 2012, but has remained at that level since and compares poorly with the

¹ Paragraph 22 of the impact assessment in the consultation document https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229738/consultation-document.pdf

² North Report of the Review of Drink and Drug Driving Law, June 2010. Report available at: <http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/>

³ Regulations to specify the drugs and corresponding limits for the new offence of driving with a specified controlled drug in the body above the specified limit – A Consultation Document, Department for Transport, July 2013.

⁴ Analysis by Ministry of Justice – from Ministry of Justice data from official databases, on proceedings brought and numbers of convictions.

much higher successful prosecution rate in magistrates' courts for drink driving, where only 4% of prosecutions do not result in conviction. The lower conviction rate for drug driving is believed to result from the need to establish:

(1) that the driver was impaired, and (2) that the impairment was due to drugs⁵.

For drink-driving it is necessary only to establish that the drink drive limit has been exceeded (i.e. the specified limit for alcohol in breath, blood or urine). The Government proposed a Bill in May 2012 that included a new offence of driving with a specified controlled drug in the body, above the specified limit for that drug. The new offence came into force in England and Wales on 2 March 2015.

The aim of the new offence was to simplify the process for prosecuting drug drivers, and ultimately reduce the number of people killed and seriously injured as a result of drug driving.

Evaluation of the new legislation

In September 2013 the DfT commissioned an evaluation of the new offence. The specification for the work⁶ indicated that:

The primary objective of this requirement is to scope, develop and deliver a suitable programme of evaluation to assess the implementation, operation and short-term impacts of the new drug driving offence. The project should include collection of data over a baseline period and shorter-term impacts of the new offence (initial analysis).

The specification indicated that the evaluation should address the following key research themes:

- Operation and enforcement of the drug driving offences
- Drug driving and road traffic collisions
- Offending behaviour and recidivism
- Attitudes to the offence
- Cost-benefit analysis.

Over the course of the research, it was agreed that the last theme should be disregarded as it would be too early to conduct a meaningful cost-benefit analysis, as longer term impacts are yet to be realised. In particular, it was too early to meaningfully assess the drug driving related road traffic collision benefits.

This report presents the results of the research undertaken to support the evaluation.

⁵ Paragraph 19 of the impact assessment in the consultation document https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229738/consultation-document.pdf

⁶ Specification. RM2248-SB246 – Evaluation of Section 5A of the Road Traffic Act 1988 drug driving legislation: Scoping, establishment of baseline data, and initial analysis. 25/07/2013, Version 3.0.

Our approach

An evaluation framework (based on a programme logic model) was developed that captured all the inputs, activities and outputs associated with implementation of the new legislation. We mapped the evaluation questions for the research onto this framework and assessed the availability and quality of potential data sources to answer the evaluation questions. The evaluation questions are summarised below:

a) Operation and enforcement

- How many people have been saliva tested by police, and with what result?
- How many people have been arrested, investigated for the new Section 5A offence, and had a blood sample taken, and what were the results of the blood tests?
- For individuals, what are the time intervals between saliva tests and blood samples?
- Where blood samples are requested, how many people fail to provide a blood sample and why? How many people are charged with failing to provide a blood sample?
- Does extent of use of the new offence vary between police forces?
- How well do key stakeholder groups think that the new offence is working in practice?
- Is there any evidence of negative impacts on groups such as those taking medication for chronic illness?

b) Drug taking and road traffic collisions

- What is the effect of the new offence on the prevalence of:
 - Driving under the influence of drugs?
 - Collisions due to drug driving?
 - Numbers of people killed or seriously injured due to drug driving?

c) Offending behaviour and recidivism

- How many court proceedings have been brought for the new Section 5A offence? How many were found guilty?
- What impact has the new Section 5A offence had on the numbers of proceedings for the existing Section 4 impairment offence?
- How many of those convicted under the new offence have previous convictions for drug driving, and how does this compare with those found guilty of the existing offence? Is there a link with other types of offending behaviour?

d) Attitudes to the offence

- Are drivers aware of the new Section 5A offence?
- What are the public attitudes towards drug driving? What is the effect, if any, of the new offence on these attitudes?

In undertaking this exercise we identified those data sources that could be used to establish a baseline for the key measures, i.e. we identified data sources that

enabled us to measure a range of key indicators both prior to the introduction of the new drug driving offence, and approximately one year after its introduction, so that any changes could be identified and evaluated. The measures identified were quantifiable so far as practicable, but this was supplemented by qualitative information provided through interviews with key stakeholders such as: the police and the Crown Prosecution Service (CPS); Coroners; forensic laboratories and the Home Office Centre for Applied Science and Technology (CAST); policy stakeholders and medical stakeholders.

Key Findings

- Police are using the new offence – prosecutions under the new Section 5A were higher in 2015 than for the pre-existing Section 4 impairment drug driving offences, and the latter were at a similar level to 2014. This suggests that the new offence is being used in addition to the existing Section 4 offence, and not simply replacing it. It also suggests that police forces are still using the existing offence where appropriate, and that the new offence has led to additional police activity against drug drivers, rather than being used as an easier route to convicting those who would have been convicted in any case. There is evidence that use of the new offence rose steadily throughout 2015 and has increased in 2016.
- The majority of preliminary drug screening tests (saliva tests) are carried out at the roadside indicating that police forces are employing the drug screening kits during traffic operations. For the period when we collected this data, most of the drivers tested were young men and 55% of the tests were positive for cannabis, cocaine or both.
- On the basis of the data collected to date, higher conviction rates for drug driving prosecutions under the new legislation are being realised. Section 4 offence conviction rates have been approximately 80% since 2012, whereas in 2015, proceedings brought for Section 5A offences had a conviction rate of 98% - which is similar to those achieved for drink driving (96%). Note however, that this may in part be because cases with 'not guilty' pleas take longer to make their way through the system and so many of these have not yet been tried.
- Public awareness of the new offence has increased since the awareness campaign around its introduction. 16% of drivers were aware of the new offence before it was introduced. This increased to 48% of drivers after the legislation was implemented.
- Approximately 77% of drivers and 67% of non-drivers think that the punishment for drug driving should be the same as that for drink driving, and similar proportions think that drug drivers are unlikely to be caught. These attitudes have not changed since introduction of the new legislation.
- While it is too soon to determine whether there is a statistically significant and sustained downward trend, the percentage of people who reported taking illegal drugs in the last twelve months and who also reported driving while under the influence of those drugs, reduced from 9.2% in 2014/15 to 5.0% in 2015/16.

- Based on interviews with a small number of police forces, they have concerns about the costs of enforcement going forward, particularly related to the costs of blood analysis tests.
- From interviews with relevant stakeholders, we found no evidence that users of prescribed medicines that fall into those categories of drugs covered by the legislation, have been adversely affected by the new regulations. Similarly, we found no evidence that the associated concerns raised by patient representative groups have been realised. However, the offence is still relatively new so there may be a need to monitor this over a longer period to confirm this.
- There is no evidence that illicit drug use amongst the general public has changed materially since 2009-10. Cannabis and powder cocaine remain the most commonly used drugs.
- As well as removing drug drivers from the roads, police forces believe that an additional, and unanticipated, benefit is being realised from enforcement of the new offence. Specifically, they believe that it is disrupting wider criminal behaviour. This is supported by evidence that 67% of those convicted of drug driving offences have one or more previous convictions.

Conclusions

Overall we conclude that the processes associated with introducing the new offence have been implemented successfully.

It is too early to say whether road safety benefits arising from a reduction in drug driving related road traffic collisions have been realised. Further monitoring of the road traffic collision data will be needed to test if this is the case, and as there is no counterfactual, impact assessment will not be straightforward. However, if the theory of change proves to be correct we would expect road safety benefits to be realised in the longer term.

Recommendations for ongoing monitoring

As our research looked only at short term effects and impacts, we were asked to consider whether there was a need for ongoing monitoring. In this context, we recommend the following:

- DfT should maintain dialogue with a few police forces or perhaps the CPS, regarding defence strategies, as new defences are still being tested, and in our sample, most 'not guilty' plea cases were yet to be tried.
- Monitoring of Section 4 and Section 5A proceedings brought, and associated convictions, should continue, to retain an overall picture of convictions for drug-driving.
- The Ministry of Justice (MoJ) should repeat the analysis of Section 4 and Section 5A proceedings brought by individual police forces. Our research suggested differences in the extent to which drug driving offences are used by different police forces. If differences persist, consider a focused piece of qualitative research with a sample of forces to explore the reasons for differences.
- STATS19 contributory factors (CFs) for drink and drugs should continue to be monitored to test and validate the associated road safety benefits from

reduced drug driving that were assumed in the original impact assessment. Any future revision to the impact assessment analyses could also consider unanticipated effects, such as disruption to general crime.

- There remains a need to improve understanding of the extent to which drugs are a CF in road traffic collisions nationally. To address this, we recommend that the DfT and the Home Office consider a trial (which may be regional) where preliminary drug screening tests are administered to all drivers involved in road traffic collisions where a STATS19 record is completed.
- Related to the previous recommendation, consider modifying the STATS19 form to include a box that records the findings from any preliminary drug screening test administered to the driver.

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Glossary

A and B blood samples	In the context of the new drug driving offence, when a blood sample is taken for analysis, this is divided into two – the A sample and the B sample. The A sample is sent to a forensic laboratory for analysis, while the B sample is offered to the suspect, with instructions for storage, and details of where they can have the sample analysed, if they wish to.
ACPO	Association of Chief Police Officers
ADHD	Attention deficit hyperactivity disorder
BZE	Benzoylcegonine
CF	Contributory factor (from STATS19 record)
CPS	Crown prosecution service
CREST	Database with details of cases that proceed to Crown Courts
CSEW	Crime Survey for England and Wales
DfT	Department for Transport
DH	Department of Health
DRUID	Driving under the influence of drugs, alcohol and medicines – this project brought together researchers from across Europe, and aimed to gain new insights into impairment caused by drugs, alcohol and medicines, and their impact on road safety. It ran from October 2006 to October 2011,
DVLA	Driver and Vehicle Licensing Agency
FIT	Field impairment testing
GMC	General Medical Council
GP	General practitioner
Home Office CAST	Home Office Centre for Applied Science and Technology
KSI	Killed or Seriously Injured
Libra	Database with details of offences that proceed to Magistrates' Courts
MDMA	Methylenedioxymethamphetamine
MGDD	Manual of guidance drink and drug driving - the MGDD is a set of forms used by police forces in England and Wales when dealing with drink and drug driving offences
MoJ	Ministry of Justice
NFA	No further action
NICE	National Institute for Health and Care Excellence

NPCC	The National Police Chiefs Council (this replaced ACPO in April 2015)
NPS	New psychoactive substances
ONS	Office for national statistics
PLM	Programme logic model
PNC	Police National Computer
RTC	Road traffic collision
Section 4	Section 4 of the Road Traffic Act 1988 addresses: <i>Driving, or being in charge, when under the influence of drink or drugs.</i>
Section 5A	Section 5A of the Road Traffic Act 1988 addresses: <i>Driving or being in charge of a motor vehicle with concentration of specified controlled drug above specified limit.</i>
STATS19	Database managed by DfT with information on personal injury road traffic collisions
THC	Delta-9-tetrahydrocannabinol – the active ingredient in cannabis

1 INTRODUCTION

1.1 This report presents the results of an evaluation of the drug driving offence in Section 5A of the Road Traffic Act 1988, which came into force on 2 March 2015. The information provided in this report aims to set out the position of a range of key indicators both prior to the introduction of the new drug driving offence, and approximately one year after its introduction, so that any changes can be identified and evaluated. The key indicators or measures considered:

Proceedings brought and convictions

- Numbers of proceedings brought and convictions for drug driving, and for drink driving (to provide context)
- Percentages of proceedings brought for drug driving and drink driving where the defendant was found guilty
- Average fines for drug driving and drink driving
- Age distributions for those found guilty of drug driving, and for those found guilty of drink driving
- Numbers of previous offences for those found guilty of drug driving.

Awareness and attitudes

- Public awareness of the existing Section 4 drug driving offence, and the new Section 5A offence (prior to it coming into force)
- Public attitudes to punishment for drug driving compared with punishments for drink driving
- Public perceptions of how dangerous drug driving is compared with drink driving
- Public perceptions of the likelihood that drug drivers would be caught.

Prevalence and frequency of drug driving

- Percentage of drug drivers who reported having driven under the influence of illegal drugs
- Percentage of drivers who reported taking illegal drugs who also reported having driven while under the influence of illegal drugs
- Frequency of drug driving among those who reported both taking illegal drugs and driving while under the influence of those drugs.

Road safety measures

- Numbers of road traffic collisions where drug-driving was cited as a contributory factor by attending police officers
- Numbers of road traffic collisions where drug driving was cited as a contributory factor by attending police officers, normalised by billions of vehicle miles driven
- Numbers of fatalities and serious injuries in road traffic collisions where drug driving was cited as a contributory factor by the attending police officer, normalised by billions of vehicle miles driven
- For context and comparative purposes, all of these road safety measures for drug driving were repeated for drink driving.

- 1.2 This report is structured around a programme logic model (PLM) that provides a theory of change for how the policy is intended to achieve its objectives – see Section 3 for more detail. The report is structured as follows:
- **Section 2** - provides background to the report, outlining the policy background, the legislation and regulations that have changed, and how drug driving is enforced in practice.
 - **Section 3** - describes the evaluation approach adopted for this study. The programme logic model (PLM) is described, the research questions are highlighted and the main data sources used to inform the research are highlighted.
 - **Section 4** - provides a brief commentary on the inputs required and activities undertaken to introduce the new offence, including plans made by a range of interested parties, their experiences of implementing those plans, and any residual concerns related to the introduction of the new legislation.
 - **Section 5** - examines available data for the outputs shown on the PLM developed for this study. This covers outputs before and after the introduction of the new offence including:
 - information on the legislation put in place
 - information on numbers of arrests, prosecutions and convictions
 - any previous offences for those convicted
 - availability of preliminary drug screening devices
 - accredited laboratory analysis methods in support of the new law.
 - **Section 6** - presents data for the outcomes and impacts – the ultimate effects of the introduction of the new offence - including:
 - Change in awareness of drug driving laws, attitudes to drug driving, and perceptions of likelihood of arrest
 - prevalence and frequency of drug driving
 - road safety, including numbers of road traffic collisions where at least one person has been injured and where drug driving has been identified as a possible contributory factor, and the numbers of fatalities and injuries associated with those collisions
 - comments on the potential impact on those taking prescribed medicines, and impact on public health.
 - **Section 7** – presents our conclusions from the research to date
 - **Section 8** – presents our recommendations, including recommendations for ongoing monitoring.
 - **Appendix A** provides information on the key data sources used to inform this study.
 - **Appendix B** lists the evaluation questions that formed the main focus for our research.
 - **Appendix C** provides details of the findings from qualitative interviews we carried out with stakeholders.
 - **Appendix D** shows the bespoke form used to collect information on those instances where people were stopped and saliva tested, by a selection of police forces.

Purpose of this report

- 1.3 This report presents relevant baseline data as well as information collated during the first year following implementation of the new legislation, for the following areas:
- **Operation and enforcement of drug-driving offences** – including plans for implementation of the new offence
 - **Offending behaviour and recidivism** – including numbers of prosecutions and convictions, and previous offending behaviour of those convicted of drug-driving offences
 - **Attitudes to and awareness of drug-driving and drug-driving offences** – including attitudes to drug-driving among the general public, which are compared with attitudes to drink-driving
 - **Road traffic collisions** – including numbers of collisions where drug-driving was cited as a contributory factor, and the numbers of injuries and fatalities associated with these collisions.
- 1.4 This report therefore sets out the position before introduction of the new offence and indicates how this baseline information has changed since implementation of drug-driving legislation. The evaluation report aims to evaluate early implementation of the new offence (the process), and looks at early outcome measures to assess whether any conclusions can be drawn relating to impact.

2 BACKGROUND

2.1 In this section we discuss the background and context for the evaluation study.

Policy background

2.2 The Review of Drink and Drug Driving Law by Sir Peter North⁷ concluded that there was “**a significant drug driving problem**” with some research estimating as many as 200 drug driving-related deaths a year in Great Britain⁸. However, in 2011, around 30% of the prosecutions in magistrates’ courts for driving while impaired through drugs did not result in convictions⁹. This compares poorly with the equivalent figure for drink driving, where only 4% of prosecutions in magistrates’ courts for exceeding the drink drive limit result in a failure to convict. The lower conviction rate for drug driving was believed to result from the need to establish impairment on a case by case basis, as well as the need to demonstrate that the impairment arose from being under the influence of drugs¹⁰.

2.3 These factors contributed to the Government’s decision to propose a Bill in May 2012 that included a new offence of driving with a specified controlled drug in the body, above the specified limit for that drug. The Bill, which is now the Crime and Courts Act 2013, received Royal Assent on 25 April 2013. Section 56 of the Crime and Courts Act 2013 inserted a new section (Section 5A) into the Road Traffic Act 1988. Section 5A(8) includes a regulation-making power, exercisable by the Secretary of State in relation to England and Wales and by Scottish Ministers in relation to Scotland, to specify the controlled drugs to be covered by the new offence, and the corresponding limit for each. The Drug Driving (Specified Limits) (England and Wales) Regulations 2014 were established on 24 October 2014 and the new offence came into force in England and Wales on 2 March 2015. The Drug Driving (Specified Limits) (England and Wales) (Amendment) Regulations 2015 which added amphetamine were established on 23 March 2015 and came into force on 14 April 2015.

2.4 The overall objective of the new offence is to improve road safety by reducing the risk that drug drivers pose to themselves as well as other road users, by reducing its prevalence in the driving population¹¹. To achieve this DfT aims to:

⁷ North Report of the Review of Drink and Drug Driving Law, June 2010. Report available at: <http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/>

⁸ Regulations to specify the drugs and corresponding limits for the new offence of driving with a specified controlled drug in the body above the specified limit – A Consultation Document, Department for Transport, July 2013.

⁹ Analysis by Ministry of Justice.

¹⁰ Paragraph 19 of the impact assessment in the consultation document. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229738/consultation-document.pdf

¹¹ Paragraph 22 of the impact assessment in the consultation document https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229738/consultation-document.pdf

1. Deter people from taking illegal drugs in the first place and those who abuse* their medication.
2. Enable more effective enforcement against those who persist in taking illegal drugs and those who abuse their medication and continue to drive.
3. Increase the efficiency of enforcement activity against drug drivers.

**Note – ‘abuse’ here should be interpreted as taking prescribed medication other than in accordance with the directions of a healthcare professional, or taking over-the-counter medication other than in accordance with the manufacturer’s instructions.*

Legislation and regulations

- 2.5 The new offence came into force on 2 March 2015, initially specifying blood concentration limits for 16 different substances, with amphetamine added on 14 April 2015. The blood concentration upper limits for each of the specified substances are provided in Table 1 below.
- 2.6 Other legislation related to drink and drug driving enforcement, introduced around the same time, may have had a confounding effect on some of the measures we look at. These are discussed here.

Table 1: Substances included in the new drug driving offence, and blood concentration limits

	Threshold upper limit in blood
Generally illicit drugs	
benzoylecgonine	50µg/L
cocaine	10µg/L
delta-9-tetrahydrocannabinol (cannabis and cannabinol)	2µg/L
ketamine	20µg/L
lysergic acid diethylamide (LSD)	1µg/L
methylamphetamine	10µg/L
methylenedioxymethamphetamine (MDMA, ecstasy)	10µg/L
6-monoacetylmorphine (6-MAM, heroin, diamorphine)	5µg/L
Generally medicinal drugs	
amphetamine	250µg/L
clonazepam	50µg/L
diazepam	550µg/L
flunitrazepam	300µg/L
lorazepam	100µg/L
methadone	500µg/L
morphine	80µg/L
oxazepam	300µg/L
temazepam	1,000µg/L

Source: <https://www.gov.uk/government/collections/drug-driving#table-of-drugs-and-limits>

Removal of the statutory option

- 2.7 The 'statutory option' in relation to drink driving was removed from legislation on 10 April 2015. The statutory option allowed people being investigated for drink driving to opt for a blood or urine sample to be used evidentially instead of a breath specimen, where the lower of two breath alcohol readings was below 50 µg per 100ml (the prescribed limit is 35 µg per 100ml)¹². A survey showed that where custody centres have resident nurses (so that there is little delay in taking a blood sample), almost all statutory option cases resulted in positive blood or urine tests. However, where there is no nurse or doctor, and one must be called, the consequent delay meant that some suspects had sufficient alcohol eliminated from their bodies to pass the further evidential test. The impact assessment for removal of the statutory option estimated that there were 5,758 statutory option cases in England Wales in 2011¹³. Therefore, removal of the statutory option may increase the availability of clinicians to take blood samples for drug driving offences, including both the Section 4 impairment offence and the new Section 5A offence. In addition, fewer blood samples for analysis of alcohol content should be sent to forensic laboratories and so there should be more capacity at forensic laboratories for analysis of samples taken for drug driving offences, which were expected to increase.

Condition assessment no longer needs to be undertaken by a doctor

- 2.8 From April 2015 a registered healthcare professional (i.e. a nurse or a paramedic), in addition to a doctor, can judge whether a suspect has a condition that might be due to having taken a drug.
- 2.9 This judgement is a necessary requisite for taking blood under Section 7 of the Road Traffic Act 1988 and should result in fewer delays to taking evidential blood samples. Formerly, a doctor was required to make that judgement and this was often associated with a time delay until a doctor could be called to assess the suspect's condition. In addition, if a preliminary drug screening proves 'positive', then blood can be taken without the need for an opinion from a doctor or other healthcare professional.
- 2.10 In addition, a registered healthcare professional (i.e. a nurse or paramedic) can now, in the course of an investigation, take a blood specimen from a person who may be incapable of consenting for medical reasons. This provision is for use in hospital settings where, for example, a driver may have been taken following a road traffic collision if injured.

Drug driving offences in practice

- 2.11 There are a number of different scenarios that might lead to a suspect being charged with drug driving. The description provided here illustrates a typical situation but is not comprehensive and does not include all possibilities. For example, a separate procedure is used by police if a suspect is taken to hospital following a road traffic

¹² This option has been in place since the introduction of breathalysers, when there were concerns over the reliability of the technology. The North Review recommended the removal of the option, which uses significant resources and can allow some drivers with positive breath tests to avoid prosecution as blood tests can take some time to organise, during which levels of alcohol in the blood decrease.

¹³ Drink Driving: Removal of Statutory Option (North Reforms): Consultation Impact Assessment, IA No: DFT00187, 28/11/2012. DfT. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/25624/impact-assessment.pdf

collision. The scenario here is intended to provide an overview of a typical pathway, to aid understanding of the evaluation report. Note that both the Section 4 and Section 5A offences include being in charge of a motor vehicle, as well as driving. The description below assumes the suspect was driving.

- 2.12 Police may stop a driver they suspect of drug-driving, or who has committed a moving traffic offence, or they may be called to the scene of a collision. In the latter two cases, they may then suspect that the driver is under the influence of drugs.

Field impairment testing

- 2.13 For the existing Section 4 offence, impairment evidence must be collected, as evidence will be required that the driver was impaired, and that the impairment was due to drugs. While impairment evidence is not necessary to support a charge for the new Section 5A offence police officers are advised to conduct a field impairment test (FIT) where possible – for reasons to be explained later. The police officer will generally conduct a FIT at the roadside, a safer location nearby, or at the police station or custody suite. FITs are conducted by specially trained police officers. The results are recorded in a standardised format. Field impairment testing covers, among a fuller list of other factors, the following areas:

- Assessing the size of the suspect's pupils, and the condition of their eyes (this can help indicate whether drugs are present and what type of drug has been used).
- Romberg test – a test of whether the suspect can remain still, and judge whether a certain amount of time has passed.
- Walk and turn test – tests ability to follow multiple instructions, to stand still, and to perform the actual walk and turn as instructed.
- One-leg stand test – ability to balance on one leg.
- Finger and nose test – where the suspect is asked to close their eyes and touch the tip of their nose with the forefinger of one hand (this tests spatial awareness).

- 2.14 If the FIT is performed poorly, then this may be evidence of impairment. Following arrest (the FIT may be carried out before or after arrest), if there has been no saliva test undertaken then, to allow the investigating officer to request a blood sample, a healthcare professional must assess the suspect and determine that they have a condition that might be due to having taken a drug.

- 2.15 The suspect may be arrested for the Section 4 offence only, the Section 5A offence only, or for both. Typically, officers are advised to arrest for both offences where there is sufficient evidence.

Preliminary screening - Saliva testing

- 2.16 Saliva testing may be carried out at the roadside or at the station. It is not necessary for the new Section 5A offence that a saliva test be carried out. However, if a saliva test indicates a positive result for cannabis or cocaine (or both), then a blood sample can be requested without seeking an opinion from a healthcare professional. A healthcare professional will of course still take the blood sample.

- 2.17 When the new offence came into force two preliminary screening devices were available for use by police forces (at the end of 2016 this was still the case). A 'positive' result from a screening device allows the police to request a blood sample without seeking a doctor's opinion regarding whether the suspect has a condition that

might be due to having taken a drug. The two devices available, which both use saliva as the test medium, were:

- The Draeger Drug Test 5000, type approved with effect from 18 December 2012 for preliminary screening for cannabis at a police station¹⁴. From 13 March 2015 the Draeger Drug Test 5000 was type approved for cocaine as well as cannabis, and for use at a police station or elsewhere, for instance at the roadside¹⁵.



Figure 1: Draeger Drug Test 5000 saliva test device

- The Securetec DrugWipe 3S S303G device, type approved with effect from 20 February 2015 for preliminary screening for cannabis and cocaine carried out at a police station or elsewhere, for instance at the roadside¹⁶.

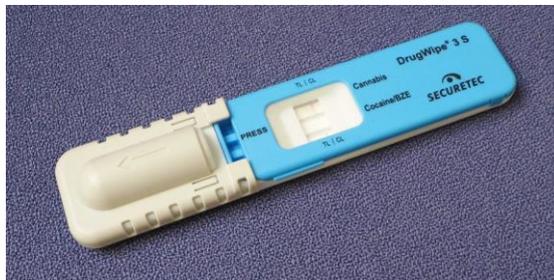


Figure 2: Securetec DrugWipe 3S saliva test device

Laboratory analysis of blood samples

- 2.18 Police forces have access to several forensic laboratories to undertake analysis of blood samples. The accreditation process for analysis of blood samples to test for the drugs prescribed in the legislation was complete for three laboratories when the new offence was introduced, with a further laboratory subsequently being accredited. Initially, one of the laboratories was accredited for analysis of all drugs specified in the

¹⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/391176/approval_-_final.pdf

¹⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430136/150313_Approval_Draeger_DrugTest_5000_Order.pdf

¹⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430132/150218_Approval_Securetec_DrugWipe_Order.pdf

regulations, while the other three were accredited for the analysis of tetrahydrocannabinol (THC), cocaine, and benzoylecgonine (BZE) only. Two of those laboratories achieved accreditation for all drugs specified in the regulations within the first year of the introduction of the new offence. By Autumn 2016, four laboratories were accredited for blood analyses for all of the drugs specified in the regulations, while a further three were accredited for THC, cocaine and BZE, with one of those three accredited also for amphetamine.

- 2.19 Suspects can refuse to allow a blood sample to be taken, but in such cases may be charged with failure to provide a sample. In some cases, there are genuine reasons that mean blood cannot be obtained, for example medical reasons such as poor veins. For the new Section 5A offence, blood is currently the only available evidential matrix – that is, only the concentration of a specified substance in **blood** can be used as evidence. For the Section 4 offence however, the concentration of a substance is not relevant – the suspect must be impaired, and that impairment must be due to a drug (or drugs). If a blood sample cannot be obtained, a urine sample can be requested, and this is an acceptable evidential matrix. Thus, if for any reason a blood sample cannot be obtained, it is useful for the officer to have conducted a field impairment test so that a Section 4 charge can be pursued.
- 2.20 Assuming that a blood sample is taken to support a possible Section 5A charge, then a syringe is used to take a blood sample which is then divided into two – an A sample and a B sample. The A sample is kept under refrigeration until it can be transported to a forensic laboratory, while the B sample is offered to the suspect, along with information on where the suspect can have the sample analysed if they wish to. The suspect is usually bailed to return to the police station at a later date.

Blood sample analyses

- 2.21 The blood sample must be analysed at a laboratory accredited by UKAS for the analysis of blood for the purposes of Section 5A of the Road Traffic Act. The raw analysis results are modified by applying ‘guard banding’. ‘Guard banding’ reflects the practice of deducting a certain amount from the analysis result to reflect analytical uncertainty. The amounts deducted for guard banding are reviewed periodically.

Charge

- 2.22 When blood analysis results are returned, if the concentration of any of the specified substances is above the relevant limit, the police may decide to charge the suspect with a Section 5A offence. If the blood analysis demonstrates that a drug was present, but below the relevant limit, then if impairment evidence is available, the police may decide to charge the suspect with a Section 4 offence.

3 EVALUATION APPROACH AND METHODOLOGY

- 3.1 In September 2013 DfT commissioned this study with the primary objective to scope, develop and deliver a suitable programme of evaluation to assess the implementation, operation and short-term impacts of the new drug-driving offence. The first phase in developing the evaluation framework was to scope what could be done practically, and we reported this in an earlier scoping report¹⁷.
- 3.2 An experimental approach was considered impractical for this evaluation, as there was no true contemporaneous counterfactual available. Our approach was to use a theory of change presented as a logic model to identify how the new offence was expected to bring about its intended outcomes and to collect information on measures identified along the logic chains both before and after introduction of the new offence. In the absence of a counterfactual, this was considered the most appropriate approach.
- 3.3 **Note** - the lack of a counterfactual and the short-term nature of the data collection and analysis means that a robust impact assessment is not yet possible.

The Programme Logic Model

- 3.4 A programme logic model (PLM) is a graphical representation of how all the resources, activities, inputs and outputs associated with an intervention can combine and interact to realise intended outcomes. It is one means of presenting a theory of change. Figure 3 presents the logic model for the new drug-driving law in diagrammatic form. In the logic model arrows are used to illustrate the links between inputs, activities, outputs and outcomes and impacts. The dotted line between 'Screening capacity available' and 'Section 5A offence used by police' is intended to show that while the availability of screening capacity is not essential to enable use of the new offence, it is expected to make the offence easier to use.
- 3.5 As an example of the links, at the lower end of the diagram, central government resources funded an awareness campaign. Once this had been delivered (an output), then the outcome was expected to be improved awareness of the offence, and increased perceived risk of arrest, resulting in reduced drug impaired driving. For this example, the baseline involved looking at awareness of the existing and new drug driving offences before the THINK! awareness campaign¹⁸, and before introduction of the new offence; looking at perceptions of how dangerous drug driving is; and how likely it is that someone who drug drives will be arrested. Subsequent work involved assessing changes in these measures following the awareness campaign.

¹⁷ July 2014, Evaluation of the new Section 5A drug driving regulations – scoping report Issue 2_2, Risk Solutions D3141/R02. (Unpublished)

¹⁸ THINK! Drug Drive campaign evaluation, 29 April 2015.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454199/think-drug-drive-evaluation-2015.pdf

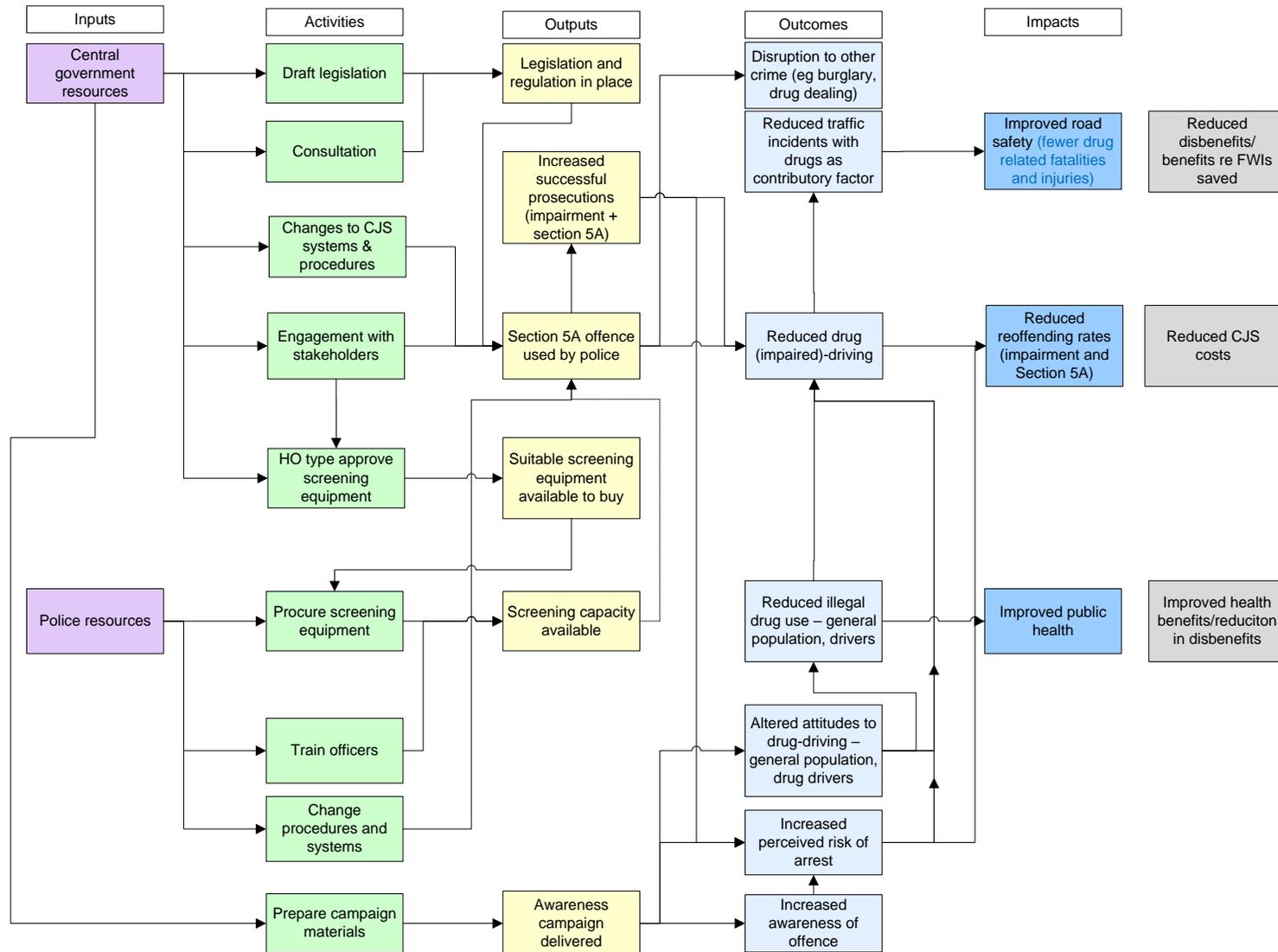


Figure 3: Programme logic model

Logic model and the structure of this report

- 3.6 We have structured this report around the logic model. Thus, Section 4 relates to Inputs and Activities – the first two columns - while Section 5 reports on areas related to outputs – the third column above – and Section 6 addresses Outcomes and Impacts – the final three columns above.

Summary of research questions

- 3.7 In the specification for this study, the DfT posed a number of evaluation questions that the research should address. The scoping phase sought to establish which of the questions could be answered and how, with a particular focus on where the information required to answer the questions could be obtained. The results of this work was published in the scoping report²⁰ and the evaluation questions are included at Appendix B of this report. Appendix B also indicates the sources, and associated quality, of relevant information. The questions are summarised below under the key evaluation research themes.

a) Operation and enforcement

- How many people have been saliva tested by police, and with what result?
- How many people have been arrested, investigated for the new Section 5A offence, and had a blood sample taken, and what were the results of the blood tests?
- For individuals, what are the time intervals between saliva tests and blood samples?
- Where blood samples are requested, how many people fail to provide a blood sample and why? How many people are charged with failing to provide a blood sample?
- Does extent of use of the new offence vary between police forces?
- How well do key stakeholder groups think that the new offence is working in practice?
- Is there any evidence of negative impacts on groups such as those taking medication for chronic illness?

b) Drug taking and road traffic collisions

- What is the effect of the new offence on the prevalence of:
 - Driving under the influence of drugs?
 - Collisions due to drug driving?
 - Numbers of people killed or seriously injured due to drug driving?

c) Offending behaviour and recidivism

- How many court proceedings have been brought for the new Section 5A offence? How many were found guilty?
- What impact has the new Section 5A offence had on the numbers of proceedings for the existing Section 4 impairment offence?

- How many of those convicted under the new offence have previous convictions for drug driving, and how does this compare with those found guilty of the existing offence? Is there a link with other types of offending behaviour?

d) Attitudes to the offence

- Are drivers aware of the new Section 5A offence?
- What are the public attitudes towards drug driving? What is the effect, if any, of the new offence on these attitudes?

Data sources and collation methods

3.8 The information presented here has been collated from different sources. We have used a mixture of primary data collection, including survey data and qualitative interviews, analysis of existing secondary data and review of published information.

3.9 Specific detail on which data sources have been drawn on is provided in individual sections. Appendix A provides more details on each of these data sources, however the key data sources are outlined briefly here.

Review of published information

3.10 Relevant published information was reviewed to understand the wider context, for example the introduction of legislation to remove the statutory option¹⁹. A list of documents reviewed is included in Appendix A.

Primary qualitative data

3.11 We interviewed a range of stakeholders from November 2013 to March 2014 during the scoping phase, and interviewed a wider range of stakeholders during February 2015, prior to the introduction of the new offence to explore their understanding of the new offence, any planning they had been involved in, and what they considered to be the most significant risks to successful introduction and operation of the new offence. In the scoping phase we conducted 12 interviews, with representatives of:

- Crown Prosecution Service
- Department of Health
- Department for Transport
- Driver and Vehicle Licensing Agency
- A forensic laboratory
- Home Office policy
- Home Office – Centre for Applied Science and Technology
- Ministry of Justice
- Four police forces.

¹⁹ The 'statutory option' in relation to drink driving was removed from legislation on 10 April 2015. It allowed people being investigated for drink driving to opt for a blood or urine sample to be used evidentially instead of a breath specimen, where the lower of two breath alcohol readings was below 50 µg per 100ml (the prescribed limit is 35 µg per 100ml).

- 3.12 In February 2015 we conducted 19 interviews, with the 12 stakeholder groups listed above, and 5 additional stakeholders, including representatives of patient groups and medical professionals, coroners, and two additional forensic laboratories.
- 3.13 We conducted 16 interviews with a similar group of stakeholders when the offence had been in place for about twelve months, to ask about their experiences regarding implementation of the new offence over that time, and whether any of the risks had been realised. In addition, we conducted interviews with representatives of an additional five police forces.

Primary data on police activity

- 3.14 Several police forces collected data relating to incidents where preliminary drug screening equipment was used. Most used a bespoke form while others provided data from their own monitoring systems; no names or dates of birth were included. The form used is included at Appendix D. Police officers completed as much of the form as possible, and follow up information on laboratory analysis results was sought from laboratories and in some cases from police forces. Information on subsequent charges brought, and court outcomes, was sought from police forces. Data were entered into an Access database.
- 3.15 In total 22 police forces provided us with data. A small number of these forces collected some data before introduction of the new offence, but too few records were obtained to use for any sort of baseline. Considering data collected after the introduction of the new offence, six forces provided data covering incidents occurring over periods of two to four months, seven provided data covering incidents occurring over periods of six to nine months, while the remaining nine forces provided us with data covering periods ranging from 13 to 18 months.
- 3.16 All forces who received grants from the DfT to support introduction of the new offence were asked to provide data for this study. These grants were administered in more than one wave (which is one reason for the different periods over which data was provided), and not all police forces found it possible to provide us with data. Two police forces collected data for 17 months although they had not been in receipt of any grant at the start of the process.
- 3.17 As the sample of police forces who collected data for us was in effect self-selecting, and within those forces we do not know (except in one case) what proportion of relevant incidents we have records for, we cannot use the absolute numbers of records to draw conclusions. However, the proportion of saliva tests giving positive results for cannabis, cocaine or both in our primary data sample is supported by some secondary data relating to saliva tests carried out nationally for seasonal drug driving campaigns.

Secondary data on criminal justice: Ministry of Justice data

- 3.18 The Ministry of Justice (MoJ) has access to data extracts from Libra, CREST and PNC. These include numbers of proceedings brought, numbers of convictions, and details of penalties such as fines and custodial sentences. Libra has details for offences that proceed to Magistrates' Courts. CREST includes details for cases that go to the Crown Court. Extracts from PNC (the Police National Computer) allow MoJ to access details of offences disposed of by police caution only, and to look at previous offences.

- 3.19 MoJ have worked with the project team to understand the evaluation questions, and have run queries on their Court Proceedings Database to provide information for this report. The information they have provided includes information on both drug and drink driving and is relevant to proceedings brought, convictions, and previous offences for those found guilty of drug driving. This includes information on the pre-existing Section 4 (impairment) offences and also the new Section 5A offences.
- 3.20 Information provided relates to defendants for whom these offences were the principal offences for which they were dealt with. When a defendant has been found guilty of two or more offences the principal offence is the offence for which the heaviest penalty is imposed. Where the same disposal is imposed for two or more offences, the offence selected is the offence for which the statutory maximum penalty is the most severe. Every effort is made to ensure that the figures presented are accurate and complete. However, it is important to note that this data has been extracted from large administrative data systems generated by the courts and police forces. As a consequence, care should be taken to ensure data collection processes and their inevitable limitations are taken into account when those data are used.

Secondary data on drug driving prevalence and frequency: crime survey for England and Wales (CSEW)

- 3.21 The crime survey for England and Wales (CSEW) replaced the British Crime Survey, and so is a long-running household survey of adults aged 16 and over, resident in England and Wales. It collects data on experiences of victimisation and perceptions of anti-social behaviour through face-to-face interviews. It includes self-completion modules on drinking behaviour and drug use; the respondent completes these on a laptop computer. Since 2009, the self-completion modules have included questions asking people whether they have driven while they believed they were over the legal alcohol limit or under the influence of illegal drugs²⁰. Self-completion is used to reduce the potential for under-reporting, which would be more likely if people were asked to admit to unlawful behaviour by the interviewer. The CSEW data provides information on the prevalence and frequency of drug driving in England and Wales.
- 3.22 The CSEW is a large survey; the 2014-15 cycle, for example, aimed to interview 35,000 people²¹. The sample is based on a bespoke set of strata designed to give a nationally representative picture, and ensuring a minimum number of interviews within each police force area. Within each stratum, households are selected at random. At each household, one adult is randomly selected using an algorithm built into the interviewer's electronic contact script. The CSEW is therefore generally considered to be a reliable source of robust data.

Secondary data on awareness: THINK! data

- 3.23 THINK! is a road safety campaign run by the Department for Transport. It provides road safety information for road users, and aims to encourage safer behaviour from all road users to reduce the numbers of fatalities and injuries on the roads. The

²⁰ Reported Road Casualties in Great Britain: 2012 Annual Report, Self-reported drink and drug driving: Findings from the Crime Survey for England and Wales. DfT.

²¹ Crime Survey for England and Wales – Technical Report 2014/15, Volume One. TNS BRMB. Available at file:///Users/michelleboath/Downloads/201415crimesurveyforenglandandwalestechnicalreportvolume1_tcm77-428836.pdf

THINK! campaign is subject to ongoing evaluation; since 2006 this has been carried out by TNS BRMB, who have conducted eight surveys since November 2006²².

- 3.24 The survey is smaller than the CSEW; the July 2013 survey²³ interviewed 1,853 people, while the July 2015 survey included 1,090 interviews²². Interviews are conducted face-to-face. The sample is chosen using a random location methodology, combined with quotas. The approach is therefore less reliable than a strict probability sampling approach, but TNS believe it eliminates the most unsatisfactory features of quota sampling by giving interviewers very little choice in where to seek interviewees.

Primary data on awareness and attitudes from ONS Omnibus module

- 3.25 DfT commissioned a module in the Office of National Statistics (ONS) National Statistics Opinions and Lifestyle Survey to explore attitudes, awareness and perceptions regarding drug driving. The ONS survey uses a random probability sample stratified by region, the proportion of households with no car, socio-economic classification and the proportion of people over 65 years of age. Interviews are carried out face-to-face, and within each household, one person over the age of 16 is randomly selected for interview. Sample sizes are 2,010 addresses each month²⁴. As the only random-probability based omnibus service available, DfT considered this as providing the most robust data possible on awareness and attitudes.
- 3.26 The first wave commissioned for this research was carried out in January 2015, before the THINK! campaign on drug driving began; however, there had been some reports in the press about the new offence. Wave 2 was carried out in April 2015, after the THINK! campaign, and after the new offence came into force, and Wave 3 was carried out a year later in April 2016.

Secondary data on road traffic collisions: (STATS19 data)

- 3.27 STATS19 provides detailed information about the circumstances of personal injury road traffic collisions (RTC)²⁵, including date, time, location, the types of vehicles involved, numbers of people injured and the severity of any injuries. This information relates only to personal injury collisions on public roads that are reported to the police. Where a police officer has attended the scene of a personal injury RTC then the STATS19 record should include their observations of the factors that may have contributed to the collision occurring, including drivers being impaired by alcohol or drugs. The factors selected are based on the individual police officer's judgment; DfT acknowledges that factors that officers might find difficult to evidence, such as potential impairment by drugs, are likely to be under-reported. However, STATS19 remains a key source of information on road safety metrics.

²² THINK! Road Safety Biennial Survey 2006 – 2015, TNS BRMB, May 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525931/road-safety-biennial-survey.pdf

²³ THINK! Road Safety Survey 2013 TNS BRMB, August 2013..

²⁴ ONS Omnibus Service Methodology, Office for National Statistics.

²⁵ DfT, STATS20, Instructions for the Completion of Road Accident Reports from non-CRASH Sources. September 2011.

Secondary data on toxicology for road traffic fatalities: Coroners' data

- 3.28 This data is compiled by TRL for DfT²⁶. It provides detailed information about the levels of alcohol and drugs present in body fluid samples taken from victims of fatal road collisions aged 16 or over, as recorded by Coroners in England and Wales and Procurators Fiscal in Scotland. We have been provided with data for part of 2010, and all of 2011 to 2014²⁷.

Secondary data on motoring offences: DVLA data

- 3.29 The Driver and Vehicle Licensing Agency (DVLA) did not provide data directly but we were able to use data released under a Freedom of Information request²⁸, which allowed triangulation with some of the MoJ data.

²⁶ DRAFT PROJECT REPORT RPN2666, Alcohol and drugs in road fatalities, 2013 report based on 2011 data, TRL.

²⁷ Data for 2014 unpublished at the time of writing.

²⁸ DVLA FOI 5520 September 2016.

4 INPUTS AND ACTIVITIES

- 4.1 This section outlines the activities undertaken by a range of interested parties to allow the new offence to be put in place and implemented. It reports on what they felt went well, what might have been improved, highlights concerns about potential risks to the success of the new legislation and comments on whether those risks were realised within the first year. The findings presented here are drawn largely from semi-structured interviews with stakeholders completed in the scoping phase, in February 2015 and February and March 2016 (12, 20 and 21 interviews respectively). The interview sample was purposive, that is, selected with a purpose rather than randomly. DfT suggested a range of interviewees who had been involved in the design and planning of the new law (e.g. policy staff), who had a role to play in operation and enforcement (e.g. police, forensic laboratories) or represented groups that might be affected (e.g. medical stakeholders). Interviews varied in length from 30 to 90 minutes.
- 4.2 The observations reported here are based on analysis of information collected through interviews with a wide range of stakeholders, including representatives of the organisations noted in the following groups:
- **Police and CPS**
 - Police forces
 - ACPO, and its replacement, NPCC
 - Crown Prosecution Service (CPS)
 - **Coroners**
 - The Coroners' Society
 - **Laboratories and CAST**
 - Home Office (Centre for Applied Science and Technology (CAST))
 - LGC forensic services
 - ROAR Forensics
 - Radox Laboratories
 - **Policy stakeholders**
 - DfT
 - Home Office
 - Ministry of Justice (MoJ)
 - Department of Health (DH)
 - Driver and Vehicle Licencing Agency (DVLA)
 - **Medical stakeholders**
 - DVLA
 - The Sickle Cell Society
 - Royal Pharmaceutical Society
 - British Pain Society
 - A manufacturer of opiate medicines.

Table 2: Numbers of interviews conducted with stakeholder groups

Stakeholder Group	Scoping phase interviews	Interviews in February 2015	Interviews in February and March 2016
Police and CPS	5	6	10
Coroners		1	
Laboratories and CAST	2	4	3
Policy stakeholders	5	5	5
Medical stakeholders		5	3

- 4.3 Details of the observations for each stakeholder group are included at Appendix C.
- 4.4 Some information has also been drawn from published sources (gov.uk and the UKAS website), for example to confirm dates and accreditations. Any delays to completion of necessary activities can affect the extent to which desirable outputs are achieved, and the timescales over which changes in these outputs can be realised. These, in turn, may affect the extent, and over what timescales, the desired outcomes and impacts will be achieved.
- 4.5 As Figure 3 indicates, a number of activities were necessary to enable the new offence to be implemented. Activities to draft the legislation were complete in time for the new offence to be brought into force on 2 March 2015, including completion of consultations on the levels to be set for the specified substances. Consideration of the responses to the initial consultation of 9 July to 17 September 2013 led the government to conclude that there was sufficient support to allow limits to be set for 16 substances, but there was significant concern from the medical community regarding the limit originally proposed for amphetamine²⁹. As a result, further consultation on amphetamine was conducted subsequently, and as noted in Section 1, amphetamine was added to the list of substances specified in the regulations on 14 April 2015.
- 4.6 As the new offence relates to illicit and prescription drugs, the DfT was not the only Department with an interest in its introduction. The Home Office, Ministry of Justice and Department of Health were particularly interested. Other interested parties include police forces, the CPS, the medical community (including general practitioners (GPs), forensic medical examiners, forensic nurses, pharmacists and specialist pain doctors) and third sector organisations.
- 4.7 All of the stakeholders took some actions in relation to preparing for the introduction of the new legislation. For some, this meant ensuring they briefed their members on the new offence, and had sufficient understanding of the new offence to provide information when queries were received, while for others e.g. police forces, new processes were required, and training of staff was necessary. Police also had to ensure that they could comply with the requirements for collection and storage of blood samples to be analysed for the new offence, e.g. ensuring that samples could be kept chilled. Forensic laboratories had to apply for accreditation to allow them to

²⁹ Concerns related to the increasing use of dexamphetamine and lisdexamphetamine in the treatment of attention deficit hyperactivity disorder (ADHD) in adults, and so whether it was appropriate to use a 'zero tolerance' approach to setting a limit or a road safety risk approach.

conduct evidential analyses of blood samples. CAST were pursuing type approval tests for drug screening devices – not essential to the introduction of the new offence, but a facilitating measure and seen as an important factor in creating a deterrent effect.

- 4.8 Some stakeholders thought that timescales were generous for the tasks they had to complete, and other organisations were generally happy with the level of interaction they had with DfT, and the manner in which interfaces were managed.
- 4.9 Some organisations would have liked more time. This applied particularly to **forensic laboratories** and the time available to develop and accredit their blood sample analytical processes. When the offence was introduced, not all laboratories were accredited to analyse blood samples for all substances specified in the Section 5A regulations. However, many stakeholders were pleased with what had been achieved in the time available, including the availability of type approved screening devices and accredited analytical techniques for the drugs they considered most important. Overall, while stakeholders thought that, ideally, it would have been good to have full analytical capability in place, they thought it was both pragmatic and beneficial to commence the offence as soon as practicable and enforceable, and to continue to develop the science capability (and case law) alongside its introduction.
- 4.10 Several interested parties needed to train staff about the new offence. In addition to police forces, this applied in particular to the CPS, court staff, and forensic laboratory staff. Other organisations, while not requiring formal training, needed to brief staff or members; this applied to medical practitioners and pharmacists, for example. Several stakeholders noted that not all relevant staff training was completed in time for the introduction of the new offence, and that additional time would have been welcomed. For example, those police forces who planned to use the DrugWipe device were not able to complete initial training until the offence had been in place for four to six weeks.
- 4.11 However, while stakeholders thought that additional time would have been useful, they also felt that a great deal had been achieved in the time available, and that overall, enough had been done to support the introduction on 2 March 2015.
- 4.12 Medical stakeholders expressed some concern about what advice practitioners should give to patients, given the need to balance patient interests and the public interest, although additional guidance had been issued by the General Medical Council (GMC) stressing that road safety was a public interest issue. They were also concerned that they might have large numbers of queries to deal with, from healthcare professionals, but this concern was not realised.
- 4.13 Many different stakeholders were concerned about the handling of 'B' blood samples. These will be given to suspects who have blood taken, so that they can have their own analyses run. Police forces, following Association of Chief Police Officers (ACPO) briefing advice, planned to give suspects a leaflet telling them that the sample must be refrigerated, and giving them details of where they can have their sample analysed. Many drugs will break down rapidly if blood samples are not refrigerated, particularly cannabis, and there is concern that defendants' samples may not be stored correctly, and analyses would produce completely different results from the 'A' samples. One stakeholder noted that blood test kits that could record whether a sample had been held under the correct conditions would be useful – although it is not clear whether this would be practicable. As with any new offence, many interviewees were interested to see how defence lawyers would approach it, and what case law might develop. Based on our primary data and interviews with police

and laboratory staff a year after the introduction of the new offence, few of those arrested took up the opportunity to have their B blood samples tested, but police remained concerned that this might change and had not yet been tested in court.

4.14 Many of the concerns that stakeholders had expressed had not been realised in practice:

- They had seen no evidence that individuals taking medication included in the regulations had been adversely affected.
- Some stakeholder groups had been concerned that they would receive many queries about the new offence from their members, but this had not been the case. They thought that this was because DfT had provided information to allow them to develop guidance ahead of the introduction of the new offence.
- Several stakeholders had been concerned that defendants might fail to store 'B' blood sample correctly, and then obtain their own analysis, which might appear to show lower concentrations of drugs. This had not proved to be a problem but some concerns remained.
- Some stakeholders were concerned that use of the new offence by police forces might be low, because of the costs of preliminary screening devices and blood analyses.
- Some stakeholders were concerned that the opposite might be true – that the new offence might be very popular, placing high demands on forensic laboratories, who might not have sufficient capacity to meet that demand. In practice, while some delays were reported, capacity increased steadily to meet demand (in part, due to the removal of the statutory option for drink driving, and a consequent reduction in demand for blood alcohol testing).

4.15 Notwithstanding these unrealised fears, there remains outstanding concerns relating to the following areas:

- **Costs**
Police forces expressed concerns about costs relating to saliva testing devices, and in particular, the costs associated with analysis of blood samples.
- **Risks that officers may stop collecting impairment evidence**
Police forces, and some government departments, expressed concerns that the availability of preliminary drug screening devices might lead officers to rely on this technology, and to stop collecting impairment evidence if the preliminary drug screen proves positive. This is important because if impairment evidence is not collected, and then no blood sample can be obtained, a Section 4 charge cannot be made.
- **Storage and use of 'B' samples**
Police and the CPS have no means of knowing how a 'B' sample has been stored, which might adversely affect any subsequent analysis (from the prosecution perspective).
- **The number of cases where, for medical reasons, blood could not be collected**
While blood remains the only acceptable evidential matrix, a blood sample is necessary to support a Section 5A charge. Our primary data collection suggests that the most common cause for lack of a blood sample is medical, often relating to poor veins. Several forces also noted that the equipment was not ideal; health

care professionals had expressed a desire for finer needles, and alternative collection equipment, specifically vacuum blood collection systems.

- **Potential for new defence strategies to emerge.**

Cases where suspects plead not guilty take longer to reach court. For those forces we spoke to, there had been few not guilty pleas, and because most of these had changed to guilty pleas on the day, there was little experience of trials where the defendant pleaded not guilty, and so there remained scope for new defence strategies to emerge.

Awareness Campaign

4.16 The DfT's THINK!³⁰ campaign aims to reduce the number of deaths and injuries on the road, by providing information and advice to influence road user behaviour. To support the drug drive law change, THINK! developed an anti-drug drive campaign that ran from 16 February to 29 March 2015. The campaign had three main objectives:

- To raise awareness of the new drug driving legislation and build knowledge and understanding of what it means for drivers
- Increase awareness and salience of the consequences of a drug drive conviction
- Increase the belief that you are likely to be caught and convicted if you drug drive.

4.17 The campaign targeted an 'all adults' audience with PR and local press adverts to raise awareness of the new legislation and the consequences of being caught. In addition, the campaign targeted those considered most likely to drug drive (young men aged 17 to 34) to challenge and deter such behaviour, using adverts created for YouTube, radio and out of home locations. A summary of media channels, budget allocation and timings is presented in Table 3.

Table 3: Elements of THINK! drug driving campaign

Element	Spend (input)	Start date	End date
Radio	£223,107	16/02/2015	29/03/2015
Digital – display and partnerships	£277,592	16/02/2015	29/03/2015
Digital – biddable (YouTube)	£371,431	02/03/2015	29/03/2015
Video on demand	£29,759	05/03/2015	29/03/2015
Out of home advertising – washroom panels	£132,800	16/02/2015	29/03/2015
Regional press	£33,210	16/02/2015	02/03/2015

Source: TNS BMRB³¹

4.18 As well as the formal evaluation of the THINK! campaign, DfT commissioned a module in the ONS National Statistics Opinions and Lifestyle Survey to determine

³⁰ think.direct.gov.uk

³¹ THINK! Drug Drive campaign evaluation, 29 April 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454199/think-drug-drive-evaluation-2015.pdf

baseline measures for attitudes, awareness and perceptions regarding drug driving, as described in paragraph 3.25. Findings related to awareness of drug driving legislation, attitudes to drug driving and perceptions regarding drug driving are included in Section 6 (paragraph 6.8 onwards).

5 OUTPUTS

- 5.1 This section looks at measures for outputs, beginning with information on the use of saliva testing, its results, and the laboratory results of subsequent blood samples. We also report on subsequent charges for those arrested from our primary data collection, and information on the proportion found guilty.
- 5.2 We report the results from an analysis of data on drug driving prosecutions for all police forces in England and Wales up to the end of 2015, and analysis of previous offences for those found guilty of drug driving offences up to the end of 2015. This includes data for Section 4 offences for all years addressed, and for the new Section 5A offence, from its introduction to the end of 2015. In addition, some information for 2016 is included, based on information provided by DVLA to a third party, following a freedom of information request. Information on the numbers of prosecutions and convictions is of interest because the theory of change (as set out in the programme logic model in Figure 3) suggests that increased use of the new offence will result in an increase in convictions for drug driving offences. We are also interested in whether the introduction of the new offences appears to have had any effect on the use of the pre-existing Section 4 offences.
- 5.3 Finally, we consider the THINK! awareness campaign, as the theory of change suggests increased awareness of the new offence, and increased perceived risk of arrest, may help to achieve the desired outcomes and impacts.
- 5.4 This section draws on published information relating to the introduction of the new offence, for example information from www.gov.uk on the substances included in the offence. Information on numbers of prosecutions and convictions, and on previous offences for those convicted of drug driving offences, is drawn from information provided by the Ministry of Justice, from the extracts they hold from PNC, Libra and CREST.
- 5.5 Information on the type approval of preliminary drug screening devices is drawn from www.gov.uk, information on the availability of laboratory capacity for analysis of blood samples from UKAS³², and from interviews with representatives of three of the laboratories used. Information on the THINK! awareness campaign is from THINK! evaluation materials.

Saliva tests and blood analyses

- 5.6 Data on saliva tests presented here is from primary data collected by the 24 police forces who contributed to this research, as described in paragraph 3.14 onwards. The data is based on the results from 4,292 preliminary drug screening tests. For the data provided, 93% of preliminary drug screening (saliva) tests were carried out at the roadside, after a driver had been stopped, with only 7% of the tests being undertaken at a station. The data shows that 54% of preliminary screening tests for drugs were positive for either cannabis, cocaine, or both. Only a handful of tests were 'not valid', and anecdotal evidence (from interviews with police forces) suggests that these may have been a result of user error. This suggests that police officers find the preliminary drug screening equipment straightforward to use.

³² The United Kingdom Accreditation Service, which is responsible for accrediting the laboratory analysis procedures <https://www.ukas.com/>

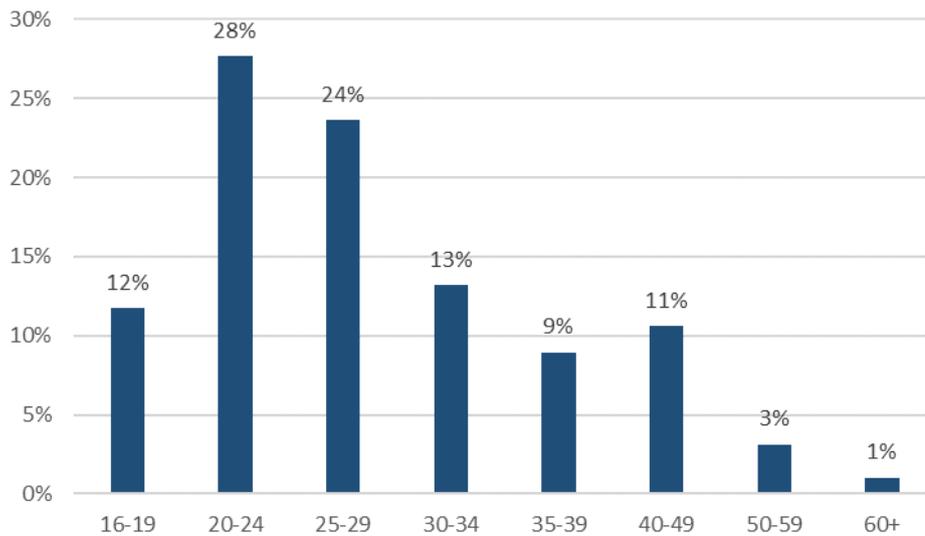


Figure 4: Age distribution for suspects saliva tested

Source: Risk Solutions – Primary data recorded by police forces
 Base: 3,660, 22 police forces

5.7 As Figure 4 shows, the age distribution of those saliva tested is skewed to younger age groups, with more than half of those stopped aged below 30 years. As Figure 5 shows, the percentage of saliva tests giving positive results varies by age group, with the peak percentage for those aged 20 to 24. Those stopped are also predominantly male, with approximately 94% of those stopped and saliva tested being men. For men, 61% of tests were positive (base 3,200) while for women, 51% of tests were positive (base 200).

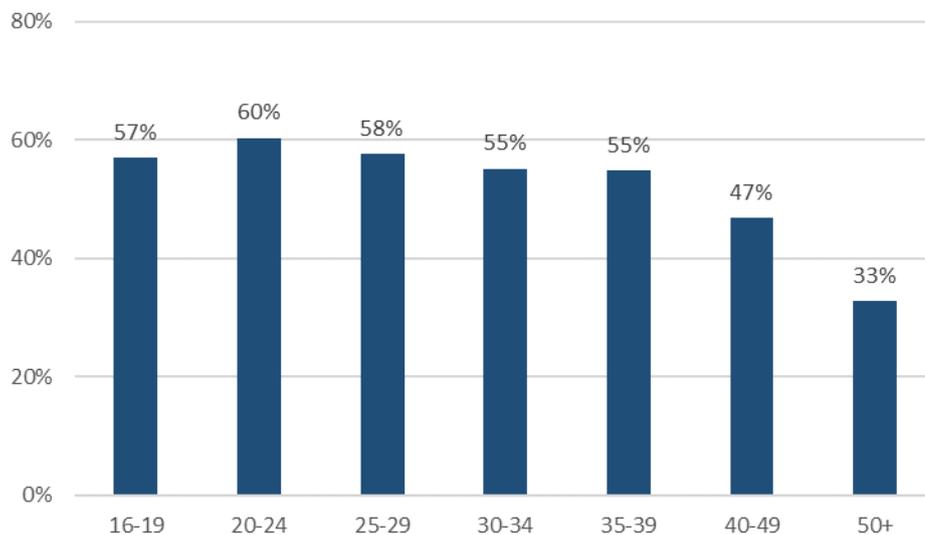


Figure 5: Percentage of saliva tests giving positive results, by age group

Source: Risk Solutions – Primary data recorded by police forces
 Base: 16-19, 428; 20-24, 1001; 25-29, 852; 30-34, 479; 35-39, 323; 40-49, 383; 50+, 153. Data from 21 police forces.

5.8 We have also looked at ethnicity, for those records where police recorded ethnicity. The key question is whether there is any evidence of ethnicity bias associated with who is stopped and saliva tested. To address this we looked at the percentage of tests for different ethnic groups that were positive. If we saw a significantly lower percentage of positive tests for a particular ethnicity, that might be evidence of

adverse bias. Figure 6 shows no evidence of any significant differences in the numbers of tests proving positive. There is, for example, more difference between age groups and between men and women. (Note that the base sample is particularly low for the 'mixed' ethnicity figure.)

5.9 We therefore conclude that there is no evidence of ethnicity bias amongst those being stopped and saliva tested.

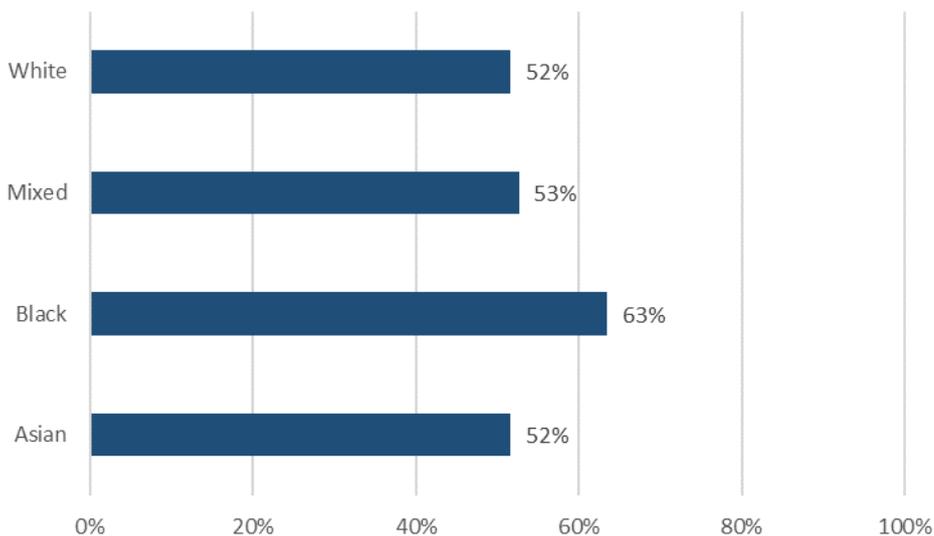


Figure 6: Percentage of saliva tests that were positive, by ethnicity

Source: Risk Solutions – Primary data recorded by police forces
 Base: White: 1,516, Mixed: 38, Black: 126, Asian: 277. Data from 21 police forces

5.10 Just under 97% of the positive saliva tests in our database were administered after 1 March 2015. Of these positive tests, 75% were positive for cannabis only, 14% for cocaine only, while 11% indicated the presence of both cannabis and cocaine. This is illustrated in Figure 7.

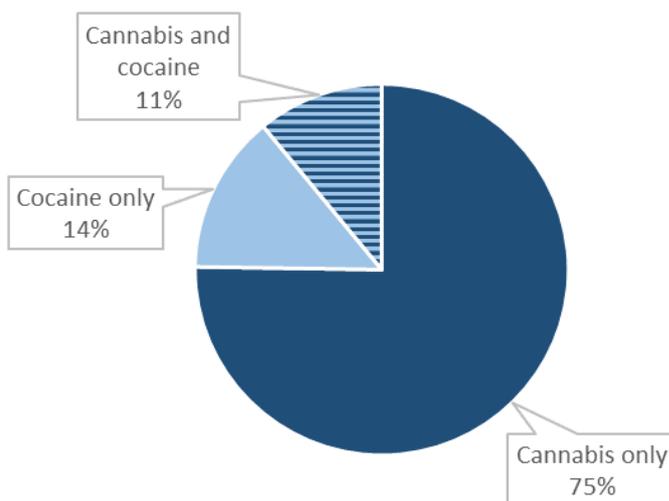


Figure 7: Mixture of cannabis and cocaine positive tests among positive saliva tests

Source: Risk Solutions, Base: 2,061, 23 police forces. Note: this is for tests after the introduction of the new offence, to ensure that only tests able to detect both cannabis and cocaine were included.

Field impairment testing

- 5.11 Note that as preliminary screening tests only for cannabis and cocaine, police officers have been encouraged to continue to collect impairment evidence. DfT provided some funding to police forces, to support introduction of the new offence, which could be used towards the costs of preliminary screening equipment, laboratory analyses, and drug recognition, awareness and field impairment testing training.
- 5.12 Our primary data collection form included an indication of whether field impairment testing had been performed, and the results of any such testing. Some forces used their own reporting forms, which did not include this, so the base for this information is lower. We found that following the introduction of the new offence, when people were stopped and subsequently saliva tested, only 7% of records submitted to us (Base: 2,071, 20 police forces) indicated that field impairment testing had been carried out. This might be in part due to officers not completing the form, but it may also indicate that impairment evidence is not being collected in many cases. Paragraph 5.14 provides further evidence that this may be the case.

Blood samples and laboratory analyses

- 5.13 A positive saliva test, or evidence of impairment supported by the judgment of a medical professional allows a health care professional to request a sample of blood for analysis. For the positive saliva samples in our records, after introduction of the new offence, 88% of cases had a blood sample taken for analysis (base 2,080, 22 police forces). This leaves approximately 1 in 8 arrests where no blood sample was taken. Figure 8 shows the reasons for this. In over half of the cases where no blood was taken, the reason given was on medical grounds, usually poor veins. Several officers we interviewed noted that healthcare professionals had noted that finer needles would increase the likelihood that blood could be obtained in such cases, and expressed a preference for the use of vacuum tube blood extraction systems³³. However, we note that under current legislation, the use of vacuum blood extraction is not permissible.
- 5.14 Just under a third of the 'no blood sample' cases were a result of suspects refusing to provide a sample. Only 5% of cases resulted from needle phobia. The 10% of cases marked as 'other' were either not known, a result of religious belief or due to lack of availability of a healthcare professional. Looking at the cases where medical reasons or needle phobia was given as the reason for no blood sample, in very few cases – about 5% - had the officer collected impairment evidence.

³³ This system for taking blood samples uses a double-ended needle with the external point contained in a barrel for safety. Once the needle has been inserted into a vein, a sealed evacuated sterile tube is then pushed onto the needle, within the barrel, to collect blood.

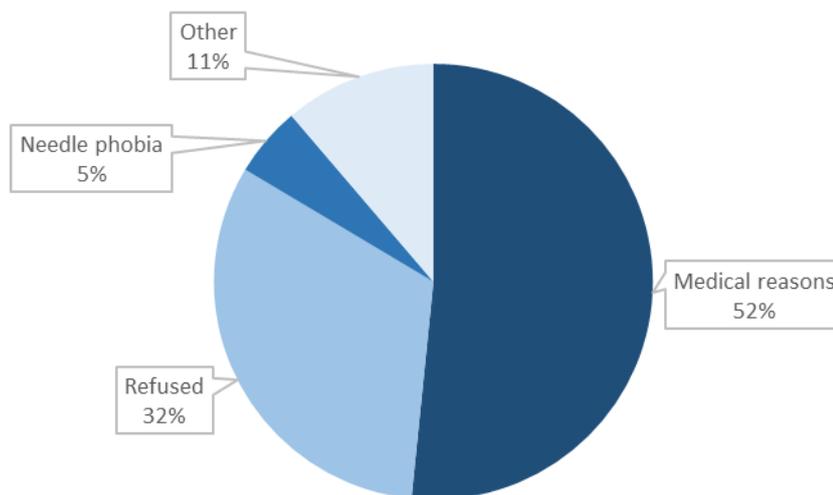


Figure 8: Reasons for lack of blood sample following positive saliva tests

Source: Risk Solutions.

Base: 248, 17 police forces

Blood analysis results

- 5.15 For blood samples taken where the preliminary saliva test was positive for cannabis (or tetrahydrocannabinol (THC), the active component), 30%³⁴ of blood tests were at or below the limit for THC specified in the regulations – which is 2 µg/litre. Interviews suggest that some officers have been demotivated by such results, and believe that this percentage – which they perceive as high – is a result of guard banding. Guard banding reflects the practice of deducting a certain amount from the analysis result to reflect analytical uncertainty. The amounts deducted for guard banding is reviewed periodically. We have not been able to identify any evidence to quantify the impact of any police demotivation, but the concern is that over time police enthusiasm for enforcing drug driving could wane if they perceive there is a relatively low chance of successful prosecution.
- 5.16 Figure 9 shows the results from the forensic laboratory analyses of blood samples reported to us, banded into different levels of THC found in the blood samples. Note that these values are all following deduction of guard bands.

³⁴ The values of 17% and 14% shown on the figure have been rounded; the unrounded values sum to 30%.

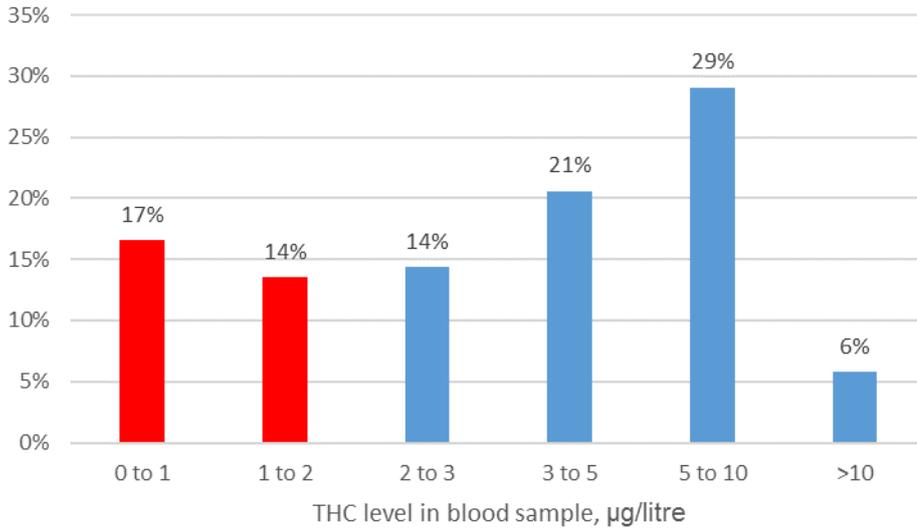


Figure 9: Blood analysis results for THC where saliva tests were positive for THC

Source: Risk Solutions
 Base: 1,121, 17 police forces

5.17 The percentage of analyses for cocaine and benzoylecgonine (BZE) that prove to be at or below the limit (10 µg/litre for cocaine, and 50 µg/litre for BZE) cannot be viewed in isolation. This is because BZE is the main metabolite of cocaine. Cocaine itself has a relatively short half-life, while BZE persists for a longer period of time. When considering analyses for saliva tests that were positive for cocaine, it is necessary therefore to look at both cocaine and BZE. So, while Figure 10 indicates that 60% of those testing positive for cocaine when saliva tested return blood results under the limit for cocaine, Figure 11 shows that more blood tests return results above the BZE limit.

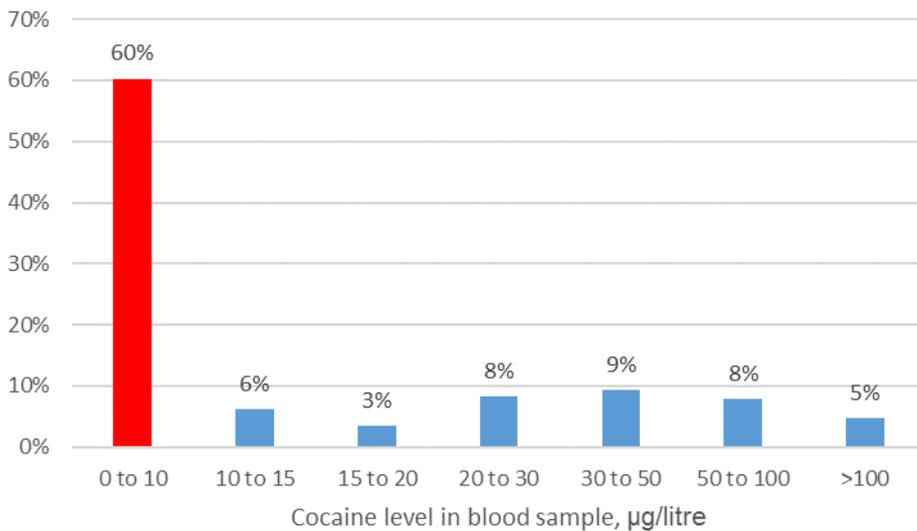


Figure 10: Blood analysis results for cocaine where saliva tests were positive for cocaine

Source: Risk Solutions
 Base: 292, 17 police forces

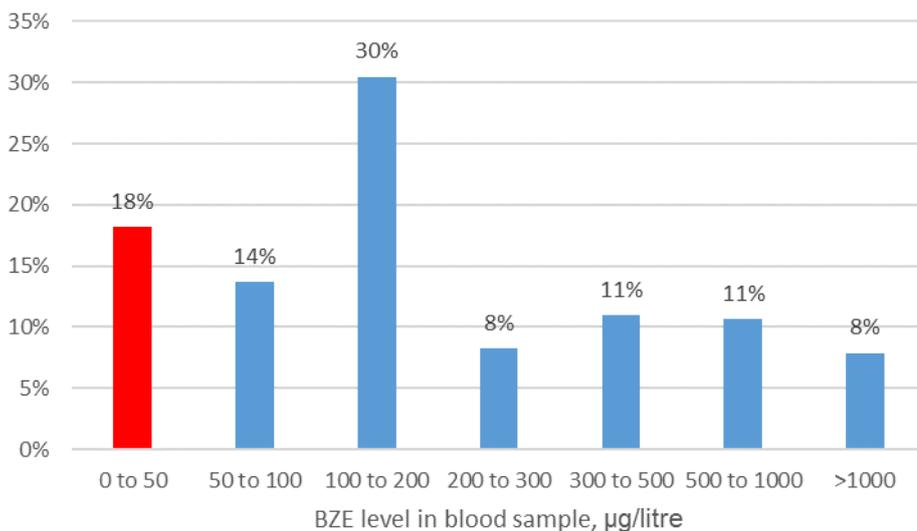


Figure 11: Blood analysis results for BZE where saliva tests were positive for cocaine

Source: Risk Solutions
 Base: 292, 17 police forces

- 5.18 Looking at the results overall, we can say that for preliminary drug screening tests conducted after the introduction of the new offence that were positive for cocaine, and for which we have blood analysis results (base 292), about 83% of the results are either above the specified limit for cocaine or above the specified limit for BZE.
- 5.19 Our records include 1,265 where a positive saliva test was recorded, a blood sample was taken, a Section 5A analysis conducted, and the results of that analysis were available. These are for blood samples taken after the introduction of the new offence.
- 5.20 It is worth noting that the records for which we have blood analysis results are in effect pre-filtered as they are follow saliva tests that look for THC (cannabis) and cocaine only. The blood analysis results cannot therefore be expected to provide robust or representative information on the prevalence of other substances covered by the regulations. However, it is interesting to note that some saliva tests that were positive for cannabis or cocaine also returned results for other substances above the specified limits for those drugs (in some cases, where the blood results for cannabis and cocaine were below the specified limits).

Table 4: Number of blood samples containing substances covered by regulations

Substance	Number of blood samples:			
	containing substance		exceeding limit for substance	
THC	1074	84%	785	62%
Cocaine	245	19%	134	11%
BZE	364	29%	291	23%
Ketamine	10	0.8%	7	0.6%
LSD ¹	0	0%	0	0%
Methylamphetamine	0	0%	0	0%
MDMA (Ecstasy)	19	1.5%	17	1.3%
6-MAM (Heroin metabolite)	2	0.2%	2	0.2%
Amphetamine	23	1.8%	4	0%
Clonazepam	0	0%	0	0%
Diazepam	29	2.3%	2	0.2%
Flunitrazepam	0	0%	0	0%
Lorazepam	0	0%	0	0%
Methadone	16	1.3%	2	0.2%
Morphine	45	3.6%	4	0.3%
Oxazepam	17	1.3%	0	0%
Temazepam	10	0.8%	0	0%

Source: Risk Solutions

Base: 1,272, 17 police forces

In addition there were a very small number of analyses that were not Section 5A analyses which contained one or more of THC, cocaine, BZE, MDMA, 6-MAM, Diazepam, Methadone, Morphine, Oxazepam or Temazepam.

- 5.21 As Table 4 shows, few of the blood samples contain substances other than those screened for by the saliva tests, as might be expected (treating BZE as one of those substances, although technically the saliva test screens for cocaine). The most common other substance, morphine, was found in only 3.6% of blood samples. The most common substance found at a level exceeding the specified limit was MDMA, found in 1.3% of samples. It must be stressed that the values in this table should not be interpreted as meaning that these other substances are not being used by drug drivers. The table merely indicates the extent to which those who have used cannabis or cocaine and have then been stopped by the police, have also used these other substances as well.
- 5.22 As noted earlier, the time between saliva testing and taking a blood sample is important because the concentration of a drug will decrease with time. Therefore, the sooner a blood sample can be taken, the more closely it will reflect blood concentration while the suspect was driving. Figure 12 shows (for samples taken

after the introduction of the new offence, where we have information³⁵) the time between saliva tests and blood samples being taken. In some forces, arrests for Section 5A offences are treated as time-critical and prioritised where possible. The figure shows that about 24% of samples are taken within one hour, with the majority – 61% - taken within 1.5 hours of the initial saliva test. About 1 in 5 samples are not taken until at least 2 hours after the initial saliva test.

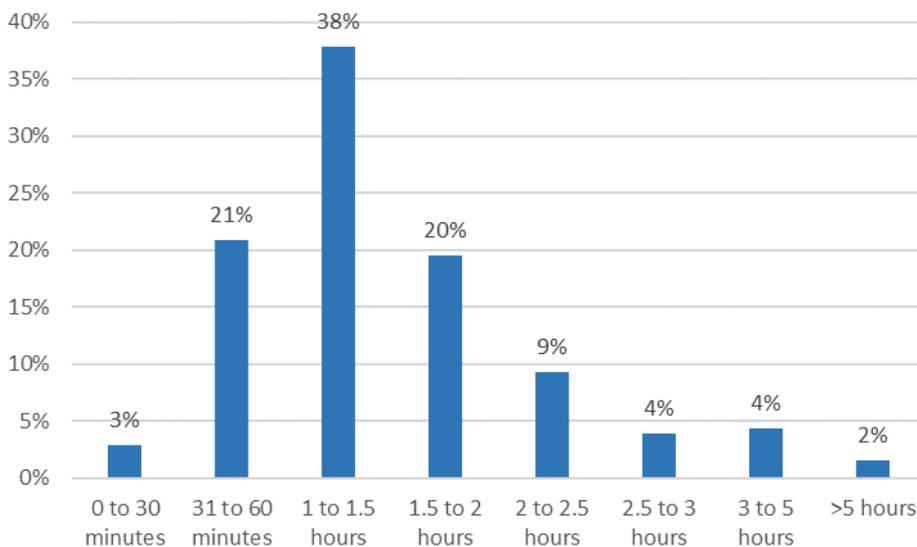


Figure 12: Time between saliva test and blood sample being taken

Source: Risk Solutions. Base: 1,441; 18 Police Forces

Police disposals for our sample

5.23 For positive saliva tests, information provided to us by police forces suggests that 61% result in Section 5A charges, as shown in Figure 13. Nearly 1 in 10 result in a Section 4 charge or a charge of failure to provide (where the suspect refuses to allow a blood sample to be taken). The 30% of cases where no further action (NFA) is taken include some cases where blood could not be taken (about a third of these NFA cases), and some where blood analysis results did not support a Section 5A charge. We saw no cases in our sample where people were arrested for Section 4 then charged with Section 5A; those charged with Section 5A offences had been arrested either for both, or just Section 5A.

³⁵ There is no evidence that missing data would affect this distribution.

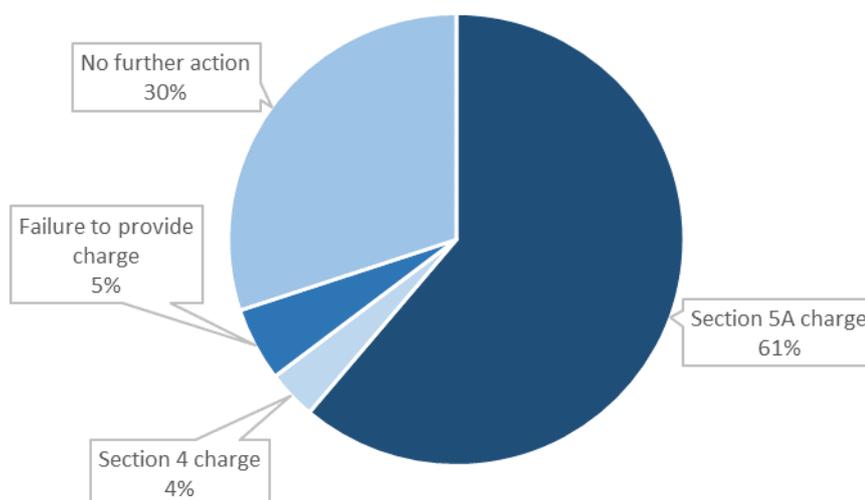


Figure 13: Disposals (where known) for positive saliva tests

Source: Risk Solutions
Base: 1,460

Prosecutions and convictions

- 5.24 To establish a baseline for operation and enforcement of drug-driving offences, we sought to look at numbers of arrest data for individual police forces, and at numbers of prosecutions and convictions for drug driving at a national level (for England and Wales). While some data is available on numbers of arrests, police forces could not easily provide this. This is because the form in which data are routinely recorded and held did not support production of the data of particular interest to this study. Arrests are the first stage in achieving increased convictions for drug-driving³⁶ and so lack of information on baseline numbers of arrests meant that if the evaluation had not found an increase in proceedings brought for drug driving in the first year of the new offence, it would not be possible to determine whether this was because arrests did not increase (or indeed fell). However, as described below, we do have evidence that proceedings brought for drug-driving have increased.
- 5.25 As Figure 14 illustrates, there is a reduction in the numbers of cases along each step in the process from a suspected drug driver being stopped by police to conviction. Not all of those stopped are arrested, and of those arrested, subsequent investigation may not provide sufficient evidence to support a charge, and so people may be released. For example, while initial drug screening may indicate that someone was drug driving, subsequent analysis of a blood sample may not support prosecution, and so no further action might be taken. It is also possible that not all those charged will proceed to court; in some cases, for example, prosecutors may discontinue proceedings. For cases that do proceed to court, some people will be found not guilty.

³⁶ Although ultimately, we note that the aim will be to reduce the prevalence of drug driving so that arrests would then fall.

5.26 The Ministry of Justice (MoJ) was able to provide data on the numbers of proceedings brought, and as this is the next step along the potential prosecution process from arrests, we have used this information.

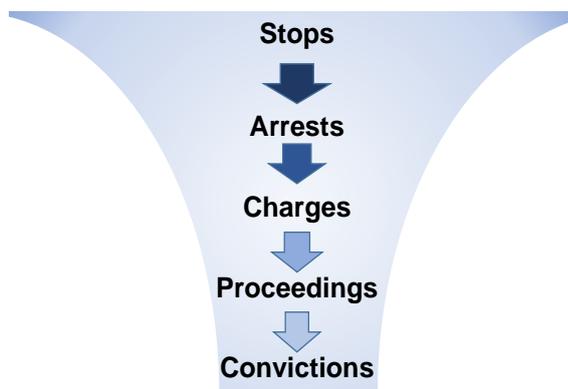


Figure 14: From initial stop to conviction

Note: This diagram should not be interpreted as implying any particular relationship between the numbers at different stages, or to imply any scale relationships.

Proceedings brought in 2015 and proxies for 2016

5.27 Section 5A came into force on 2 March 2015. As Figure 15 shows, the first Section 5A proceedings brought entered the court system in April 2015, and increased steadily to the end of 2015. The apparent dip in November may represent increased proceedings in the prior two months, following the summer drug driving campaign, as a linear trend explains more than 90% of the variation between months. The figure also suggests that Section 4 proceedings brought have not been affected by the introduction of the new offence, that is, the new offence may be additional to the Section 4 proceedings brought.

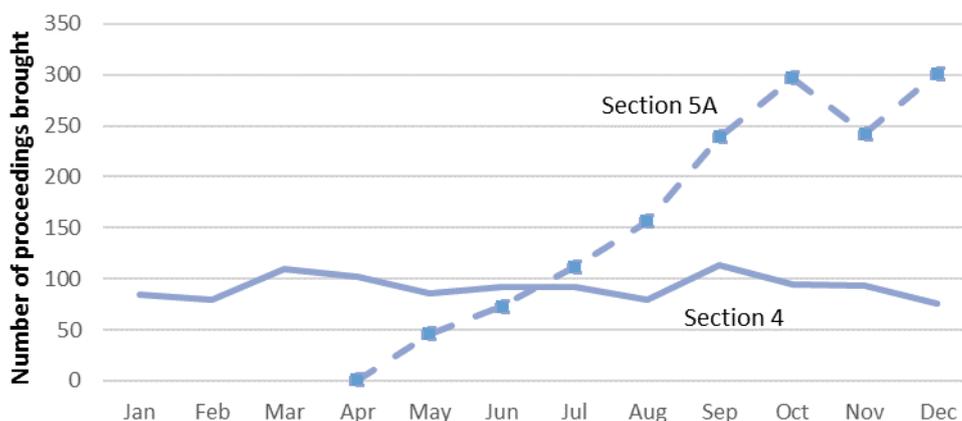


Figure 15: Proceedings brought month-by-month in 2015 for drug driving

Source: Ministry of Justice analysis of Libra and CREST, Risk Solutions

5.28 There are 43 police forces in England and Wales. Figure 16 shows the numbers of forces who brought proceedings for Section 5A offences month by month. As for Figure 15, it shows a slow start to implementation of the new offence, but with steady growth in its use through 2015. A small number of police forces (three of the 43 police forces in England and Wales) had brought no Section 5A proceedings by the end of 2015.

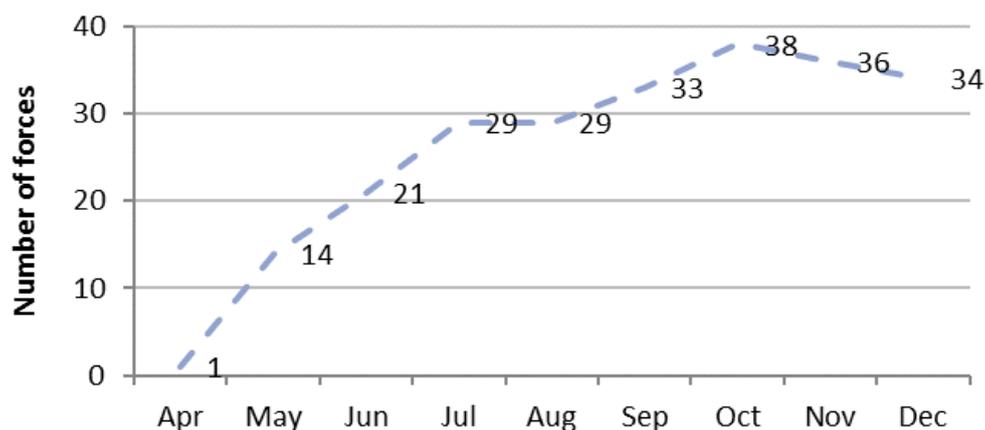


Figure 16: Numbers of forces bringing proceedings month-by-month in 2015 for Section 5A offences

Source: Ministry of Justice analysis of Libra and CREST, Risk Solutions

- 5.29 Some additional information relating to prosecutions is available from DVLA endorsement data for the relevant offence codes, obtained by a third party through a freedom of information request, and also from information on the national summer drug driving campaign. Offence codes DG10 and DG60 stay on a person's driving record for 11 years from the date of conviction, while endorsements for offence code DG40 stays on a driving record for only four years. The numbers of offences in Table 5 are the total numbers of offences on record at 12 November 2016. At that date, the offences in the table below had been in force for less than two years, so there were no 'old' offences that would have dropped out of the records - thus the 9,856 DG10 offences represent all endorsements for that offence since its introduction.
- 5.30 We have information from MoJ indicating that there were some 1,442 convictions for Section 5A offences in 2015. There may be some timing differences between convictions recorded by MoJ and endorsements by DVLA but we can estimate convictions from 1 January 2016 to 12 November 2016 as the 10,041 offences in the DVLA records less the 1,442 for 2015, from MoJ data. This gives an estimate of 8,599 convictions for the first 316 days of 2016. (Note that DfT's impact assessment for the new offence³⁷ used a central scenario of 8,800 proceedings per year for the new offence.) While the absolute numbers here are subject to uncertainty, for example this simple analysis does not account for the fact that some individuals may have more than one endorsement – one for each drug in their blood over the specified limit, we can conclude that the use of Section 5A offences by police forces continued to rise in 2016, and that DfT's impact assessment central scenario for proceedings brought was of the correct order of magnitude.

³⁷ Paragraph 47 of the impact assessment in the consultation document https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229738/consultation-document.pdf

Table 5: DVLA Endorsement Data on Section 5A offences

Offence code	Offence	Number of offences on record
DG60	Causing death by dangerous driving with drug level above the specified limit	1
DG10	Driving or attempting to drive with drug level above the specified limit	9,856
DG40	In charge of a vehicle while drug level above specified limit	184
	Total	10,041

Source: DVLA³⁸

Note: these are total endorsements on record from introduction of the new offence on 2 March 2015 until 12 November 2016.

- 5.31 The National Police Chiefs' Council (NPCC) summer drink and drug driving campaign, which ran from 10 June to 10 July 2016, provides further evidence of the increasing use of the Section 5A offence in 2016. Note that Figure 15 shows a peak (in December 2015) of about 300 proceedings brought within a single month. As shown in Figure 13, for the records we collected from a range of police forces, about 61% of positive saliva tests result in a Section 5A charge being brought (some of the remainder resulting in Section 4 or failure to provide charges). Using this 61% estimate suggests that the national figure of 1,028 positive drug screening tests reported in Table 6, could result in 627 proceedings being brought as a result of saliva tests conducted during the campaign. These would probably not all appear in the proceedings figures in a single month, but in any case indicates a significant increase in use of the new offence in 2016, compared with 2015. The NPCC Christmas 2016 drink and drug driving campaign showed a similar level of activity, with 2,642 saliva tests administered, and just over 48% of those giving positive results.

³⁸ Freedom of Information Request DVLA ref FOIR5649, 18 November 2016. Available at: <https://www.whatdotheyknow.com/request/366846/response/897681/attach/html/2/FOIR5649%20Daniel%20Potter.pdf.html>

Table 6: NPCC Summer 2016 Drink and drug driving campaign – regional breakdown of preliminary drug screening

Region	Saliva tests administered	Number of positive tests	Positive tests as percentage
National	2,588	1,028	40%
North East	85	46	54%
North West	550	241	44%
Yorkshire & Humberside	170	70	41%
Wales	180	117	65%
West Midlands	256	136	53%
East Midlands	53	25	47%
Eastern	258	90	35%
South West	70	30	43%
London	476	145	30%
South East	490	128	26%

Source: National Roads Policing Intelligence

Proceedings brought in 2015 by police force

- 5.32 Figure 17 shows the use by different police forces in 2015 of the Section 4 and Section 5A offences. It shows prosecutions in 2015 per million population for the pre-existing Section 4 impaired by drugs offences (left most part of each bar), and the new Section 5A offences (right most part of each bar). To protect anonymity, we have not used force names on the chart; each letter represents a separate police force. Drug driving prosecutions per million population vary considerably between forces; both in total and for Section 4 on its own and Section 5A on its own. Some forces made little use of the new offence in 2015; a small number brought no proceedings for Section 5A offences.

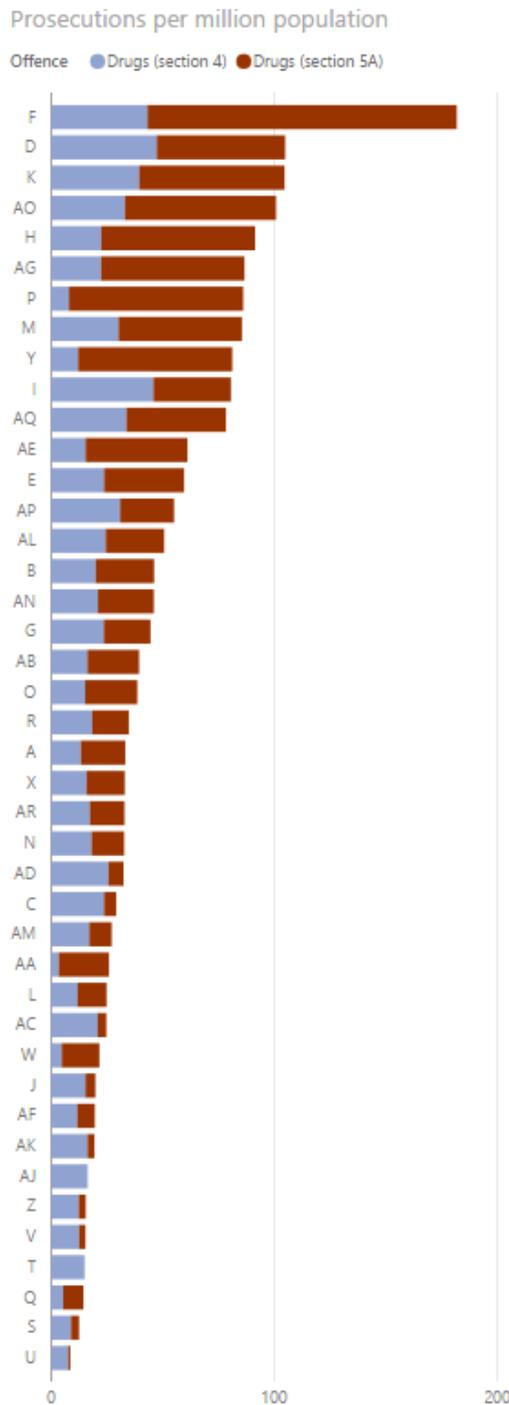


Figure 17: Proceedings brought for drug-driving 2015 by police force

Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice

Reference: 285-15³⁹; ONS Census data, Risk Solutions

³⁹ The figures used relate to defendants for whom these offences were the principal offences for which they were dealt with. When a defendant has been found guilty of two or more offences it is the offence for which the heaviest penalty is imposed. Where the same disposal is imposed for two or more offences, the offence selected is the offence for which the statutory maximum penalty is the most severe. Every effort is made to ensure that the figures presented are accurate and complete. However, it is important to note that these data have been extracted from large administrative data systems generated by the courts and police forces. As a consequence, care should be taken to ensure data collection processes and their inevitable limitations are taken into account when those data are used.

Proceedings brought 2009 to 2015

5.33 Figure 18 shows the numbers of proceedings and convictions in England and Wales for each of the years 2009 to 2015 for Section 4 offences. These relate to prosecutions for the Section 4 ‘impaired by drugs’ offence and ‘impaired by drugs or alcohol’. The chart shows that there was a reduction in the numbers of proceedings brought for Section 4 drugs cases offences between 2011 and 2012, which was sustained in 2013, 2014 and 2015. Also, the number of cases listed as ‘impaired by drugs or alcohol’ has reduced, while the number listed as ‘impaired by drugs’ has increased. This might indicate increased awareness of drug impairment, or more careful coding of cases.

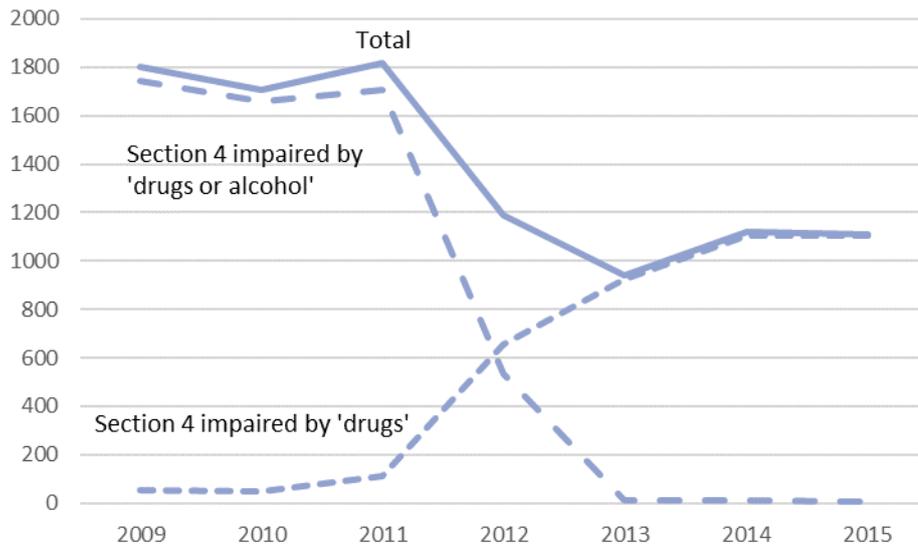


Figure 18: Drug driving: Section 4 proceedings brought 2009 to 2015

Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice
Reference: 285-1539; Risk Solutions

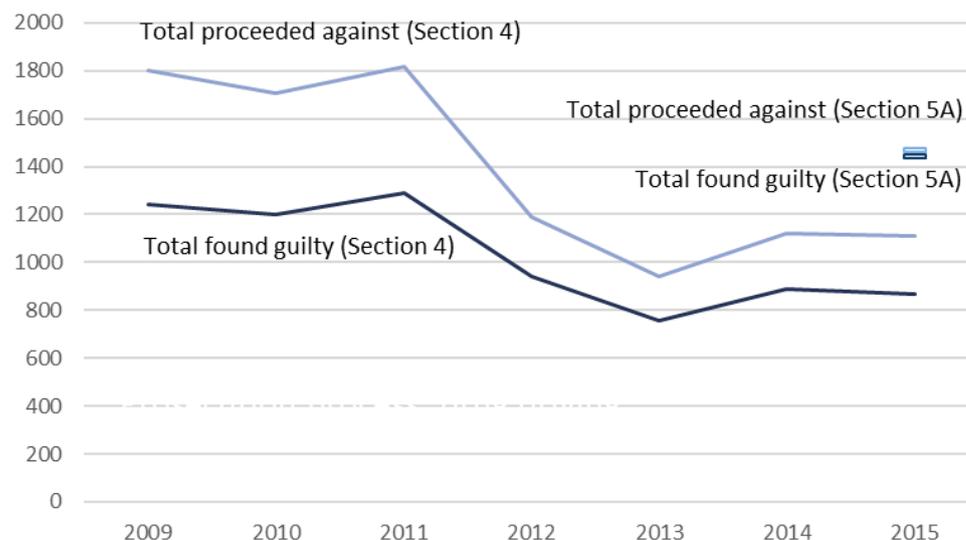


Figure 19: Drug driving: Section 4 drug driving proceedings and convictions 2009 to 2015, Section 5A proceedings and convictions for 2015

Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice
Reference: 285-15³⁹; Risk Solutions

5.34 Figure 19 shows the total proceedings brought for drug driving under Section 4 – the ‘total’ line from Figure 18 – and Section 5A offences for 2015; it also shows the numbers found guilty. One of the key risks mentioned by several of those we interviewed, particularly those in the Criminal Justice System, from police forces, to NPCC to the CPS, was that over time, police officers might become reliant on preliminary screening devices, stop collecting impairment evidence, and rely only on the new Section 5A offence. At the current time, the only suitable matrix for evidential analysis for Section 5A is blood, and so if a blood sample cannot be obtained, or if the sample is analysed but is not found to contain a level of a specified drug that supports a Section 5A prosecution, impairment evidence would be necessary to support a Section 4 (impaired by drugs) prosecution.

5.35 It is too soon to determine whether this risk will be realised over the longer term. However, Figure 19 shows that the number of convictions for Section 4 offences in 2015 was similar to the number in 2014, which suggests that use of Section 4 drug-driving offences has not been affected by the introduction of the new Section 5A offences. Section 5A proceedings brought appear to be additional to Section 4 drug-driving offences, rather than replacing them. Also, as Figure 19 shows, more proceedings were brought for Section 5A offences than for Section 4 offences. As Figure 20 shows, the percentage found guilty of Section 4 drug-driving offences has remained at around 80% over the last four years; for the new Section 5A offences, 98% of proceedings brought in 2015 resulted in convictions. Note, however, that many of the cases in our sample with ‘not guilty’ pleas had not yet been tried, and so this figure may change.

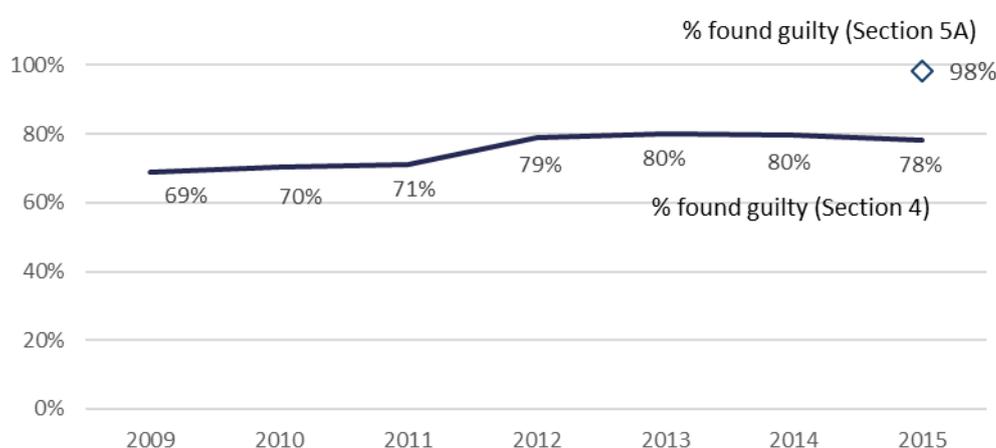


Figure 20: Drug driving: ‘impaired by drugs or alcohol’ and ‘impaired by drugs’, found guilty (as percentage of proceedings brought) 2009 to 2015

Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice
 Reference: 285-15³⁹; Risk Solutions

5.36 Police forces we spoke to told us that their training in advance of, and around the time of the introduction of the new offence emphasised the importance of dual arrest, and the collection of impairment evidence so that a Section 4 offence can be pursued as a fall back if necessary. As paragraph 5.13 notes, in about 1 in 8 cases for which we have records (from primary data collection by police forces), it was not possible to obtain a blood sample. This makes it important to continue to monitor the numbers of Section 4 (impaired by drugs) proceedings **and** the numbers of proceedings brought for the new Section 5A offence, to monitor the overall proceedings and prosecutions for drug driving offences.

5.37 Drug driving is often compared with drink driving as the offence in Section 4 of the Road Traffic Act 1988⁴⁰ referred to being ‘unfit to drive through drink or drugs’. The impact appraisal for the new legislation drew comparisons between drink driving and drug driving enforcement rates. In addition, the DRUID study⁴¹ highlighted the increased road safety risks associated with driving while under the influence of drugs **and** alcohol. Consequently, for contextual purposes, it is interesting to look at drink driving trends. The trend for drink driving proceedings and convictions is shown in Figure 21, with a steady downwards trend from 2009 to 2014, which appears to have levelled off in 2015 (although it is too soon to determine whether this is a change to the overall trend). Comparing Figure 19 with Figure 21 also shows that the numbers of proceedings brought for drink driving are significantly higher than for drug driving. In 2014 the number of drink driving proceedings brought was a factor of 37 higher than those for drug driving. Proceedings brought for drug-driving have increased following the introduction of the new Section 5A offences, but drink-driving proceedings remained higher than those for drug driving in 2015, by a factor of 16.

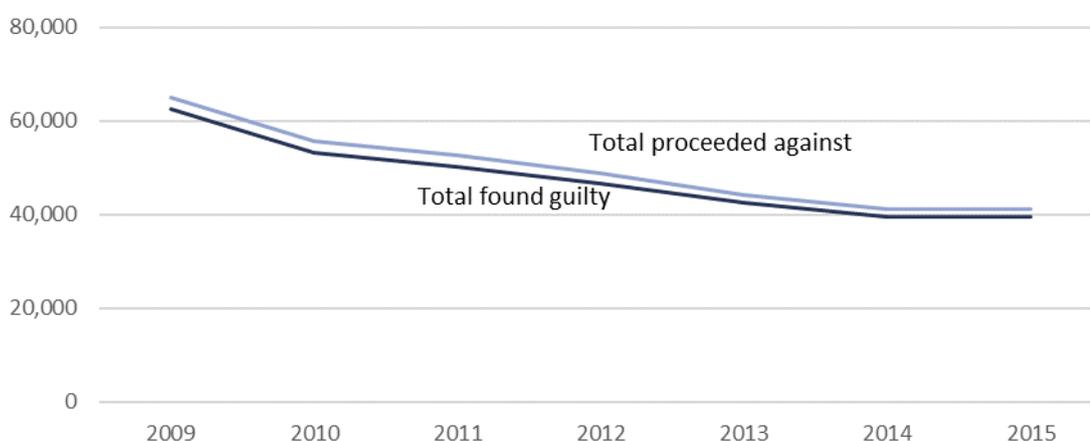


Figure 21: Drink driving: Numbers of proceedings and convictions 2009 to 2015

Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice
 Reference: 285-15³⁹; Risk Solutions

Comparison with drink driving conviction rates

5.38 Figure 22 presents data on relative conviction rates for drug driving and drink driving. It shows that while prosecutions for the Section 5 drink driving offence have a conviction rate of about 96%, the conviction rate for Section 4 drug driving offences has been steady at around 80% over the last four years, although there has been an increase over the conviction rates between 2009 and 2011. The dotted line shows the conviction rate for Section 4 and Section 5A drug driving offences combined, approximately 90% in 2015, given the 98% conviction rate for Section 5A offences. In information we have been provided with directly from police forces, we have 473 Section 5A charges where we know the court outcome; of these, just over 97%

⁴⁰ Under Section 4 of the Road Traffic Act 1988, a person driving or attempting to drive – or in charge of – a mechanically propelled vehicle on a road or other public place, while unfit to drive through drink or drugs, is guilty of an offence.

⁴¹ Driving under the influence of drugs. Report from the expert panel on drug driving. K Wolf et al.. DfT March 2013.

resulted in convictions, in line with the data provided by MoJ, which covers more police forces.

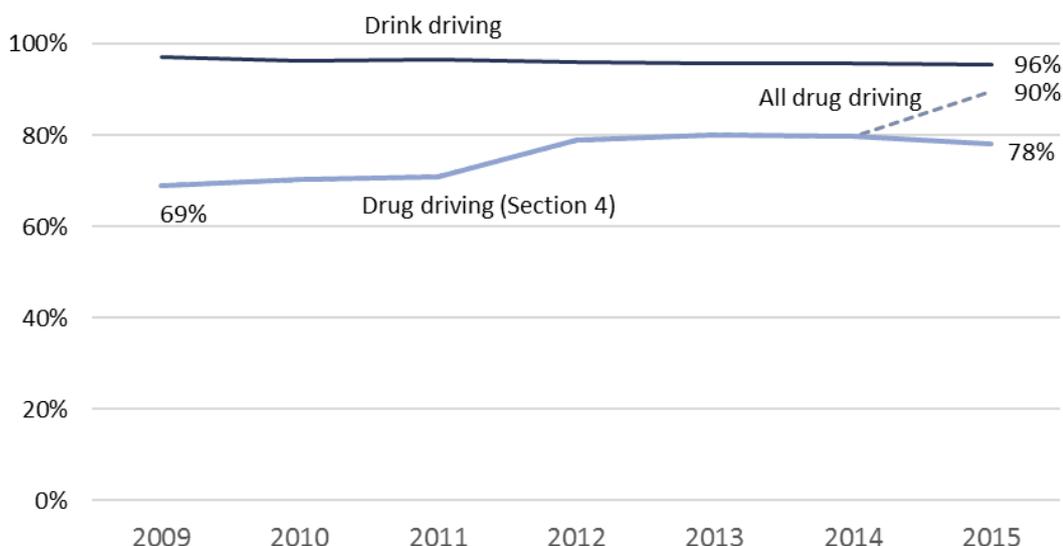


Figure 22: Conviction rates for drug driving and drink driving, 2009 to 2015

Source: Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice

Reference: 285-15³⁹; Risk Solutions

Note: for drug driving, this includes cases coded as impaired by drugs, as well as those coded as impaired by alcohol or drugs.

Penalties imposed for drug driving offences

5.39 Looking at information from primary data collection by police forces, of the 879 records in our sample where we know a Section 5A charge was brought, we have details of the penalties imposed by the court in 610 cases. Table 7 shows details of the lengths of disqualification from driving for records in our sample. Clearly, the most common period of disqualification from driving observed is 12 months, but there was some variation, with 89 (15%) of the cases in our sample being disqualified for 24 months or longer. However, it must be noted that we do not have access to information available to the courts that might explain the variation. There are a small number of cases not included below – a few with disqualification periods of fewer than 12 or more than 36 months, two cases where we know there was a disqualification but the length is not known, and in four (‘in charge’ offences) there was no disqualification (but penalty points were imposed).

Table 7: Lengths of disqualification from driving in our sample

Length of disqualification from driving (months)	Number of cases
12 months	411
13 to 23 months	102
24 months	21
25 to 36 months	57

Source: Risk Solutions, Primary data collection by police forces.

Base: 610 – cases where Section 5A charge was brought, defendant was found guilty, and penalties are known (In a further 269 cases, we do not know the penalties imposed.)

Note: a small number of cases included disqualifications for periods of less than 12 or more than 36 months – these are not shown.

- 5.40 The data we have been provided with by police forces includes some more serious cases where people have been charged with, for example, causing death by dangerous driving with a drug level in the blood above the specified limit. These more serious cases take longer to investigate and to go to court. We do not have follow-up information for these cases on court outcomes or penalties imposed. However, there have been a number of such cases reported in the media. One such case is included in the box below.

Swift conviction of drug driver

On 12 August 2016, a speeding motorist crashed into another car in Eastbourne, killing the two occupants of the other car. Police conducted field impairment testing, which the driver performed poorly. Police also used a DrugWipe saliva test, which proved positive for cocaine, and this allowed police to request a blood sample without requiring a healthcare professional to determine whether the driver had a condition that might be due to a drug, saving time.

The motorist was a 24-year old man, who pleaded guilty to two counts of causing death by dangerous driving. The case was dealt with under Better Case Management⁴², which helped to ensure it was dealt with swiftly. The driver was sentenced to six years in jail for each offence, to run concurrently, and was disqualified from driving for eight years. He will be required to take an extended retest if he reappplies for a driving licence.

Observers had estimated his speed at up to twice the applicable 30mph limit, and he was reported to have weaved in between anti-terror barriers before turning into the road where he collided with the other vehicle.

The driver was found to have a breath alcohol level of 46mg per 100ml, compared with the legal limit of 35mg/100ml. **More shockingly, the level of benzoylecgonine – the major metabolite of cocaine – in his blood was 800 µg/litre, compared with the specified upper limit of 50 µg/litre.**

Source: <http://www.sussex.police.uk/news/jail-for-eastbourne-fatal-hit-and-run-driver-who-was-16-times-the-drug-driving-limit/>, Sussex Police.

- 5.41 To explore how Magistrates deal with drug driving as an offence compared with drink driving (for which they have much more experience over many years), we have compared fines imposed for drug driving and drink driving. Figure 23 shows average fines for drug driving and drink driving from 2009 to 2015. The average fine for drug driving represents the average fine for cases coded as impaired by drugs, and does not include those where the impairment was coded as due to alcohol or drugs.
- 5.42 We have also looked at fines in cases where police have provided us with information on court outcomes. For the 644 cases in our records where a Section 5A conviction was recorded, we have penalty information for 592 cases. The average fine was £182, with a median fine of £132 and the most common fine being £120. The maximum fine in our records was £1,000. In almost 16% of these 592 records, no fine was recorded. In approximately a third of these cases, community orders for

⁴² Better Case Management links a number of initiatives aimed at improving the way cases are processed through the criminal justice system. More detail can be found at <https://www.judiciary.gov.uk/publications/better-case-management/>

unpaid work were made, ranging from 20 to 250 hours. In 13% of cases, curfew orders were made, with electronic tagging. In a few cases, offenders were referred to youth offending panels, and in others, offenders were imprisoned, or given a suspended prison sentence.

- 5.43 Average fines for drug driving appear to be consistently lower than those for drink driving; in 2014, the average fine for drug driving was 77% of the average fine for drink driving. In 2015 the average fine for drug driving was 71% of the average fine for drink-driving, as fines for the new Section 5A offences were lower than those for the Section 4 offences.
- 5.44 We have explored the possibility that this might be related to the age of convicted drug drivers. The data suggests that drug drivers are relatively young, and so might have lower incomes than drink drivers (who tend to be older on average), in which case the court might impose lower fines as the older drivers are likely to be more wealthy. Figure 24 shows that the age profile for those convicted of drink driving is older than that for those convicted of drug driving. It also shows that those convicted of the new Section 5A offence have a younger age profile than for those convicted of the Section 4 offence.
- 5.45 We investigated this further by looking at drug driving fines and comparing these with drink driving fines by age group. We found that for each age group, average fines for drink driving were higher than drug driving fines, which suggests that other factors have affected the relative size of fines for these two offence groups. We do not have relevant data to investigate this further.

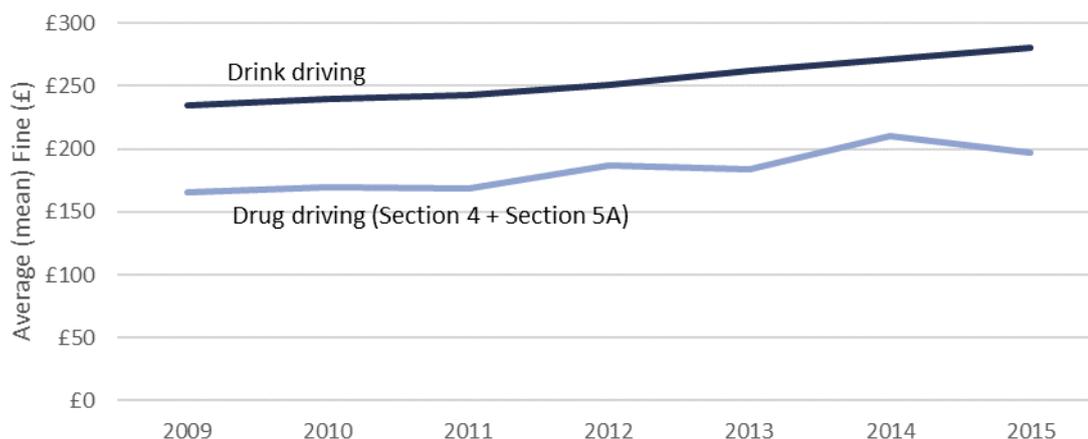


Figure 23: Average fines for drug driving and drink driving 2009 to 2015

Source: Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice
 Reference: 285-15³⁹; Risk Solutions

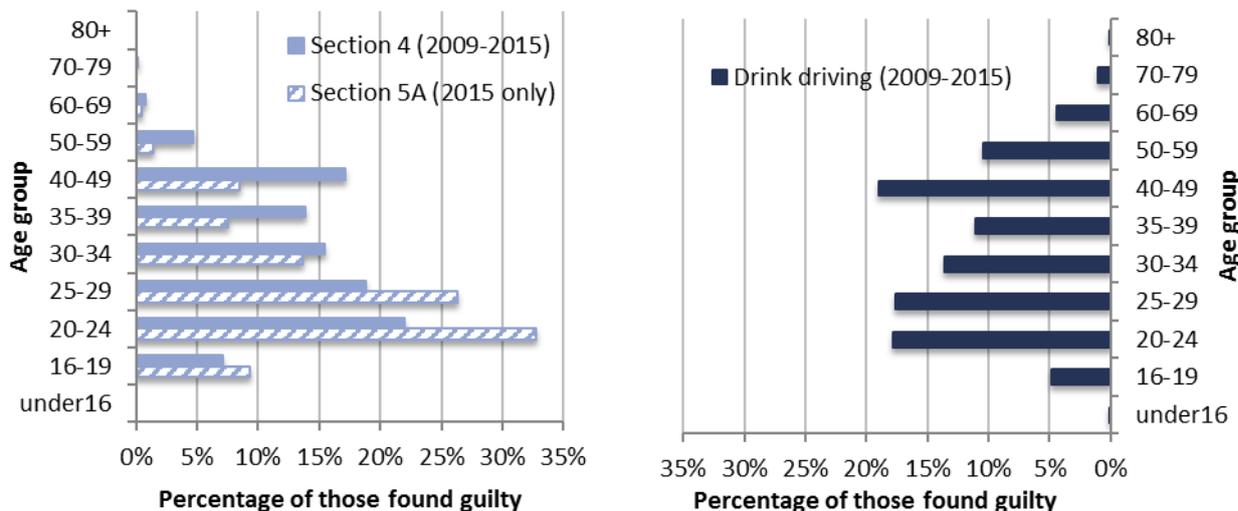


Figure 24: Age distributions for those found guilty of drink and drug driving, 2009 to 2015

Source: Court Proceedings Database, Justice Statistics Analytical Services, Ministry of Justice

Reference: 285-15³⁹; Risk Solutions

Note: Age group bins are not equally sized

Previous offences

5.46 An area of research that the DfT suggested was whether or not there was evidence that people caught drug driving had a previous criminal record. For example, there is evidence that some drug users are responsible for between a third and a half of acquisitive crimes⁴³. We undertook analysis to consider previous convictions and our findings are reported below.

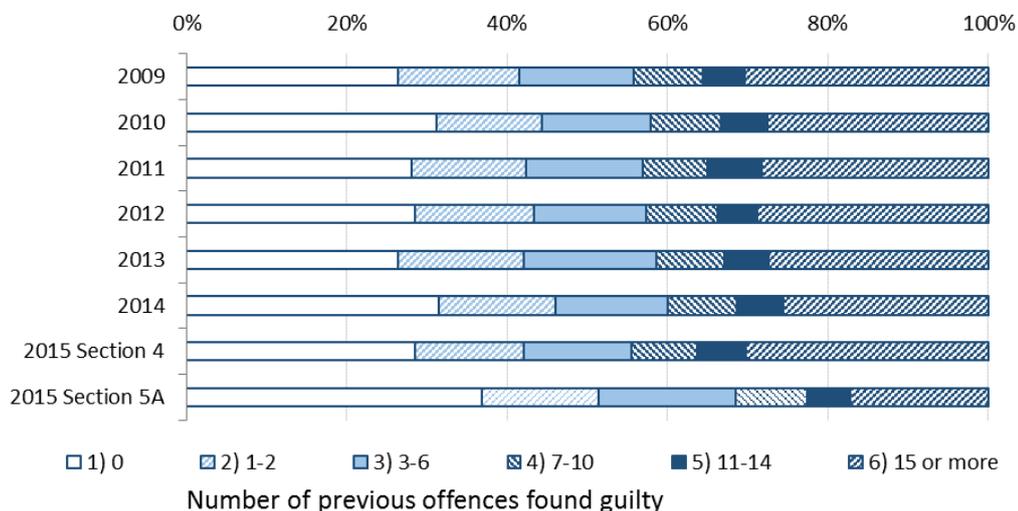


Figure 25: Criminal record (for any criminal offence) of drug drivers

Source: Ministry of Justice analysis of PNC data, Risk Solutions

Bases: 2009: 897; 2010: 930; 2011: 1,028; 2012: 942; 2013: 869; 2014: 1,019, 2015 Section 4: 1,054, 2015 Section 5A: 1,577

⁴³ Home Office Drug Strategy 2010 – Reducing Demand, Restricting Supply, Building Recovery https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

5.47 Figure 25 shows the numbers of previous convictions (for any criminal offence), for those found guilty of a drug driving offence. This does not appear to show any significant trend over time. It does suggest that there is a higher proportion of first time offenders among those found guilty of the Section 5A offence than among those found guilty of Section 4 offences. Figure 26 shows the data for 2015 (for Section 4 and Section 5A combined) in a matrix format. Each of the 100 figures shown represents 1% of those found guilty of a drug driving offence in 2015. For example, there are 33 grey figures representing the 33% of those found guilty in 2015 who had no previous convictions, while the 22 orange figures at the foot of the matrix represent the 22% who had 15 or more previous convictions.



Figure 26: Numbers of previous offences (any criminal offence) for drug drivers in 2015

Source: Ministry of Justice, Risk Solutions

Note: For those found guilty of Section 4 offences or Section 5A offences. Base: 2,631

5.48 We next look at what types of offences these previous offences were. Figure 27 shows that for the period 2009-2014, about 6% of those found guilty of drug driving offences had been previously convicted at least once for a drug driving offence. It also shows that in comparison with the convictions under Section 4, a lower proportion of those convicted of Section 5A offences have previous drug-driving offences, which is consistent with Figure 25.

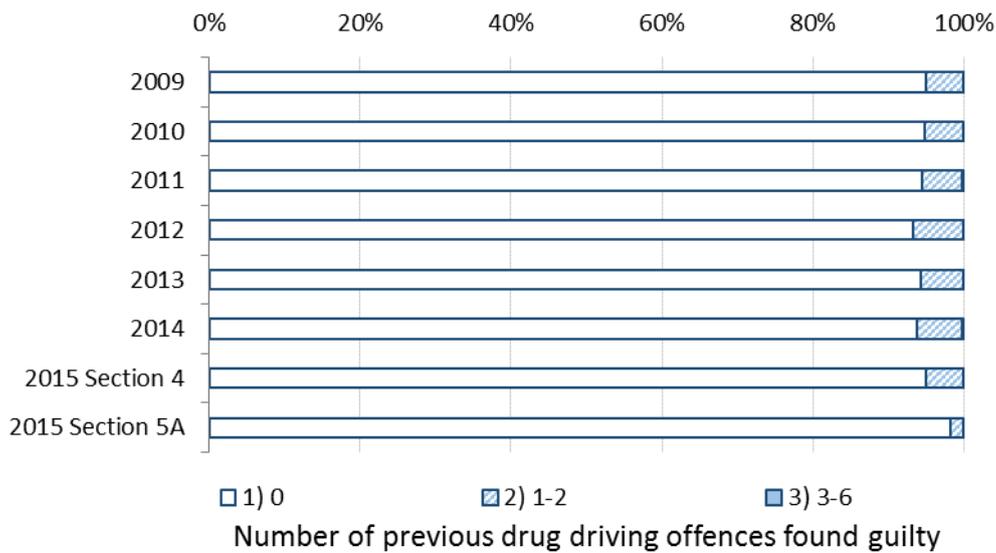


Figure 27: Drug driving record of drug drivers

Source: Ministry of Justice, Risk Solutions

Bases: 2009: 897; 2010: 930; 2011: 1,028; 2012: 942; 2013: 869; 2014: 1,019, 2015 Section 4: 1,054, 2015 Section 5A: 1,577

5.49 Figure 28 shows the proportion of those convicted of drug driving who had been previously convicted at least once for drink driving. For those convicted of Section 4 offences about 19% of those convicted had been previously convicted of drink driving. Again, there is a higher proportion of Section 5A offenders with no previous convictions for drink-driving. Comparing this with Figure 27 suggests that those found guilty of drug driving offences appear to be more likely to have been previously found guilty of drink driving offences than drug driving offences.

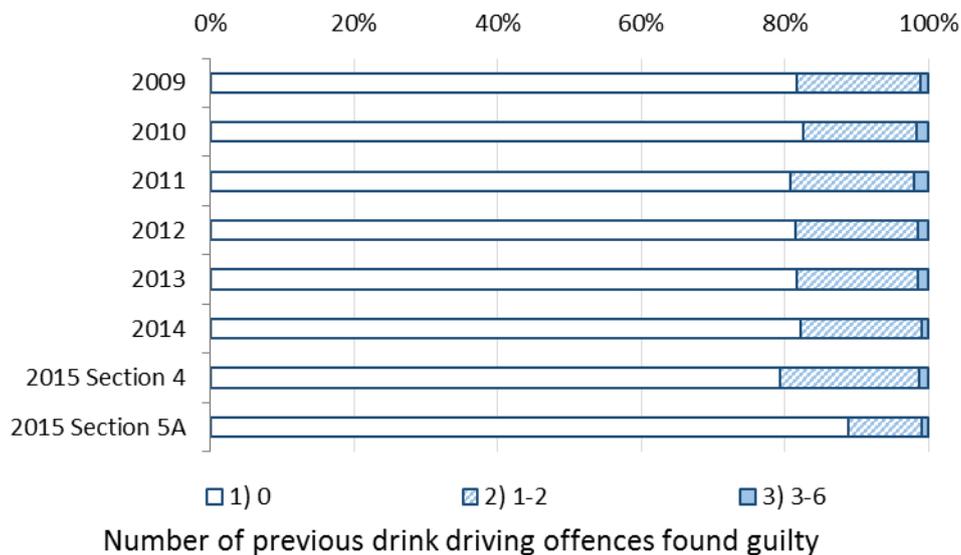


Figure 28: Drink driving record of drug drivers

Source: Ministry of Justice, Risk Solutions

Bases: 2009: 897; 2010: 930; 2011: 1,028; 2012: 942; 2013: 869; 2014: 1,019, 2015 Section 4: 1,054, 2015 Section 5A: 1,577

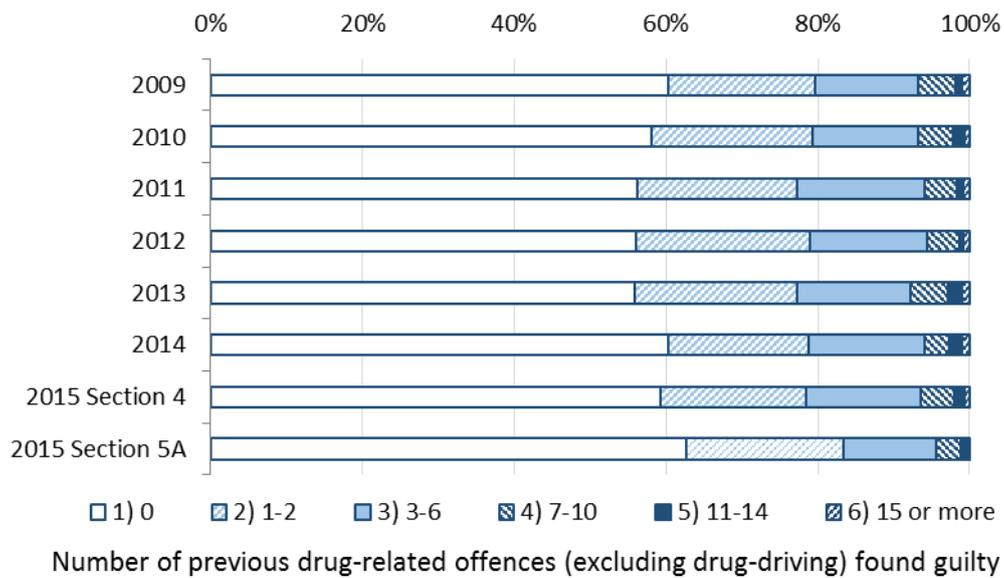


Figure 29: Drug related criminal record of drug drivers

Source: Ministry of Justice, Risk Solution

Bases: 2009: 897; 2010: 930; 2011: 1,028; 2012: 942; 2013: 869; 2014: 1,019, 2015 Section 4: 1,054, 2015 Section 5A: 1,577

5.50 Next, we looked at previous convictions for drug-related offences, excluding drug driving. Figure 30 shows a similar profile for those convicted of Section 5A offences and Section 4 offences. 40% of those found guilty of a drug driving offence in 2014 had a criminal record for drug related offences other than drug driving. Figure 30 shows the data for 2015 in a matrix format. Each of the 100 figures shown represents 1% of those found guilty of a drug driving offence in 2014. For example, there are 60 grey figures representing the 60% of those found guilty in 2014 that did not have any drug-related previous convictions (excluding previous drug driving offences).



Figure 30: Drug-related previous offences for drug drivers in 2015 (excluding previous drug-driving offences)

Source: Ministry of Justice, Risk Solutions

Note: For those found guilty of Section 4 offences or Section 5A offences. Base: 2,631

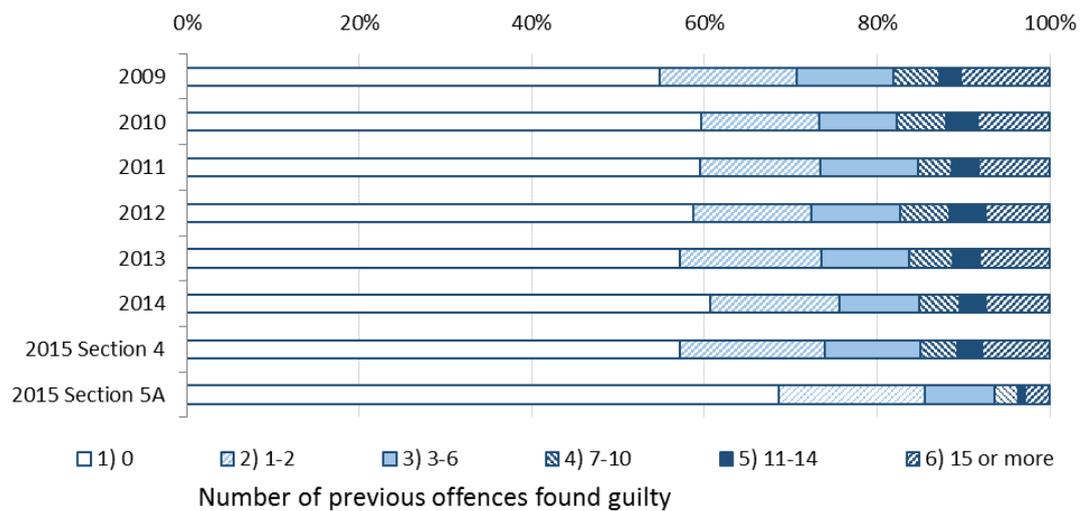


Figure 31: Previous theft and burglary offences for drug drivers

Source: Ministry of Justice, Risk Solution

Bases: 2009: 897; 2010: 930; 2011: 1,028; 2012: 942; 2013: 869; 2014: 1,019, 2015 Section 4: 1,054, 2015 Section 5A: 1,577

5.51 We also looked at how many convicted drug drivers had previous theft or burglary offences. As Figure 31 shows, for those convicted of Section 4 drug driving offences, more than 40% have previous convictions for theft or burglary (with the exception of 2014 where the figure was just below 40%). For the new Section 5A offences, there are more people with no previous convictions for theft or burglary, but more than 30% have one or more theft or burglary convictions.



Figure 32: Previous burglary and theft offences for drug drivers in 2015

Source: Ministry of Justice, Risk Solutions

Note: For those found guilty of Section 4 offences or Section 5A offences. Base: 2,631

Summary

5.52 From the data presented in Figure 26, Figure 29 and Figure 32⁴⁴, it appears that approximately 67% of those convicted of drug driving have a pre-existing criminal record and that previous offences include a relatively high number of theft/burglary and drug-related offences (but not drug-driving). Note, however, that to have a higher degree of certainty around the mix of offences in past convictions, it would be necessary to conduct considerable additional analyses looking at detailed criminal

⁴⁴ Information provided relates to defendants for whom these offences were the principal offences for which they were dealt with. When a defendant has been found guilty of two or more offences the principal offence is the offence for which the heaviest penalty is imposed. Where the same disposal is imposed for two or more offences, the offence selected is the offence for which the statutory maximum penalty is the most severe.

histories and comparing across offence groups. Those convicted of the new Section 5A offences are less likely to have previous convictions than those convicted of Section 4 drug driving offences. The figures also show that fewer than 10% of drug drivers have been previously convicted for drug driving; in 2015 about 3% of those convicted had previous drug driving convictions. Drug drivers are more likely to have been previously convicted of drink driving than drug driving.

Summary of Section 5

Screening devices and laboratory analyses

- 5.53 Most of those stopped and saliva tested by police are men (94%) and are young – more than half aged below 30 years. We found no evidence of any ethnicity bias. Around 93% of tests in our sample were carried out at the roadside rather than at police stations, and 54% of tests were positive. Of those, 75% were positive for THC (cannabis) only, 14% for cocaine only, and 11% for both cocaine and cannabis.
- 5.54 In approximately 1 in 8 cases where a saliva test was positive, no blood sample was subsequently taken. Only 5% of those cases were a result of needle phobia, with most, 52%, being a result of medical reasons, mostly ‘poor veins’. In 32% of those cases with no subsequent blood sample, this was a result of refusal by the suspect to provide a sample.
- 5.55 Subsequent blood tests showed that where a saliva test was positive for THC, 30% of these were at or below the limit of 2µg/litre of blood (after deducting the ‘guard band’ for analytical uncertainty); comprising 17% of tests that were at or below 1µg/litre, and 14% greater than 1µg/litre but at or below 2µg/litre. Most blood samples (61%) were obtained within 90 minutes of the saliva test being completed, but 10% were not obtained until more than 2.5 hours after the initial saliva test.

Prosecutions and convictions

- 5.56 The numbers of proceedings for drug driving have decreased over recent years, with a small increase in 2014, although this was probably not significant. Conviction rates for drug driving offences were lower than for drink driving offences (80% compared with 96%). The introduction of the new offences led to a 130% increase in proceedings brought for drug driving in 2015 compared with 2014, and there is evidence that these have continued to rise in 2016. Conviction rates for the new offence are high – similar to those for drink-driving. Fines imposed for drug driving appear to be lower than for drink driving.
- 5.57 **Use of the Section 5A offences** appears to have grown steadily through 2015 since its introduction, and there is evidence that its use has continued to grow in 2016. In 2015, we can observe differences in its use by different police forces; the reasons for this are not clear. Use of the pre-existing Section 4 impaired by drugs offences does not appear to have changed; the prosecutions for Section 5A offences appear to be **additional** to those for Section 4. 2015 saw more prosecutions for Section 5A offences than for Section 4 offences, despite its being available for only ten months of the year, and being taken up slowly at the beginning of those ten months. Conviction rates for the Section 5A proceedings brought in 2015 were higher than for Section 4 offences brought – 98% compared with 78%. This resulted in a weighted conviction rate of 90% for drug driving offences. It should be noted however, that in our sample,

a number of cases with 'not guilty' pleas had yet to be tried and so the 98% conviction rate may change over time.

Previous offences

- 5.58 It appears that 67% of those convicted of drug driving have a pre-existing criminal record and that this criminal record is not solely for drug related offences. Previous offences appear to include a relatively high number of theft/burglary and drug-related offences (but not drug-driving). Note however, that there is some uncertainty around this. Those convicted of the new Section 5A offences are, however, more likely to have no previous convictions than those found guilty of Section 4 offences. The figures also show that about 10% of drug drivers will have been previously convicted for drug driving but they are more likely to have been convicted of drink driving.

6 OUTCOMES AND IMPACTS

- 6.1 This section looks at measures for the outcomes and impacts on Figure 3 (the logic model setting out how the policy is intended to result in outcomes and impacts) and relates to the ultimate objectives of the new offence. The key outcomes and impacts relate to:
- increased awareness of drug driving offences, along with increased perceived risk of being caught, contributing to altered attitudes to drug driving, and reduced frequency of drug driving
 - reduced re-offending, and reduced criminal justice system costs
 - reduced numbers of road traffic collisions where drugs have been cited as a potential contributory factor, resulting in reduced injuries and fatalities and improved road safety.
- 6.2 In addition, the scoping study for the evaluation suggested (as included in the theory of change described by the logic model in Figure 3) that disruption to other crime might result from implementation of the new offence.
- 6.3 Note, however, that assessing the impact of the new offence is difficult, for two main reasons. Firstly, there is no counterfactual – no way of comparing with what would have happened without the new offence, all else being equal. We are using a before and after approach, looking at the baseline prior to the policy's implementation, and comparing this with the situation after policy implementation. This approach does not allow us to rule out the effect of influences other than the new drug driving offence; it does not allow any observed effects to be attributed directly to the policy. The second reason is that our data and observations relate largely only to the first year after introduction of the new offence, when many impacts may not be observed for some time.
- 6.4 First, we present baseline measures for attitudes to drug driving, awareness of the existing and new drug-drive offences, and perceptions of the likelihood of being caught if driving under the influence of drugs. These are of interest because the theory of change suggests that increased awareness of the new offence, and altered attitudes to drug-driving and increased perceived risk of arrest should result in reduced drug driving, and hence improved road safety. Data for awareness and attitudes is drawn from a module commissioned by DfT for this project in the ONS National Statistics Opinions and Lifestyle Survey, from fieldwork carried out in January 2015. This is before the launch of the THINK! awareness campaign, and so provides a baseline. We compare these with measures from the second and third waves of the survey.
- 6.5 We then look at available measures for the prevalence and frequency of drug driving, using data drawn from the Crime Survey for England and Wales. The key objectives relate to road safety, and so the next part of this section looks at measures for collisions due to drug driving, and a range of measures relating to fatalities and injuries as a result of drug driving. The metrics presented are from analysis of STATS19 data, combined with DfT data on vehicle miles to allow more meaningful year-by-year comparisons.
- 6.6 We also discuss concerns relating to potential adverse consequences, largely relating to those taking prescribed medicines (there were concerns that patients might not take prescribed medication if they feared being stopped for drug driving), and effects

on public health. Potential adverse consequences are included because the theory of change and interviews with stakeholders during the scoping phase highlighted the possibility of some unintended consequences. The effects on public health are included because the theory of change suggests that the policy may have impacts on public health, through increasing awareness of impairment as a result of drug use. Data sources here include qualitative data from interviews with stakeholders, and review of available data on public health in the area of drugs.

- 6.7 Finally, we look at disruption to general crime as this is an area where social benefits may be being realised that were not originally considered, nor anticipated, in the Impact Assessment for introduction of the new legislation.

Attitudes, awareness and perceptions

- 6.8 As the programme logic model in Figure 3 illustrates, part of the theory of change relies on:
- Increasing awareness of the fact that driving while impaired due to the use of drugs (illicit, prescribed or over the counter) is an offence
 - Increasing perceived risk of arrest for the offence
 - Altering attitudes to drug driving.
- 6.9 As noted earlier, DfT ran a campaign to inform the public about the new offence, with activities beginning in mid-February 2015 and continuing to late March 2015. Before this, TNS BMRB (now known as Kantar Public UK) conducted online interviews nationally with men aged 17 to 29 both before and after the campaign, to measure campaign recognition, awareness and attitudes. The focus of the evaluation of the THINK! Campaign is on young men, and on recreational drugs such as cannabis, cocaine and ecstasy.
- 6.10 In addition, DfT commissioned a module in the ONS National Statistics Opinions and Lifestyle Survey to determine baseline measures for attitudes, awareness and perceptions.

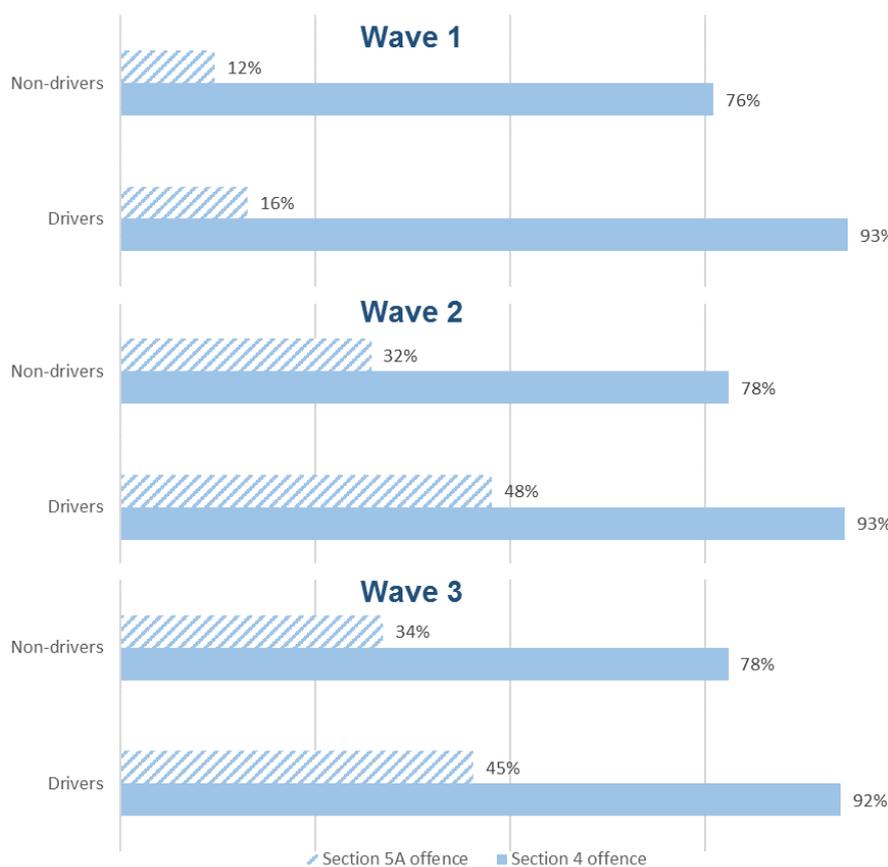


Figure 33: Awareness of existing Section 4 offence and new Section 5A offence by drivers and non-drivers

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions
Base: Wave 1: 1,062; Wave 2: 1,005; Wave 3: 999.

- 6.11 The baseline (first wave) survey indicated that 93% of drivers and 76% of non-drivers were aware that there was an existing offence which made it illegal to drive if their driving ability was impaired because they had taken drugs. Of those surveyed, 75% (base 949) said they were aware that this also included the effects of prescription drugs as well as the effects of illegal drugs. Awareness of the new Section 5A offence was lower than awareness of the pre-existing offence. Figure 33 shows that for Wave 1, before the offence was introduced, 12% of non-drivers and 16% of drivers said they were aware of the new offence. In April 2015 (Wave 2 survey) there was no significant change in awareness of the Section 4 offence, but awareness of the Section 5A offence increased significantly, with 48% of drivers and 32% of non-drivers saying they were aware of the new offence. There was no significant change from Wave 2 to Wave 3 (April 2016).
- 6.12 Table 8 shows that awareness was higher among men than women for Wave 1. This difference was statistically significant. Awareness increased among men and women between Waves 1 and 2 for the Section 5A offence; however, the difference in awareness between men and women for Wave 2 was no longer significant. There was again no significant change between Waves 2 and 3.

Table 8: Awareness of Section 4 and Section 5A offences by men and women (drivers and non-drivers)

	Wave 1 January 2015	Wave 2 April 2015	Wave 3 April 2016
Section 4			
Women	84%	87%	84%
Men	93%	89%	92%
Section 5A			
Women	11%	39%	39%
Men	19%	47%	44%

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions

Base: Wave 1: Section 4 offence 1,062, Section 5A offence 1,063. Wave 2: Section 4 offence 1,005 Section 5 offence 1,005

- 6.13 Table 9 shows awareness by age group for the existing Section 4 and new Section 5A offences for Wave 1, before the introduction of the new offence, for Wave 2, just after its introduction, and Wave 3, a year later. The differences in awareness of the existing offence by age group are not significant. Interestingly, for the new offence, awareness in Wave 1 (before the new offence was introduced) was lower among 16 to 24 year olds and 25 to 44 year olds than among older age groups. The difference between awareness for the 16 to 24 year olds and other age groups was statistically significant.

Table 9: Awareness of Section 4 and Section 5A offences by age group

	Wave 1 January 2015	Wave 2 April 2015	Wave 3 April 2016
Section 4			
75 and over	84%	81%	77%
65 to 74	93%	89%	88%
55 to 64	87%	91%	89%
45 to 54	93%	90%	93%
25 to 44	88%	88%	89%
16 to 24	85%	87%	86%
Section 5A			
75 and over	19%	39%	40%
65 to 74	22%	47%	42%
55 to 64	19%	48%	37%
45 to 54	19%	49%	46%
25 to 44	12%	43%	47%
16 to 24	5%	28%	29%

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions

Base: Wave 1: Section 4 offence 1,062, Section 5A offence 1,063. Wave 2: Section 4 offence 1,005 Section 5 offence 1,005.

- 6.14 Table 9 shows that following the THINK! campaign and other publicity associated with the introduction of the new offence, awareness of the new offence increased among all age groups, and by a greater factor among younger age groups. In April 2015, although awareness appears to be lower among 16 to 24 year olds than other age groups, the confidence intervals are such that the difference is not statistically significant. One potential contribution to the lower awareness reported among the 16-24 year old age band may be that 16 year olds are not yet part of the driving population and so are less likely to be aware of the offence. However, we do not have access to data that would allow us to assess this.
- 6.15 There was no significant change in general awareness between Wave 2 and Wave 3.
- 6.16 Overall, In April 2015, and in April 2016, 86% of those who were aware of the new Section 5A offence said they were aware that it included drugs that were usually prescribed drugs as well as those that are usually illicit.

Attitudes to punishments, perception of danger

- 6.17 The survey asked respondents how they thought the punishments for drug driving should compare with those for drink driving. As Figure 34 shows, most people - 77% of drivers and 67% of non-drivers - said that they thought punishments should be the same, with only 12% of drivers and 16% of non-drivers saying punishments should be more severe. These figures are from the Wave 1 survey – however, there were no significant changes from this in the Wave 2 or Wave 3 surveys. Table 10 shows information on attitudes for all three survey waves; it shows, for example, that in April

2016, 13% of people thought that punishments for drug driving should be more severe than punishments for drink driving.

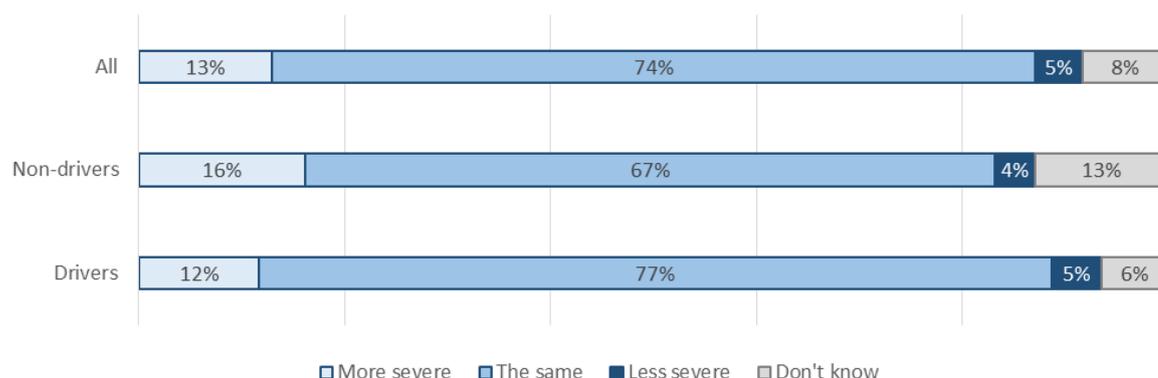


Figure 34: Attitudes to punishments for drug driving Wave 1, January 2015

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions
 Base: 1,091 respondents

Table 10: Attitudes to punishments for drug driving in comparison with drink driving, all respondents

		More severe	The same	Less Severe	Don't know
Wave 1	Jan 2015	13%	74%	5%	8%
Wave 2	Apr 2015	12%	75%	5%	8%
Wave 3	Apr 2016	13%	81%	4%	1.5%

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions
 Base: Wave 1: 1091; Wave 2: 1001; Wave 3: 983.

6.18 This is broadly in line with perceptions of how dangerous respondents thought drug driving was, in comparison with drink driving. Most people - 76% of drivers and 64% of non-drivers - thought that they were equally dangerous, while only 11% of drivers and 13% of non-drivers thought that drug driving was more dangerous than drink driving. Again, these figures are for the Wave 1 survey, but there were no significant changes for Wave 2 or Wave 3; Table 11 shows the information for all three waves on attitudes to the dangers of drug driving in comparison with drink driving.

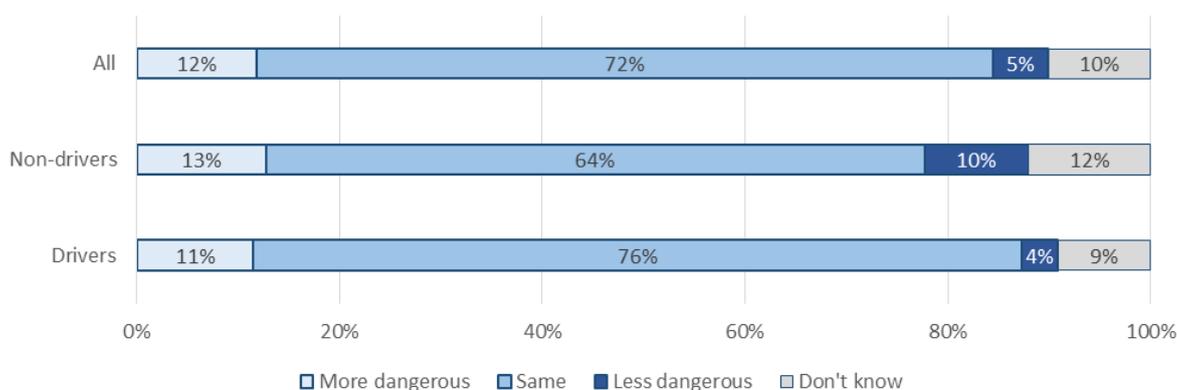


Figure 35: Attitudes to dangers of drug driving Wave 1, January 2015

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions
 Base: 1,090 respondents, 761 Drivers, 329 Non-drivers

Table 11: Attitudes to dangers of drug driving in comparison with drink driving

	More dangerous	The same	Less dangerous	Don't know
Wave 1 - January 2015	12%	73%	6%	10%
Wave 2 - April 2015	10%	73%	8%	9%
Wave 3 - April 2016	13%	76%	8%	3%

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions
 Base: 1,092 respondents. 762 Drivers, 330 Non-drivers

Likelihood of being caught

6.19 Respondents were asked about their perceptions of the likelihood of being caught drug driving. As Figure 36 shows, most people thought that drug drivers were unlikely to be caught. Interestingly, almost twice as many non-drivers as drivers think that drug drivers are likely to be caught. These are the figures for the Wave 1 survey. The figures for the Wave 2 survey are again very similar. Results for all respondents are shown in Table 12. As Table 12 shows, in the Wave 3 survey, there may have been an increase in the number of people who think drug drivers are very or fairly likely to be caught, but this increase is not statistically significant.

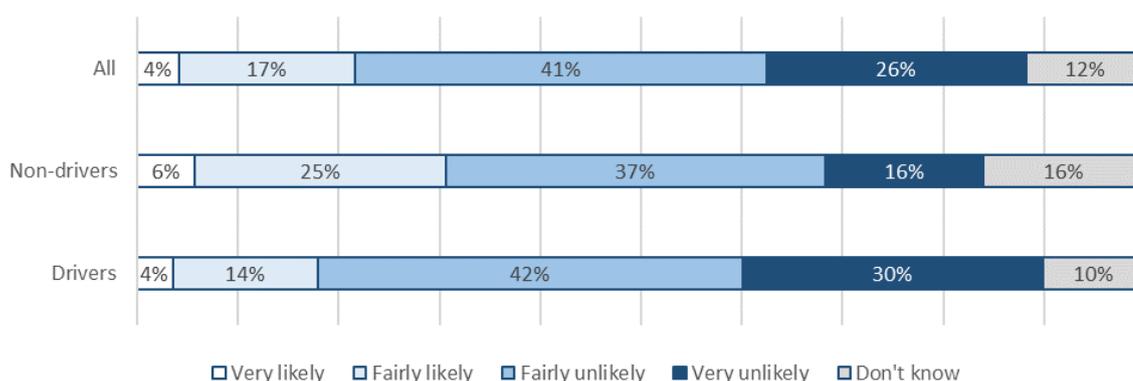


Figure 36: Perceptions of likelihood of being caught

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions
 Base: 1,092 respondents. 762 Drivers, 330 Non-drivers

Table 12: Perceptions of likelihood that drug drivers will be caught

	Very likely	Fairly likely	Fairly unlikely	Very unlikely	Don't know
Wave 1 - January 2015	4%	17%	41%	26%	12%
Wave 2 - April 2015	4%	17%	39%	29%	10%
Wave 3 - April 2016	6%	25%	47%	19%	2%

Source: ONS Opinions and Lifestyle bespoke questions, Risk Solutions
 Base: 1,092 respondents. 762 Drivers, 330 Non-drivers

Summary

6.20 From the information provided in this section we can say that:

- There was high awareness of the existing drug driving legislation before introduction of the new regulations, with higher awareness among male drivers than female drivers. Awareness of the new offence increased (among drivers, from 16% to 48%) after the publicity around its introduction but no significant

increase was observed a year later. Awareness does not now differ significantly between men and women.

- While there was generally a high awareness of the existing drug driving legislation across all age groups surveyed (84-93%), awareness of the new offence (5-22%) was lower prior to its introduction, particularly among the 16 to 25-year old group. After its introduction, and the publicity surrounding the introduction, there was no longer a significant difference by age group as awareness increased more among younger people.
- Most people think that the punishment for drug driving should be the same as for drink driving (74% in Wave 1, 75% in Wave 2 and 81% in Wave 3, with the differences between waves not statistically significant), and a similar proportion think that drug driving is about as dangerous as drink driving (73% in Waves 1 and 2, and 76% in Wave 3, with the difference between waves not statistically significant). Among the non-drivers, about 10% of the respondents think that drug driving is less dangerous than drink driving. This has not changed in subsequent omnibus waves.
- Most people (~80%) think that drug drivers are unlikely to be caught although 31% of non-drivers believe that they will be caught, compared with 18% of drivers. There has been no significant change in this in subsequent survey waves.

Prevalence of drug driving

- 6.21 The prevalence of drug driving has been assessed primarily through reference to the Crime Survey for England and Wales (CSEW) - (See Section 3 for further information on CSEW). This includes some self-completed questions, where the respondent enters data themselves, so that the interviewer cannot see their answers. This part of the survey includes some questions about driving under the influence of alcohol and or drugs.
- 6.22 Figure 37 shows the percentage of **all drivers** who reported having driven while under the influence of illegal drugs in the previous 12 months. The chart suggests that drug driving has reduced in prevalence since 2009/10. There was a small increase in 2013/14 over 2012/13, followed by an apparent decrease in 2015/16. However, as the confidence intervals overlap, we cannot say that the figures for 2012/13 to 2015/16 are statistically significantly different.

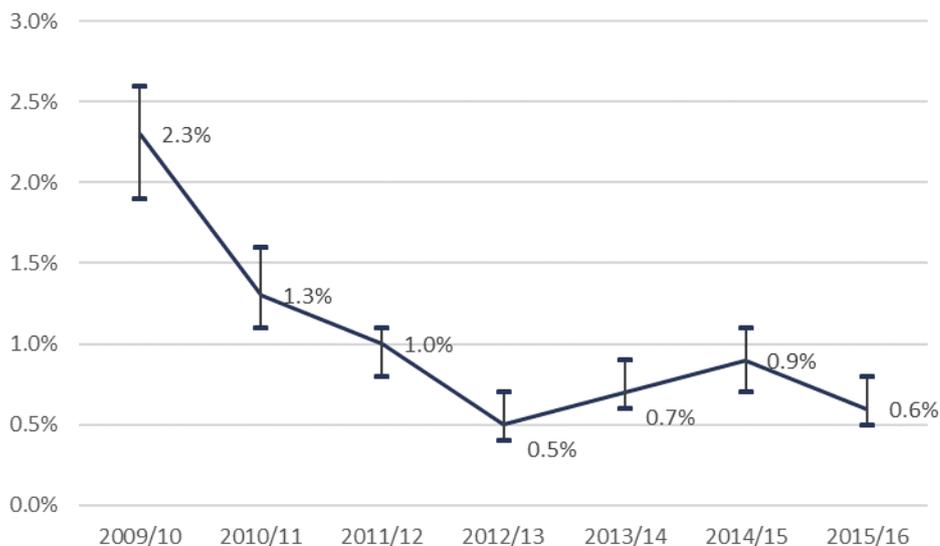


Figure 37: Percentage of drivers who reported having driven under the influence of illegal drugs in the last 12 months

Source: ONS Crime Survey for England and Wales, Risk Solutions

Base: 2009/10 10,507, 2010/11 10,221, 2011/12 19,935, 2012/13 15,652, 2013/14 15,805, 2014/15 14,606, 2015/16 15,510

Note – the bars on the chart represent the 95% confidence limits around each data point.

- 6.23 The THINK! campaign has carried out surveys of drivers, and their July 2013 survey indicated that 1% of respondents had driven after smoking cannabis, while for driving after taking Class A drugs the figure was less than 1%. The THINK! survey undertaken in July 2015⁴⁵ indicated that 2% of respondents had driven after smoking cannabis, and 1% after taking class A drugs. These results are a little higher than the values in Figure 37. This may be a result of different sampling strategies between the two surveys. Another survey, by the RAC⁴⁶, reports that 7% of those surveyed admitted to driving ‘under the influence of either illegal drugs or banned prescription medication’, compared with 6% in the previous year’s survey – the sampling method used for this survey is not known.
- 6.24 Figure 38 looks **at drivers who have taken illegal drugs** in the last 12 months. This shows that in 2013/14 11.3% of such drivers reported having driven while under the influence of illegal drugs in the past 12 months. The value for 2015/16 is significantly⁴⁷ lower than previous values on the chart.

⁴⁵ THINK! Road Safety Biennial Survey 2006 – 2015, TNS, May 2016

⁴⁶ RAC Report on Motoring 2016, September 2016 ISBN 978-0-9576829-3-1. Sample size was 1,714, sampling methodology not stated.

⁴⁷ Statistically significant different at a 95% confidence level.

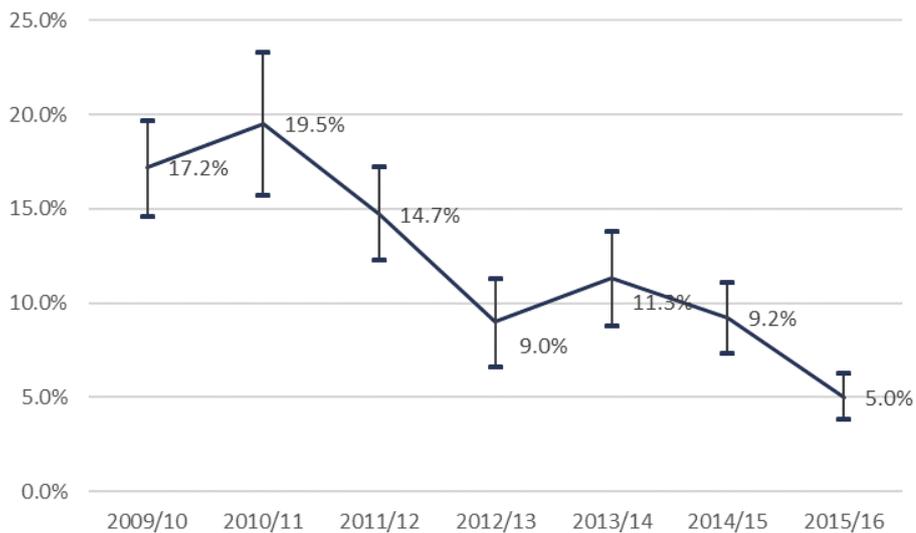


Figure 38: Percentage of drivers who reported taking illegal drugs in the last 12 months who also reported having driven while under the influence of illegal drugs in the last 12 months

Source: ONS Crime Survey for England and Wales, Risk Solutions
 Base: 2009/10 1,211, 2010/11 611, 2011/12 1,156, 2012/13 826, 2013/14 887, 2014/15 1,285, 2015/16 1,829.(those who have taken illegal drugs)

6.25 Looking at the breakdown by gender, Figure 39 shows that fewer women than men report having driven while under the influence of illegal drugs. In 2015/16, 6.3% of men (11.5% in 2014/15) and 2.7% of women (4.2% in 2014/15) who had taken illegal drugs in the last 12 months reported that they had driven while under the influence of illegal drugs. For 2015/16, as a percentage of all drivers, 1.0% of men and 0.2% of women reported that they had driven while under the influence of illegal drugs in the last 12 months.

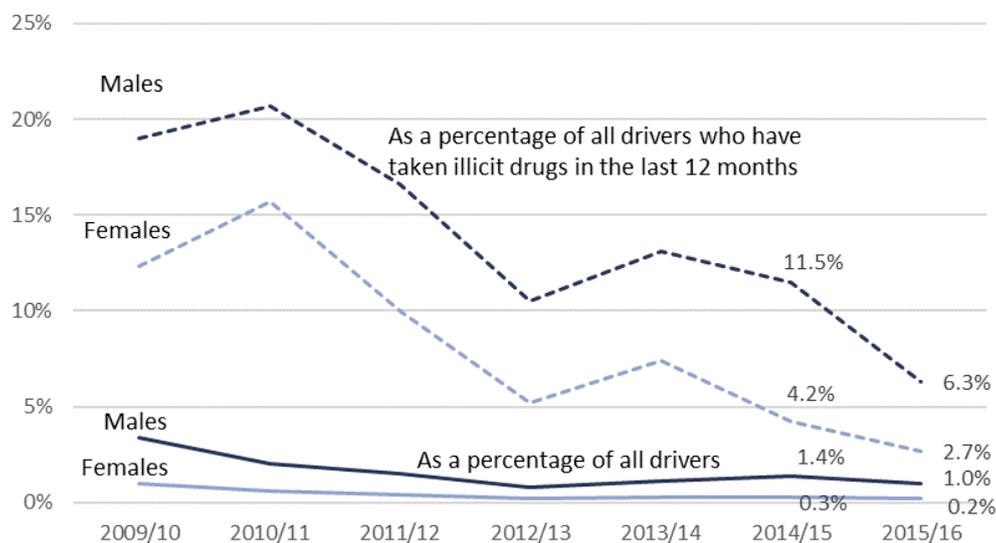


Figure 39: Percentage of drivers who reported driving under the influence of illegal drugs in the last 12 months

Source: ONS Crime Survey for England and Wales, Risk Solutions
 Bases: All Drivers: Men: 2009/10 5,237, 2010/11 4,977, 2011/12 9,743, 2012/13 7,458, 2013/14 7,689, 2014/15 7,006, 2015/16 7,362. Women: 2009/10 5,270, 2010/11 5,244, 2011/12 10,192, 2012/13 8,194, 2013/14 8,116, 2014/15 7,600, 2015/16 8,148.
 Drivers who have taken illicit drugs in the last 12 months: Men: 2009/10 845, 2010/11 435, 2011/12 806, 2012/13 559, 2013/14 584, 2014/15 829, 2015/16 1,118. Women: 2009/10 366, 2010/11 176, 2011/12 350, 2012/13 267, 2013/14 303, 2014/15 456, 2015/16 711.

6.26 Figure 40 shows the percentage of drivers in different age groups who reported having driven under the influence of illegal drugs in the last 12 months. Note that the younger age groups cover smaller age ranges than the older bands. Also note that unlike Figure 39, this shows the percentage of all drivers within an age group who reported driving under the influence of drugs, not of those who reported taking illicit drugs in the past 12 months. This shows clearly that younger drivers report higher levels of driving while under the influence of illegal drugs than older age groups, although the youngest age group (16-19) report lower levels of drug driving than the 20-24 age group. Levels of drug driving have been broadly similar since 2011/12.

6.27 Figure 40 does not show the confidence limits around the individual data points as we did not have access to this data. Consequently, the apparent convergence between different age bands from 2009/10 to 2012/13 may be subject to sampling error and we have not been able to assess this.

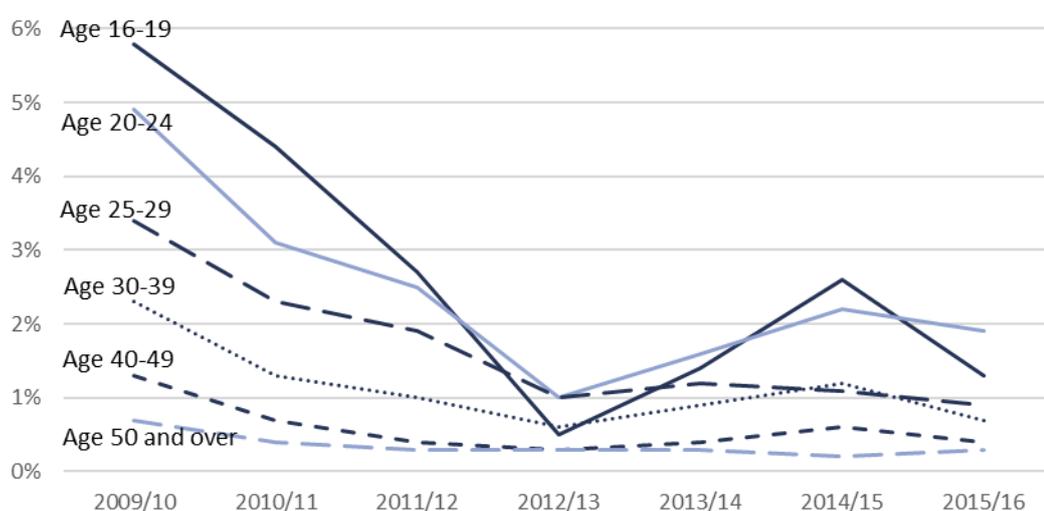
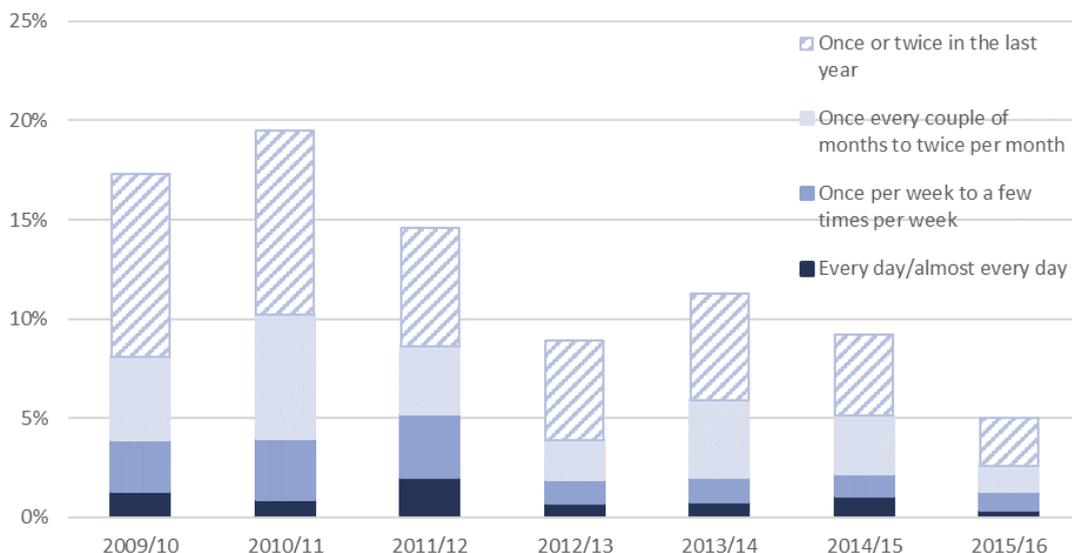


Figure 40: Percentage of all drivers who reported driving under the influence of illegal drugs in the past 12 months, by age group

Bases:	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Age 16-19	346	269	443	312	295	253	136
Age 20-24	666	596	1,188	830	835	749	456
Age 25-29	1,032	952	1,942	1,446	1,434	1,373	866
Age 30-39	2,765	2,632	5,064	4,041	3,986	3,739	2,204
Age 40-49	3,104	3,143	6,076	4,745	4,799	4,387	2,504
Age 50 and over	2,594	2,629	5,222	4,278	4,456	4,105	2,294



6.28 Figure 41 shows the frequency of self-reported drug driving among all drivers who reported having taken illegal drugs in the last 12 months. Note that 95% of such drivers said they had not driven while under the influence of illegal drugs. The last year suggests a small reduction in those reporting that they drug drive every day or almost every day although the sampling error for a base of about 1,800 means that this is unlikely to be statistically meaningful. The proportion saying they drug drive once per week to a few times per week has remained essentially unchanged.

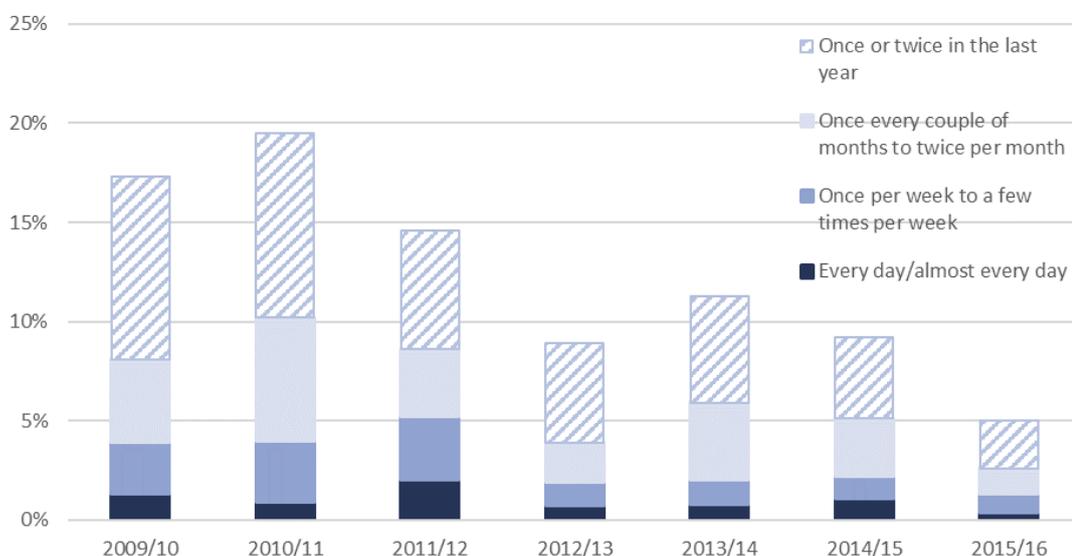


Figure 41: Frequency of drug driving as a proportion of all drivers who have taken drugs in the last 12 months

Source: ONS Crime Survey for England and Wales, Risk Solutions

Bases: 2009/10 1,211, 2010/11 611, 2011/12 1,156, 2012/13 826, 2013/14 887, 2014/15 1,285, 2015/16 1,829.

Road safety

6.29 As described in Section 2, road safety was a primary driver for introduction of the new legislation. All road traffic collisions where someone is injured are reported in

STATS19 data. Here we examine the evidence in STATS19 for drug driving as a contributory factor to road traffic collisions.

- 6.30 Table 13 shows information about the numbers of road traffic collisions in England and Wales⁴⁸ where the attending police officer considered that drug driving was a contributory factor (CF), together with information on vehicle miles travelled in each year. This sub section looks first at numbers of collisions, then at fatalities and injuries associated with those collisions.

Table 13: Traffic volumes and collisions where drug driving cited as contributory factor 2006 – 2014 for England and Wales

Year	Billions of vehicles miles (all vehicles)	Collisions with drug driving as a CF		
		Number of collisions	Number of fatalities	Number of serious injuries
2006	284.1	582	57	236
2007	286.5	633	66	232
2008	283.6	638	53	257
2009	280.8	585	47	233
2010	276.4	526	39	199
2011	277	588	49	216
2012	275.7	564	29	222
2013	276.7	554	32	225
2014	283.4	643	51	249
2015	288.7	818	60	326

Source: Source: Table TRA0106 from <https://www.gov.uk/government/statistical-data-sets/tra01-traffic-by-road-class-and-region-miles> and similar tables for previous years, STATS19, Risk Solutions

Numbers of collisions

- 6.31 Figure 42 presents data on road traffic collisions where drug driving was considered by the attending police officer to be a contributory factor, while the uppermost line shows the numbers of collisions where drink driving was considered to be a contributory factor. European research⁴⁹ suggests that the prevalence of illicit drugs in the general driving population is about 55% of that for alcohol; if this relationship extends to impairment, it implies that the numbers of incidents where drugs were a contributory factor would be 55% of the number for which drink driving was considered to be a CF. The difference between this and the numbers suggested by looking at incidents where drug driving was used as contributory factor by the reporting police officer may result from under reporting of drug driving – from under use of the CF for drug driving, as noted in the following paragraph. The middle line on Figure 42 shows data inferred on this basis. The numbers of collisions have been

⁴⁸ Road safety metrics presented in this section are for England and Wales unless otherwise stated. Scotland has not introduced the new offence, and has introduced other measures that might affect some of these measures, e.g. the introduction of a lower alcohol limit for drink driving.

⁴⁹ DRUID, Driving under the influence of Drugs, Alcohol and Medicines, DRUID Main Results, 6th Framework Programme, 2011

normalised by the aggregate vehicles miles in each year to allow meaningful comparison between years.

6.32 There is an apparent increase in the use of drug driving as a contributory factor in STATS19 reports. This is not unexpected; DfT has anecdotal and emerging research evidence that drug-driving has historically been under-used as a contributory factor. It is likely that the increase reflects increased reporting, as awareness of drug driving among police officers attending collisions is likely to have increased, for several reasons:

- The introduction of the new offence will have resulted in increased awareness
- Among roads policing officers, additional training relating to the new offence will have increased awareness, as will the introduction and use of preliminary drug screening equipment
- Most police forces have a policy in place specifying that for serious collisions drivers should wherever practicable be screened for drugs
- General publicity about the new offence will have increased awareness among police officers as well as among the general public.

6.33 For these reasons, while we present figures below year by year, it is not yet possible to determine the impact of the new offence on the numbers of collisions, injuries and fatalities where drug-driving is a contributory factor. Continued monitoring of the use of drug-driving as a contributory factor would be necessary to provide evidence that might indicate whether road safety benefits are being realised.

6.34 The lack of any clear trend for the drug driving measures prior to 2015 contrasts with the picture for drink driving, where, as the figure shows, there has been a consistent downwards trend in the number of collisions where drink driving is cited as a contributory factor. The DRUID derived line for drug driving incidents follows the trend for drink driving, as it is based on a linear relationship with drink driving. It is also clear from Figure 42 that drink driving is cited as a contributory factor more often than drug driving – by a factor of about 7 in 2014, and 5.5 in 2015.

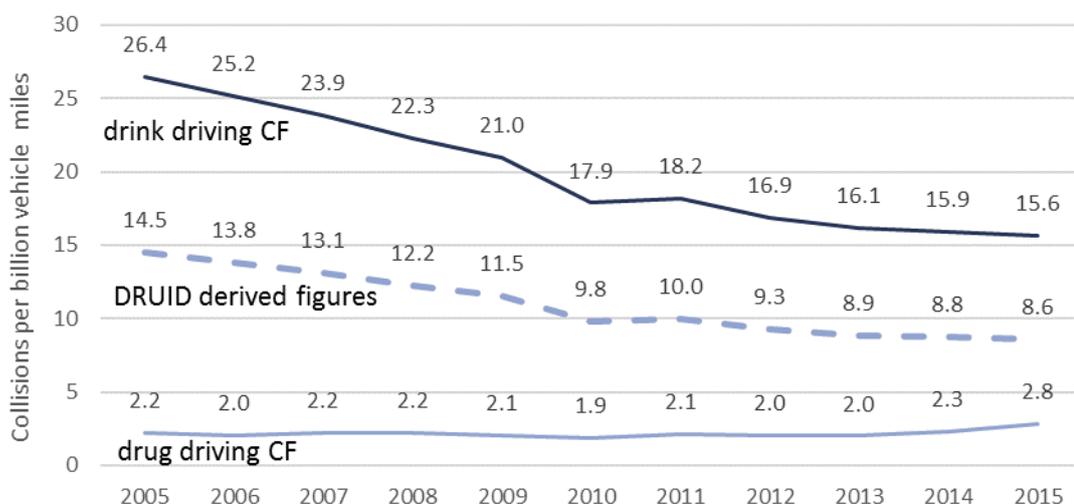


Figure 42: Collisions where drug driving stated as contributory factor – collisions per billion vehicle miles (England and Wales)

Source: STATS19, <https://www.gov.uk/government/statistical-data-sets/tra01-traffic-by-road-class-and-region-miles>, Risk Solutions

Fatalities and injuries

- 6.35 There are two key measures for looking at injuries and deaths as a result of drug driving:
- KSIs – killed or seriously injured – calculated as numbers of fatalities + numbers of serious injuries
 - Number of fatalities.
- 6.36 Looking at these year-by-year may suggest trends that are in reality caused by differences in the numbers of miles driven by year. Therefore, we have expressed the measures in terms of the numbers of KSIs, and fatalities per billion vehicle miles driven. Before looking at measures for injuries and deaths as a result of drug driving, it is informative to look at the overall picture for road safety, as indicated by data from STATS19, so for each of these measures, we first look at trends for all incidents in STATS19.
- 6.37 Figure 43 shows KSIs per billion vehicle miles for all collisions recorded in STATS19. This shows a steady downward trend⁵⁰ in fatalities and serious injuries over time.

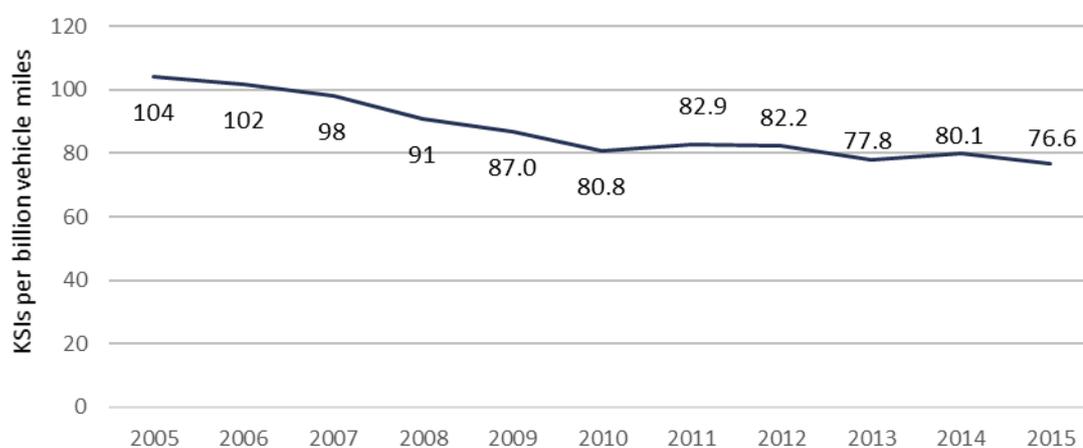


Figure 43: Number of KSIs per billion vehicle miles, all collisions in STATS19

Source: Source: STATS19, <https://www.gov.uk/government/statistical-data-sets/tra01-traffic-by-road-class-and-region-miles>, Risk Solutions

- 6.38 The lower line in Figure 44 shows the numbers of KSIs per billion vehicle miles driven for collisions where drug driving was cited as a contributory factor in STATS19. The number of KSIs per billion vehicle miles has remained relatively flat, with an average of 1.0 KSIs per billion vehicle miles for the period 2005 to 2014, and 0.97 KSIs per billion vehicle miles for 2012 to 2014. In line with the increase in collisions where drug driving was cited as a CF, there was a small apparent increase in KSIs in 2015. We consider this to be a result of increased use of the CF, rather than an actual increase in KSIs as a result of drug driving. The upper line indicates a reduction in KSIs from 2005, in line with the reduction in collisions where drink driving is cited as a contributory factor, as shown in Figure 42.

⁵⁰ Fitting a trend line (e.g. a power relationship) can account for more than 90% of the variation between years.

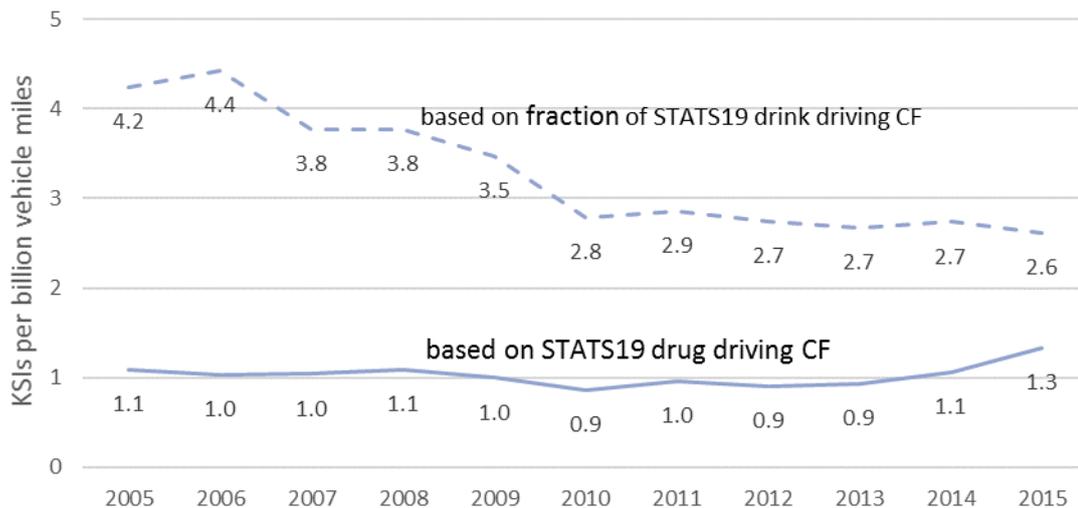


Figure 44: Number of KSIs per billion vehicle miles, collisions involving drug driving

Source: STATS19, <https://www.gov.uk/government/statistical-data-sets/tra01-traffic-by-road-class-and-region-miles>, Risk Solutions

6.39 Figure 45 shows fatalities for all road traffic collisions in STATS19, expressed per billion vehicle miles, while Figure 46 shows those where drug driving was cited as a CF. Road traffic collision fatalities have reduced from 10 per billion vehicle miles in 2005 to 5.4 per billion vehicle miles in 2015, and again, show evidence of a sustained downwards trend.

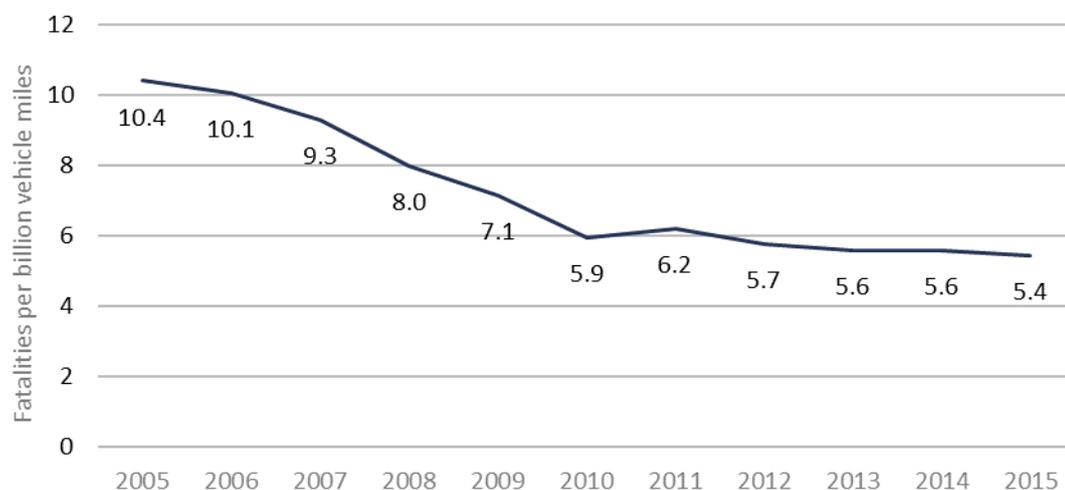


Figure 45: Number of fatalities per billion vehicle miles, all collisions in STATS19

Source: STATS19, <https://www.gov.uk/government/statistical-data-sets/tra01-traffic-by-road-class-and-region-miles>, Risk Solutions

6.40 As for other road safety measures considered here, fatalities per billion vehicle miles for road traffic collisions where drug driving was cited as a CF appear to have increased in 2015. Again, we believe this is likely to be a result of increased awareness. In particular, preliminary drug screening for drivers involved in collisions is likely to be more frequently and more consistently used for collisions where

fatalities occur, providing officers with more information to determine whether to cite drug driving as a CF. Most police forces we spoke to said that their policy is to use preliminary drug screening for serious road traffic collisions. Monitoring this metric should provide an earlier indication of the impact of the new offence on road safety than metrics including injuries. Continuing to compare it with the DRUID derived approach (based on a fraction of incidents where drink driving is cited as a CF) may also provide interesting and useful information to inform any future assessment of impact, if monitoring suggests a consistent relationship between the two over time.

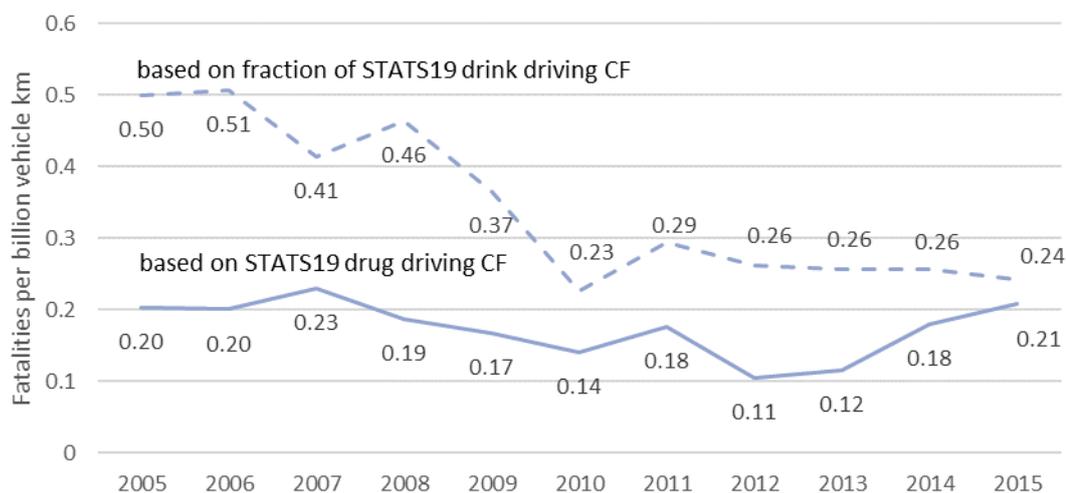


Figure 46: Number of fatalities per billion vehicle miles for collisions involving drug driving

Source: STATS19, <https://www.gov.uk/government/statistical-data-sets/tra01-traffic-by-road-class-and-region-miles>, Risk Solutions

- 6.41 We have also looked at the STATS19 data where drug driving was cited as a contributory factor to see whether drivers were men or women. Care must be exercised however as the numbers are small (see Table 13 for absolute numbers of fatalities and serious injuries), and so some variability should be expected. However, looking at 2007 to 2014, approximately 13% of KSIs and fatalities were associated with collisions where the driver was a woman, and 87% where the driver was a man. Looking at differences by age group over the same time period shows that around 33% of KSIs and fatalities where impairment by drugs was cited as a contributory factor were associated with collisions where the driver was aged under 25 years of age.

Coroner's data on toxicology tests

- 6.42 DfT supplied us with data collected by TRL on the presence of drugs in toxicology samples analysed for Coroners. The TRL work is based on samples of a variety of natures, and look only at the presence of drugs – they do not indicate impairment. Not all road traffic collision fatalities are subject to toxicological analysis, and not all results were available to TRL. In 2014, the results are based on analysis of samples for approximately 570 fatal collisions, equivalent to approximately 32% of the total number of fatal collisions recorded in STATS19 for that year. Of the driver fatalities for which TRL had data, the presence of drugs was indicated in the following proportions of road traffic collision fatalities:

Table 14: Coroners' data: driver fatalities where presence of drugs was indicated

Year	Percentage of driver fatalities where presence of drugs was indicated
2011	47%
2012	52%
2013	50%
2014	50%

Source: TRL, Risk Solutions

- 6.43 The absolute numbers from the TRL research are shown below in Table 15 and compared with data from our analyses of STATS19 data. The TRL numbers are much higher than the estimates using the STATS19 CF code for drugs, or the DRUID type approach. This is to be expected because as noted above, Coroners report only the presence of drugs. This in itself is not sufficient to establish impairment; it is possible that in many cases drugs were present in quantities that would not cause impairment. In addition, Coroners are more likely to carry out full toxicology tests if they have reason to think that drugs may have been a factor, and conversely, are less likely to do so if they have no reason to think that drugs were a factor. This could result in a bias that increases the numbers of samples proving positive for drugs.

Table 15: Fatal collisions where drugs may have been a contributory factor (whole of GB)

Year	Fatal Collisions Recorded in STATS19	Fatal collisions in STATS19 where CF for drugs used	Based on DRUID approach: 55% of figure for fatal collisions in STATS19 where CF for alcohol used	Coroners data – no. of fatal collisions where drugs detected for driver
2009	2,222	453	117	
2010	1,850	42	72	*
2011	1,901	54	91	235
2012	1,754	32	79	280
2013	1,713	36	76	293
2014	1,775	55	78	285
2015	1,616	67	75	not available

Source: STATS19, TRL, Risk Solutions

Note the figure for 2010 was not for a full year and so has not been quoted.

Potential impact on those taking prescribed drugs

- 6.44 During consultation prior to the introduction of the new offence, concerns were raised about potential adverse effects on people taking drugs for medical purposes. Some people were concerned that patients might not take their prescribed medication if they feared being stopped for drug driving, for example. The legislation includes two features to help address this:
- The regulations specify higher limits for those drugs that are generally prescribed for medical purposes, based on road safety risk, while those that are generally illegal have lower, ‘zero tolerance⁵¹’ limits.
 - As some of the ‘zero tolerance’ drugs are prescribed, albeit to relatively small numbers of people, a medical defence is available. This provision is intended to protect people against the Section 5A offence, if they are taking prescribed or over the counter medication in line with the advice of a healthcare professional, or the pack instructions for over the counter medicines.
- 6.45 However, it remains the case that if driving while impaired due to drugs (whether illicit, prescribed, or over the counter medicines), people can be charged with the Section 4 impairment offence. There is no medical defence under the section 4 offence if impaired to drive whatever drug has been taken.
- 6.46 We interviewed a number of representatives of third sector organisations, and several members of the medical community. Doctors generally thought that the legislation would make it easier to have conversations with patients about the effect of medication on driving, and whether they should be driving, particularly about doses of pain medication, where the levels that affect driving are broadly in line with doses above which evidence suggests that additional benefits in pain reduction are low.
- 6.47 Some concerns were expressed about how the medical defence would work; while those we interviewed knew it existed, they were unsure how it would operate, and therefore how to advise those who might be affected by it. This was particularly true for third sector organisations. One comment was that this would rely on ‘the intelligent discretion of the police’ to invite suspects to use the medical defence where appropriate. Police officers interviewed prior to and after the introduction of the new offence were all aware of the medical defence, and noted that normal custody procedures include asking all arrestees about any drugs they are taking, for welfare purposes, and that the MGDD suite of forms also includes for relevant information to be recorded.
- 6.48 Note also that DfT offered training on the new drug driving legislation to all police forces who requested it, and most took up the offer. This training included reference to the medical defence.
- 6.49 A selection of police forces completed forms for incidents where drug driving was suspected, and this included a request that they indicate where a medical defence was raised. We found no evidence in these forms, or from interviews with police officers, that the medical defence had been used. This does not mean that it has not been used, simply that we have no evidence to demonstrate that it has.

⁵¹ The levels are not ‘zero’ as some allowance must be made for example for accidental exposure.

Evidence on extent of use of medicines included in the regulations

- 6.50 We found little evidence on the prevalence of driving while impaired by psychoactive medicines. However, the DRUID⁵² project includes some relevant information. DRUID prevalence studies suggest that medicinal opiates and opioids and benzodiazepines⁵³ are less prevalent in the driving population in Europe than illicit drugs or alcohol, and that this is also true for drivers involved in collisions. The mean EU prevalence for benzodiazepines was 0.9% (range 0.14-2.73%). For medicinal opioids DRUID found an EU mean prevalence of 0.35% (range 0.00-0.79%). Note however, that regional differences were observed, with higher prevalence for medicinal opioids and benzodiazepines in northern European countries.
- 6.51 Interestingly, while illicit drug use appears to be most prevalent among young men, DRUID found that benzodiazepine use was most prevalent among mature female drivers and in daytime hours. The research also found that medicinal opioids were most prevalent in older drivers (above the age of 50) and among women drivers.

Public health

- 6.52 Reducing illicit drug use is one of the desirable outcomes for the introduction of the new drug driving offence. Evidence from the Crime Survey for England and Wales for 2015/16⁵⁴ suggests that the overall trend in the proportion of adults taking an illicit drug in the last year has been essentially stable at between 8% and 9% since 2009/10, following a decreasing trend from a peak in 2003/04. In 2015/16 the proportion of adults taking any illicit drug was 8.4%, similar to the value of 8.6% for 2014/15.
- 6.53 Cannabis remained the most commonly used drug, used by 15.8% of 16 to 24 year olds and 6.5% of 16 to 59 year olds. The next most commonly used drug was powder cocaine, used by 4.4% of 16 to 24 year olds and 2.2% of 16 to 59 year olds, however in the younger age group, the last year use of Ecstasy was slightly higher than for cocaine, at 4.5%.
- 6.54 Some of the interested parties we interviewed thought that a potential adverse impact of the new drug driving offence might be that drug users would switch to New Psychoactive Substances (NPS), which are not specified in the regulations. In September 2014 an Expert Panel appointed by the Home Office produced a review of NPS which provided recommendations to the Government⁵⁵. They identified at the European Level that there were 81 novel NPS detected in 2013, an increase from 74 in 2012, 49 in 2011 and 41 in 2010, the largest group being synthetic cannabinoids. NPS are readily available in the UK online, but most users obtain NPS through friends.

⁵² Chulze, H., Schumacher, M., Urmeew, R., Auerbach, K. (2012) DRUID Final Report: Work performed, main results and recommendations. 01/08/2012. Project No TREN-05-FP6TR-S07.61320-518404-DRUID. European Commission. Available at http://www.druid-project.eu/Druid/EN/Dissemination/downloads_and_links/Final_Report.pdf?__blob=publicationFile

⁵³ Benzodiazepines include clonazepam, diazepam, flunitrazepam, lorazepam, oxazepam and temazepam.

⁵⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541542/drug-misuse-1516.pdf

⁵⁵ September 2014. New Psychoactive Substances Review – Report of the Expert Panel. The Home Office. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368583/NPSexpertReviewPanelReport.pdf

- 6.55 NPS use is generally low compared to the more frequently used drugs such as cannabis, powder cocaine and ecstasy, although use is higher in certain subgroups. In 2013/14 mephedrone was the most prevalent of the NPS, but use has fallen. The 2015/16 CSEW reported a drop in last year use of mephedrone compared with 2014/15 from 1.9% to 0.9% of 16 to 24 year olds⁵⁶, and from 0.5% to 0.3% of 16 to 59 year olds; these were statistically significant reductions. The 2015/16 CSEW also reported that mephedrone use has been falling steadily since questions were first asked in 2010/11, from 1.3% of adults in 2010/11 to 0.3% in 2015/16 The CSEW for 2015/16 also reports the use of any NPS in the last year, with 2.6% of 16 to 24 year olds and 0.7% of 16 to 59 year olds using any NPS in the last year; these estimates are not statistically significantly different from those measured by the 2014/15 survey.
- 6.56 The fall may, in part, be due to control of this substance being introduced. The 2014 UK component of the Global Drug Survey (a survey which is focussed towards clubbers) suggests that 7.9% of respondents had used mephedrone in the last year, compared with 19.8% who had used ketamine, 45.2% who had used MDMA and 53.6% who had used cannabis.
- 6.57 Work at the Centre for Public Health, Liverpool John Moores University, has reviewed a number of recent major surveys that aimed to estimate the prevalence of NPS use⁵⁷. This suggests that prevalence rates are low compared with those for other illegal drugs. The review found no evidence that those who use NPS have different characteristics from those who use other drugs.
- 6.58 While reducing drug use generally is one of the desirable outcomes for the introduction of the new drug driving offence, there are other programmes aimed at reducing supply and demand of illicit drugs, and other influences on drug use. Consequently, it will be very difficult to attribute any change to the introduction of the new offence. The market for, and prevalence of use of, NPS is also subject to many other influences, and again it will be difficult to attribute any changes to the new drug driving offence.

Disruption to general crime

- 6.59 The potential for the new offence to disrupt general crime was suggested to us by police officers we interviewed in the scoping stage for the work. General crime disruption is not an objective of the policy – any effect would be an unanticipated consequence. Interviews a year after Section 5A came into force also suggested that Section 5A has been of use in disrupting general crime. This is not surprising, as disrupting criminality is one of the items prioritised in the NPCC's Roads Policing Strategy⁵⁸.
- 6.60 Quantifying the impact of Section 5A on general criminality is not straightforward. Police forces we have spoken to have not attempted to quantify any perceived benefits, but have noted that they think the new offence is having a positive effect on general crime disruption, because many of those stopped are 'known' to the police, that is, they have been arrested previously, for offences other than drug-driving.

⁵⁶ July 2016. Drug Misuse: findings from the 2015/16 Crime Survey for England and Wales. Second Edition. Statistical Bulletin 07/16.

⁵⁷ 2015, Sumnall HR, Epidemiology of Use of Novel Psychoactive Substances

⁵⁸ NPCC (2015) Policing the Roads in Partnership – 5 Year Strategy 2015 – 2020 http://library.college.police.uk/docs/NPCC/Policing_the_Roads_in_Partnership_2015.pdf

Police believe that the new offence is therefore denying some criminals use of the roads for some time, and reducing other criminal activity.

- 6.61 Merseyside Police is among those who believe the new offence has helped to disrupt crime.

Crime disruption using the new offence

The Matrix team at Merseyside Police believe the new offence - and the new technology accompanying it – can help to disrupt general crime. In March 2016, they conducted an operation targeting locations of recent firearms discharges, and locations where they knew that there were ongoing local disputes between criminal gangs, aiming to disrupt crime. The operation was not designed specifically to use the new drug driving offence to disrupt crime, the new offence was an additional tool available to police officers in the course of their work.

When a vehicle was stopped for any matter, and a power allowed it, consideration was given to carrying out saliva testing for drug use. The team used both DrugWipe devices, and a mobile Draeger device. The Draeger was transported in a police carrier, using the vehicle's on board charger to keep it charged between uses.

During March 2016 Merseyside arrested 21 people for drug driving offences – of whom the majority were persons who had been criminally active in the recent past. A number of them were members of organised criminal groups.

Matrix team officers were encouraged by the availability of the new Section 5A offence and associated technology, and expressed a wish to have permanent access to preliminary drug screening technology while on patrol. They now have their own, dedicated mobile Draeger device.

Source: Merseyside Police

- 6.62 Where police have provided follow-up data to us following arrests for the new offence, we have sought information on final charges, including charges for offences other than drug-driving. Our data includes 3,867 records where the incident took place after the introduction of the new offence. Of these, we know the final charge (including those where no further action was taken, e.g. because the saliva test was negative) for 3,075 records. We have 1,049 records where a drug driving charge was made, or a charge of failure to provide a sample of blood. Of these 1,049, around 20% show 'other' charges, including a large number of offences such as no insurance, driving other than in accordance with a licence, and no vehicle tax.
- 6.63 Around 12% of the 1,049 records where we have information on final charges include charges for possession of Class B or Class A drugs, while about 1% show charges for possession with intent to supply, or conspiracy to supply. Other charges recorded include money laundering, taking a vehicle without consent, aggravated vehicle theft, shop lifting, robbery, bilking, and criminal damage.
- 6.64 It is also worth noting information provided by Cheshire Constabulary. They started monitoring whether people arrested for drug driving had been arrested previously by Cheshire Constabulary, for any offence. Of the 594 arrests made for drug-driving since they started this monitoring, almost 60% of those arrested were already known to them; that is they had been arrested previously. This is in line with information presented on previous offences, in paragraph 5.47 onwards, which suggests that

some 67% of those convicted of a drug driving offence have one or more previous convictions and more than 20% have 15 or more previous convictions. Previous convictions include a few previous drug-driving convictions, and are dominated by acquisitive crime. This evidence supports the view that general crime disruption may be a consequence, albeit unanticipated, of the introduction of the new drug driving offence.

7 CONCLUSIONS

Objectives of the policy and of this evaluation

The overall policy objective for the new drug driving offence is to improve road safety by reducing the risk that drug drivers pose by reducing its prevalence in the driving population. To achieve this overall objective, DfT aims to:

1. Deter people from taking illegal drugs in the first place and those who abuse(⚡) their medication.
2. Enable more effective enforcement against those who persist in taking illegal drugs and continue to drive.
3. Increase the efficiency of enforcement activity against drug drivers.

Evaluation

This evaluation set out to assess the implementation, operation and short-term impacts of the new drug-driving offence.

(⚡) Note – ‘abuse’ here means taking prescribed medication other than in accordance with the directions of a healthcare professional, or taking over-the-counter medication other than in accordance with the manufacturer’s instructions..

- 7.1 Overall, while it is too soon to say whether the overall policy objective has been achieved, we conclude that the implementation of the new offence has been successful for reasons stated here.

Effective and efficient enforcement

- 7.2 We have found that police are using the new offence – prosecutions under the new Section 5A were higher in 2015 than for the pre-existing Section 4 impairment drug driving offences, and the latter were at a similar level to 2014. There is evidence that use of the new offence rose steadily throughout 2015 and has increased in 2016. Higher conviction rates for drug driving are being realised, and police have told us that they can process Section 5A cases more quickly than Section 4 cases. Therefore, more effective enforcement against drug drivers has been achieved, and the efficiency of enforcement activity against drug drivers has increased.

Road safety

- 7.3 It is too early to say whether road safety benefits have been realised – further monitoring will be needed and attribution will be difficult - however, if the theory of change proves to be correct we would expect road safety benefits to be realised.
- 7.4 While it is too soon to determine whether there is a statistically significant and sustained downward trend, the percentage of people who reported taking illegal drugs in the last twelve months and who also reported driving while under the influence of those drugs, reduced from 9.2% in 2014/15 to 5.0% in 2015/16.

Public awareness

- 7.5 Public awareness of the new offence has increased. Prior to introduction of the new offence, 12% of non-drivers and 16% of drivers said they were aware of the new offence. This increased to 32% and 48% respectively, after the new offence was implemented.

- 7.6 From interviews with relevant stakeholders, we found no evidence that users of prescribed medicines that fall into those categories of drugs covered by the legislation have been adversely affected by the new regulations. Similarly, we found no evidence that the associated concerns raised by patient representative groups have been realised. However, the offence is still relatively new and we cannot say there has been no effect, so there may be a need to monitor this over a longer period to confirm this.

Unanticipated impacts

- 7.7 As well as removing drug drivers from the roads, police forces believe the new offence has helped disruption of criminality more widely.

8 RECOMMENDATIONS

- 8.1 Our recommendations are mostly concerned with ongoing monitoring. We understand that several of these recommendations are already in hand.
- 8.2 DfT should maintain dialogue with a few police forces or perhaps CPS regarding defence strategies, as new defences are still being tested, and in our sample, most 'not guilty' plea cases are yet to be tried.
- 8.3 About 32% of those producing positive saliva tests for THC (cannabis) returned blood analyses at or below the limit. DfT should consider whether this can be addressed – perhaps through suggesting more police forces find ways of minimising the time between saliva testing and the taking of blood samples. In addition, ensure that the ongoing review of 'guard banding' for analytical uncertainty continues.
- 8.4 DfT should consider recommending that police forces consider a campaign to remind officers to collect impairment evidence where practicable. In about 1 in 8 cases we found that blood could not be taken following a positive saliva test – while about a third of these were refusals, just over half were for medical reasons.
- 8.5 Given these medical reasons – DfT should consider whether to investigate what would be necessary to allow the use of alternative means of collecting blood samples – such as finer needles, and the use of vacuum extraction systems.
- 8.6 DfT and the Home Office should consider how best to share information about previous convictions of drug drivers, and to consider more widely the role that the new offence can play in general disruption of crime, and associated policy implications.

Ongoing monitoring of statistics

- 8.7 MoJ this year released experimental statistics – consider using these to monitor proceedings brought, and convictions, looking at Section 4 and Section 5A (Section 4 remains useful where blood cannot be obtained) to retain an overall picture of convictions for drug-driving.
- 8.8 Consider asking MoJ to repeat the analysis of Section 4 and Section 5A proceedings brought by police forces. Our research suggested differences between police forces in the extent to which drug driving offences were used. If differences persist, consider a focused piece of qualitative research with a sample of forces to explore the reasons for differences.
- 8.9 Continue to monitor STATS19 contributory factors for drink and drug driving. Once the use of the drug driving CF appears to be settling, or the relationship between those for drink and drug driving is settling, revisit the impact on drug-driving related fatalities and injuries, and consider undertaking a cost benefit analysis for the introduction and operation of the new offence.
- 8.10 There remains a need to improve understanding of the extent to which drugs are a contributory factor in road traffic collisions. To address this, the DfT and the Home Office could consider a trial (possibly at a regional level) where preliminary drug screening tests are administered at every road traffic collision where a police officer is in attendance.
- 8.11 The DfT and the Home Office should consider modifying the STATS19 form to record the results of any preliminary drug screening test administered to a driver involved in a road traffic collision.

APPENDIX A – DATA SOURCES AND DOCUMENTS REVIEWED

Documents reviewed

Centre for Applied Science and Technology, Home Office (2013) *Mobile Preliminary Drug testing Devices (Version 1)*

Cusack, D.A. (2012) Medical Bureau of Road Safety. *Report on Roadside Drug Testing and Equipment and Related Matters.*

DfT (2012) *Enforcement procedures against drink-drivers and other offenders – a consultation document (initial draft)*

DfT (2013) Response to Freedom of Information Request F0009956

Wolff, K. (2013) DfT *Driving under the influence of drugs*

DfT (2011) *Stats 20 – Instructions for the Completion of Road Accident Reports from non-CRASH Sources*

DfT (2011) *Strategic Framework for Road Safety*

DVLA (2016) Response to Freedom of Information Request 5520

Goodwin, P. (2013) TransportXtra.com/ltt Who is to blame for pedestrian casualties?

Jackson, P., Hilditch, C. (Clockwork Research 2010) *The role of medicines and illegal drugs in road accidents: a scoping study.*

Jackson, P., Hilditch, C. (Clockwork Research 2010) *A review of evidence related to drug driving in the UK: A report submitted to the North review team*

North, P (2010) DfT *Report of the Review of Drink and Drug Driving Law*

(2011) *The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving.*

Primary qualitative data

We interviewed a range of stakeholders from November 2013 to March 2014 during the scoping phase, and interviewed a wider range of stakeholders during February 2015, prior to the introduction of the new offence to explore their understanding of the new offence, any planning they had been involved in, and what they considered to be the most significant risks to successful introduction and operation of the new offence. In the scoping phase we conducted 12 interviews, with representatives of:

- Crown Prosecution Service
- Department of Health
- Department for Transport
- Driver and Vehicle Licensing Agency
- A forensic laboratory
- Home Office policy
- Home Office – Centre for Applied Science and Technology
- Ministry of Justice
- Four police forces.

In February 2015 we conducted 19 interviews, with the stakeholders listed above, and some additional stakeholders, including representatives of additional groups representing patient groups and medical professionals, coroners, and two additional forensic laboratories.

We conducted a further set of interviews with a similar group of stakeholders when the offence had been in place for about twelve months, to ask about their experiences regarding implementation of the new offence over that time, and whether any of the risks had been realised (three interviewees were not available to interview). In addition, we conducted brief interviews with representatives of an additional five police forces. In total we conducted 21 interviews.

Primary data on police activity

Several police forces collected data relating to incidents where preliminary drug screening equipment was used. Most used a bespoke form while others provided data from their own monitoring systems; no names or dates of birth were included. The form used is included at Appendix D. Police officers completed as much of the form as possible, and follow up information on laboratory analysis results was sought from laboratories and in some cases from police forces. Information on subsequent charges brought, and court outcomes, was sought from police forces. Data were entered into an Access database.

In total 22 police forces provided us with data. A small number of forces collected some data before introduction of the new offence, but too few records were obtained to use for any sort of baseline. Considering data collected after the introduction of the new offence, six forces provided data covering incidents occurring over periods of two to four months, seven provided data covering incidents occurring over periods of six to nine months, while the remaining nine forces provided us with data covering periods ranging from 13 to 18 months.

All forces who received grants from DfT relating to the introduction of the new offence were asked to provide data; these grants were administered in more than one wave (which is one reason for the differences in how long data was collected for), and not all police forces found it possible to provide us with data (for a variety of reasons, including IT issues for example). Two police forces collected data for 17 months although they had not been in receipt of any grant at the start of the process.

As the sample of police forces who collected data for us was in effect self-selecting, and within those forces, we do not know (except in one case) what proportion of relevant incidents we have records for, we cannot use the absolute numbers of records to draw conclusions. However, there is no reason to think that conclusions on, for example, the proportion of saliva tests giving positive results for cannabis, cocaine or both, would differ from the results of a wider sample. We also have some secondary data relating to saliva tests carried out nationally for seasonal drug driving campaigns to compare with some aspects of our primary data.

Secondary data on collisions: STATS19 data

STATS19 provides detailed information about the circumstances of personal injury road traffic collisions (RTC)⁵⁹, including time, date, location, the types of vehicles involved, numbers of people injured and the severity of any injuries. This information relates only to personal injury collisions on public roads that are reported to the police. Where a police officer has attended the scene of a personal injury RTC then the STATS19 record should

⁵⁹ DfT, STATS20, Instructions for the Completion of Road Accident Reports from non-CRASH Sources. September 2011.

include their observations of the factors that may have contributed to the collision occurring, including drivers being impaired by alcohol or drugs.

It is believed that STATS19 records under-report all personal injury RTCs⁶⁰. In addition, the contributory factors data in STATS19 is subjective and therefore subject to some uncertainty as described here:

- Up to six from about 80 contributory factors can be identified in the STATS19 record of the circumstances surrounding an RTC where at least one person has been injured. These contributory factors relate to potential root causes of the RTC and are recorded as the judgments of the attending police officer, who is responsible for completing the STATS19 return. Individual officers may have different approaches to identifying contributory factors, and differing competences in attributing likely contributory factors. For example, a traffic officer trained in drug recognition may be more likely to identify drugs as a contributory factor than an officer not trained in drug recognition.
- There may be changes in how likely officers are to use contributory factors over time. In our baseline report, we noted in particular that when the new offence was introduced, awareness might increase and the use of impairment by drugs as a contributory factor might increase steeply.
- We conducted some analysis on the use of CFs, for example, comparing the use by forces involved in trials of drug screening devices before and during the trial, and comparing forces in the trial with forces not using devices. Our analysis confirmed that there was considerable variability in the use of the drug CF, and did not suggest any basis on which to estimate the degree to which it is underused.

Despite these uncertainties, STATS19 data is the best source of historical data that is readily available, and remains a useful source of information. While it may not provide a complete record of all RTCs involving personal injuries, it is the only national data source that provides detailed information on collision circumstances, vehicles involved and resulting casualties. It remains the most detailed and reliable single source on collisions that can be used for longitudinal research in Great Britain⁶¹. The caveats noted mean that estimates of drink driving and injuries due to drink driving derived from this source are almost certainly under-estimates. STATS 19 data are presented in Section 6.

Secondary data on toxicology for road traffic fatalities: coroners' data

This data is compiled by TRL for DfT⁶². It provides detailed information about the levels of alcohol and drugs present in body fluid samples taken from victims of fatal road collisions aged 16 or over, as recorded by Coroners in England and Wales and Procurators Fiscal in Scotland. We have been provided with data for part of 2010, and all of 2011, 2012, 2013 and 2014.

Coroners' data is incomplete, subject to bias and differs in format; for example:

- it is likely that spatial differences exist, as police in some areas may be more likely to request toxicology tests, and individual coroners are likely to differ in their approach to sending samples for toxicological analysis⁶³

⁶⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259012/rrcgb-quality-statement.pdf

⁶¹ <http://www.adls.ac.uk/department-for-transport/stats19-road-accident-dataset/?detail>

⁶² DRAFT PROJECT REPORT RPN2666, Alcohol and drugs in road fatalities, 2013 report based on 2011 data, TRL

⁶³ It is also possible that introduction of the new offence may affect how likely it is that coroners request drugs tests.

- as for blood samples taken at police stations or in hospital, the time between an incident and the sample being taken can also vary widely
- data are not comparable with blood sample analyses; samples are of a variety of tissues, not simply blood, and results are expressed in differing units.

Therefore, the available data will provide evidence of whether drugs were present or not; but will not indicate whether impairment was likely. Coroners' data can therefore provide an estimate of numbers of fatalities in road collision where drug use may have been a contributory factor, but it is subject to considerable uncertainty. Coroners' toxicology data is included in Section 6.

Secondary data on drug driving prevalence and frequency: crime survey for England and Wales (CSEW)

The CSEW replaced the British Crime Survey, and so is a long-running household survey of adults aged 16 and over, resident in England and Wales. It collects data on experiences of victimisation and perceptions of anti-social behaviour through face-to-face interviews using Computer-Assisted Personal Interviewing (CAPI), together with self-completion modules on drinking behaviour, drug use and intimate personal violence. The respondent completes these on a laptop computer. The survey covers experiences of crime in the 12 months prior to interview. Since April 2001, interviewing has been carried out continually and reported on an April to March basis. A multi-stage stratified random sample is used, with a sample size of around 40,000⁶⁴. Since 2009, the self-completion modules have included questions asking people whether they have driven while they believed they were over the legal alcohol limit, and also questions about driving under the influence of drugs⁶⁵. These data are used in Section 5. The CSEW data provides information on the prevalence and frequency of drug driving in England and Wales. It also provides information on the prevalence of illegal drug use.

The CSEW is a large survey; the 2014-15 cycle, for example, aimed to interview 35,000 people⁶⁶. The sample is based on a bespoke set of strata designed to give a nationally representative picture, and ensuring a minimum number of interviews within each police force area. Within each stratum, households are selected at random. At each household, one adult is randomly selected using an algorithm built into the interviewer's electronic contact script. The CSEW is therefore generally considered to be a reliable source of robust data.

Secondary data on awareness: THINK!

THINK! is a road safety campaign run by the Department for Transport. It provides road safety information for road users, and aims to encourage safer behaviour from all road users to reduce the numbers of fatalities and injuries on the roads. The THINK! campaign is subject to ongoing evaluation; since 2006 this has been carried out by TNS BRMB, who have

⁶⁴ Between 35,000 and 50,000 people were interviewed for the survey in each year from 2009/10 to 2012/13, and approximately half the sample completed the self-completion module towards the end of the interview. The results are weighted to ensure they best reflect a profile of the general population. (From 20)

⁶⁵ Reported Road Casualties in Great Britain: 2012 Annual Report, Self-reported drink and drug driving: Findings from the Crime Survey for England and Wales. DfT.

⁶⁶ Crime Survey for England and Wales – Technical Report 2014/15, Volume One. TNS BRMB. Available at file:///Users/michelleboath/Downloads/201415crimesurveyforenglandandwalestechnicalreportvolume1_tcm77-428836.pdf

conducted seven surveys since November 2006⁶⁷. This includes useful contextual information relating to how important an issue people think drug driving is.

The THINK! July 2013 annual survey covered the following elements:

- Awareness of, attitudes towards, and perceptions of the THINK! road safety brand
- General attitudes towards road safety, and its perceived importance in relation to other social issues
- Attitudes towards driving, and influences on driving behaviour
- Driving and road safety behaviour among different users, including the prevalence of dangerous driving behaviour.

The survey is smaller than the CSEW; the July 2013 survey interviewed 1,853 people, while the July 2015 survey included 1,090 interviews¹¹. Interviews are conducted face-to-face. The sample is chosen using a random location methodology, combined with quotas. The approach is therefore less reliable than a strict probability sampling approach, but TNS believe it eliminates the most unsatisfactory features of quota sampling by giving interviewers very little choice in where to seek interviewees¹². The THINK! campaign is discussed in Section 4 of the main report.

Primary data on awareness and attitudes from ONS Omnibus module

The THINK! campaign evaluation plans have different aims from this study, and the evaluation questions were not tailored to the needs of this research. DfT therefore commissioned a bespoke module in the ONS National Statistics Opinions and Lifestyle Survey to determine baseline measures for attitudes, awareness and perceptions. The ONS survey uses a random probability sample stratified by region, the proportion of households with no car, socio-economic classification and the proportion of people over 65 years of age. Interviews are carried out face-to-face, and within each household, one person over the age of 16 is randomly selected for interview. Sample sizes are 2,010 addresses each month⁶⁸. As the only random-probability based omnibus service available, DfT considered that this would provide the most robust data possible on awareness and attitudes.

The first wave commissioned for this research was carried out in January 2015, before the THINK! Campaign on drug driving began; however, there had been some reports in the press about the new offence. Subsequent waves were carried out in April 2015, shortly after the introduction of the new offence, and after the publicity and awareness campaign supporting its launch, and in April 2016, a year after the second wave. Data from the surveys is presented in Section 4 of the main report.

Secondary data on criminal justice: Ministry of Justice data

MoJ has access to data extracts from Libra, CREST and PNC. Libra has details for offences that proceed to Magistrates' Courts. CREST includes details for cases that go to the Crown Court. Extracts from PNC (the Police National Computer) allow MoJ to access details of offences disposed of by police caution.

Data extracts at MoJ are designed to count people, rather than offences, and MoJ analyses are often based on a principal offence (the most serious offence, that with the highest potential tariff), but queries can find other offences. Other points to note are that there are timing issues when comparing arrests, charges and convictions, as people may be arrested

⁶⁷ TNS BRMB (August 2013) THINK! Road Safety Survey 2013

⁶⁸ ONS Omnibus Service Methodology, Office for National Statistics.

in one year, but dealt with in court in the subsequent year. In addition, some individuals may appear in both Libra and CREST, as they may be sent from the Magistrates' to the Crown Court. However, MoJ analysts are aware of these issues and are accustomed to dealing with them. While in theory individuals can be tracked from one system to another, in practice names are not always recorded identically, and dates of birth are not always entered correctly, so 100% matching is not possible.

MoJ has not provided data extracts, but has provided answers to specific evaluation questions by running their own queries on datasets. Information from MoJ is presented in Section 5 of this report.

Secondary data on motoring offences: DVLA data

DVLA had hoped to provide information to allow triangulation for some of the MoJ data. However, during the course of the work, DVLA has undergone a major restructuring exercise and staff were unable to provide data on the timescales required to support the baseline. However, towards the end of our evaluation, DVLA produced some information in response to a Freedom of Information request from a third party, which we have included as evidence of an increase in use of Section 5A in 2016, compared with 2015.

APPENDIX B – EVALUATION QUESTIONS

This appendix lists the evaluation questions (other than those in Appendix C) and indicates data sources used.

The table below provides a summary of the availability of information and data to answer the evaluation questions. A tick indicates that information was expected to be available, while green indicates good quality information, and amber indicates that not all breakdowns desired may be available, or, for baseline data, limited history is available. Grey indicates that information is not relevant or was not expected to be available.

Table 16: Summary of evaluation questions

Baseline		Evaluation	
a) Operation and enforcement			
i. How many people are saliva tested by police at the roadside? At the station? Percentage indicating positive, negative, no result?			
Not relevant.		Data being collected from several forces.	✓
ii. How many people arrested for Section 5A offence? And for Section 4 impairment offence? How many of those had a blood sample taken? vii. How many people arrested for Section 4 offence and subsequently charged with new Section 5A offence?			
Limited baseline information available – insufficient for analysis		Police Forces A, B and C will collect bespoke information. Some information also available for forces in screening pilot.	✓
iii. What were preliminary saliva drug concentrations?			
Not relevant.		Not available – preliminary drug screening devices do not give concentrations.	✗
iii. What were subsequent blood concentrations?			
While this is available for a few police forces, there are few records, and the analytical processes are required only to demonstrate presence – blood concentrations are not comparable with Section 5A analysis results and so not relevant.		This data will be available for several forces who are providing information.	✓
iv. Where saliva and blood samples taken from same person, what is the time interval between the two samples being taken?			
Not relevant.		Will be available for Forces A, B and C, should be available for screening pilots.	✓

Baseline		Evaluation	
v. When blood samples are taken: which suppliers of blood test kits are used? How are samples stored? How are they transported to the laboratory for analysis? Which laboratories are used?			
Collect by interview – not addressed in this report; additional forces now providing data, more information will be sought from them and information presented in the final evaluation report.	✓	Collect by interview.	✓
vi. For drivers prosecuted for new Section 5A offence: Which drugs confirmed as present, and at what level, concentration?			
Not relevant	✓	Will be available for several police forces as evaluation proceeds.	✓
Is there evidence that a drug was being taken as prescribed or being abused?			
Not available	✗	Some police forces will record this where possible, but it is not always clear.	✓
How many drivers were using medicinal and illegal drugs?			
Not available	✗	Blood sample analysis does not cover all possible drugs, so any information will be incomplete.	✗
viii. For drivers arrested and investigated for Section 4 impairment and the new Section 5A offence: How many fail to provide a blood sample?			
Insufficient data available to provide baseline.	✗	Several police forces will record this information.	✓
How many of these claim needle phobia?			
Not available.	✗	Several forces will record this where possible – in wider form, reasons for failure to provide blood sample.	✓
How many of those claiming needle phobia are prosecuted for failing to provide?			
Not available.	✗	Several forces will record this where possible.	✓
How many of those are taken to court? How many are convicted?			
Not available.	✗	Several forces will record this where possible. MoJ data will be available to compare numbers of court proceedings and convictions.	✓

Baseline		Evaluation	
ix. Under what circumstances were drivers arrested under the new Section 5A offence (and the Section 4 impairment offence) e.g. collision-involved? Were they considered culpable for the collision?			
No baseline information available.	x	Several forces will collect information from 02/03/15 - when new offence is introduced.	✓
xi. Does the extent of the use of the new offence vary across police forces? If so, why? xii. Does the success of the use of the new offence vary across police forces? If so why?			
Not relevant		Analysis of other information will identify differences, and both quantitative and qualitative information will be used to explore reasons.	✓
xiii. For key stakeholders, how do they think the new offence is operating in practice?			
Not relevant		Information will be collected by interview.	✓
xiv. Is there any evidence of negative impacts on certain groups (e.g. those taking medication for chronic illness)?			
Not relevant – but concerns of stakeholders reported		Information will be collected by interview – hard quantitative data unlikely to be available.	✓
b) Road traffic collisions			
i. What is the effect of the new offence on: prevalence of driving under the influence of illegal drugs, or medicines?			
Limited time series information available.	✓	CSEW will collect some information. Think! survey if run, will provide further information.	✓
prevalence of collisions due to drug driving or medicine impaired driving?			
STATS19 can provide baseline information.	✓	STATS19 will continue to collect information.	✓
numbers of seriously injured casualties and fatalities due to drug driving or medicine impaired driving?			
STATS19 and Coroners' data can provide baseline information.	✓	STATS19 and Coroners' data will provide information going forward.	✓
ii. For collision involved drivers: how many had a contributory factor for drug impairment? How many of these were arrested? how many were subject to preliminary drug tests? How many of these were arrested? if the driver was arrested and provided a blood sample, is there a link between severity of incident and blood concentrations			

Baseline		Evaluation	
While contributory factors for drug impairment can be assessed – Stats19 data cannot be linked to arrest data	x	While contributory factors for drug impairment can be assessed – Stats19 data cannot be linked to arrest data.	x
c) Offending behaviour and recidivism			
i. What is the number of court proceedings for the new Section 5A offence? How many found guilty?			
Baseline information available for Section 4 impairment offence, although confirming how many are for drugs (rather than alcohol) requires assumptions to be made.	✓	Data available from MoJ going forward for new offence – similar caveat will apply to Section 4 impairment offence (although we note that use of Section 4 ‘impaired by drugs or alcohol’ has reduced over time, while use of ‘impaired by drugs’ has increased.	✓
ii. How many cases are discontinued or found not guilty due to use of the medical defence?			
Not available	x	Several forces will record this where possible, but unlikely to be available for cases that reach court.	✓
iii. What impact has the new Section 5A offence had on court proceedings/ findings of guilt for the Section 4 impairment offence?			
Not relevant		Available from MoJ. Relatively short timeframe may limit what can be observed.	✓
iv. What are the reoffending rates for the new offence? How does this compare with the Section 4 impairment offence?			
Information on previous offences analysed for those found guilty of drug driving offences	✓	Proven reoffending rates available from MoJ.	✓
v. How many drivers convicted under the new offence have previous convictions for drink driving?			
Not relevant		MoJ can provide information on previous convictions for those convicted of new offence. DVLA also has data that may assist here, and has offered to explore it further.	✓
Is there a link with any other type of offending behaviour?			
Not relevant		MoJ can look back and provide summary information on previous convictions for other offences for those convicted of the new offence.	✓

Baseline		Evaluation	
vi. Are there any predictors of reoffending?			
Not relevant		This would require a separate exercise by MoJ.	x
vii. Is there any evidence that drivers are changing the type of drug they use to avoid drugs covered by the offence?			
Not relevant		Some information available through interview.	✓
d) Attitudes			
i. Are drivers aware of the new Section 5A offence? Is this likely to change over the timeframe of the evaluation?			
Not relevant		Available if omnibus module commissioned, or if Think! survey run on appropriate timescale.	✓
ii. What are the public attitudes towards drug driving – among drivers? Among the general population? What is the effect of the new offence on these attitudes?			
Available from omnibus module commissioned by DfT – ONS Lifestyle and Opinions Survey	✓	Available from further two waves of module in ONS Lifestyles and Opinions Survey.	✓
e) Costs and benefits			
i. How can the evaluation identify whether the costs of implementing the new offence are offset by the any benefits?			
It was agreed during the course of the research that collecting meaningful cost data to cover all costs was not practicable, and that it would not be possible to assess the benefits at this early stage.			

APPENDIX C – QUALITATIVE INTERVIEWS

Police and CPS

1. What did the forward planning done by police forces ahead of the new offence involve?

Forward planning by police forces included a number of strands, including decisions on whether to buy preliminary drug screening equipment, education and training of staff, back office processes and setting policy for how to use the preliminary screeners. Training included training in how to use drug screening equipment, as well as how the new offence would operate, and ensuring that front line officers were aware that they should still collect impairment evidence, should arrest suspects for both the Section 4 and Section 5A offences where possible, and investigate both. In addition to training, police forces had to develop internal communications strategies and materials (e.g. intranet pages), to support officers in implementing the new offence.

Police also had to plan to ensure that back office infrastructure would be in place to support the new offence, such as ensuring that fridges were available to store blood samples, and that custody staff were aware of the requirements for the new offence, including appropriate storage of samples, the provision of a 'B' sample for suspects, and forthcoming changes to MGDD forms⁶⁹. Some forces also had to implement new processes for the transfer of samples to laboratories; as blood samples for analysis for Section 5A must be kept cool. Forces that previously used postal services to send samples to laboratories had made plans to use specialist courier services.

Some police forces were keen to provide refresher training in field impairment tests, and most mentioned liaison with medical services providers to ensure that they were aware of the forthcoming changes, including the changing role of nurses.

Police forces also had to set policy for the use of drug screening equipment, particularly mobile screening devices such as DrugWipe. The police forces we spoke to intended to allow specialist roads policing teams to make their own decisions about when to use screeners, while also requiring that officers called to serious road traffic collisions screened the driver for drugs, in addition to breath-testing for alcohol.

CPS had to put plans in place to produce legal guidance, and to train staff. Staff training had been necessary throughout the Criminal Justice System.

2. In putting these plans into place, which elements have gone well for police forces and the CPS?

Police forces were pleased with the support offered by DfT regarding training for staff, and the opportunity to arrange question and answer sessions with a representative from the Department. DfT staff had also reviewed training materials for some forces, which was welcomed. While most would have liked more time for training, they also felt that the timescales for introduction were adequate to allow core training to be completed and some training was carried out after the introduction of the new offence. One force noted that they had more time to prepare than was usual for

⁶⁹ Manual of guidance drink and drug driving - the MGDD is a set of forms used by police forces in England and Wales when dealing with drink and drug driving offences

legislative changes. One force noted that the introduction of the new offence had presented a good opportunity to test their joint working processes with other forces. Police forces welcomed additional grants that were made available by DfT to help pay for additional training, saliva testing equipment and blood sample analyses. Police forces reported that their officers like the saliva testing equipment available to them. One comment was that in some circumstances where field impairment testing would have been difficult, or dangerous, the ability to complete roadside preliminary drug screening using e.g. DrugWipe, was very helpful.

Several police forces reported large increases in prosecutions for drug driving, and noted that conviction rates were high. Most had seen few 'not guilty' pleas, and most of these had changed to guilty pleas on the day. Some noted that they had previously found it difficult to achieve Section 4 prosecutions because of disagreements with medical staff regarding impairment. Some noted that officers were using Section 5A to increase the numbers of drug driving arrests, rather than using Section 4 instead of Section 4. This is consistent with evidence later in this report that in 2015 proceedings for Section 4 offences are similar to the number in 2014, so Section 5A prosecutions appear to be additional to Section 4 prosecutions.

Several police forces felt that public awareness had increased. One force said officers felt that saliva testing had increased awareness of the new offence in particular among young, male cannabis users who drove. Several forces had been asked by local businesses (particularly by fleet managers) to visit them and talk to employees about the drink and drug driving including the new offence. Some had been asked to talk to local magistrates about the new offence.

Accompanying changes in legislation such as the removal of the statutory option, and changes to the role of nurses, were welcomed by police and had been found helpful. All the forces we spoke to reported that very few needle phobia cases had been observed.

In common with the Police, CPS had found DfT staff helpful and cooperative and felt that interfaces worked well.

3. In putting these plans into place, which elements have been difficult or raised concerns for police forces and the CPS?

All police forces noted that preliminary drug screening devices were relatively costly, including the cost of consumables, in comparison with alcohol breath-testing consumables – by two orders of magnitude. Some forces noted that demand for some drug screening device consumables seemed to be higher than supply when the new offence was about to be introduced and, although they noted that such devices were not essential, they were concerned that they would not have preliminary screening devices by 2 March 2015. Some interviewees noted that they would have liked 'more science' in place by March 2015 – e.g. preliminary drug screening for all substances in the regulations, – but thought that on balance it was sensible to implement the new offence sooner and take advantage of further developments in science and technology as they were introduced over time. (When the offence was introduced, on 2 March 2015, preliminary drug screening devices available to the police – saliva tests – could test for cannabis and cocaine only. This was still the case at the end of 2016)

One force noted that the expiry dates on preliminary drug screening consumables was shorter than they had been led to believe. Another force noted that for the DrugWipe device, it was at least possible to use out-of-date devices for training

purposes, but that out-of-date Draeger cassettes could not be used at all as the equipment software prevented it.

Some forces thought that the use of impairment testing by their officers had dropped. This is a potential issue because – as evidence later in this report supports – it is not always possible to obtain a blood sample from suspects. The most common reason for this is medical, often relating to poor veins. Several forces also noted that the equipment was not ideal; health care professionals had expressed a desire for finer needles, and alternative collection equipment. A small number of interviewees noted that fewer nurses were now skilled at using old-fashioned syringes for collecting blood, as in most areas of medical practice, vacuum blood collection systems were more commonly used.

A small number of forces noted that they had encountered difficulties obtaining blood samples in some hospital cases.

Police forces were concerned that many blood samples resulted in analysis results that were below the specified limits. (This is in line with evidence in this report which suggests that for cannabis 30% of positive saliva tests result in blood analysis results under the specified limit.) Officers were aware that a significant (in their view) deduction is made from the original analytical result to produce an evidential result, and felt that this was the reason. Officers were reported to be disappointed, and sometimes demotivated by the large number of blood test results that did not support a subsequent Section 5A prosecution.

Some forces had found, after a few months that the turnaround time for blood analyses was increasing. This was probably a result of a rapid increase in the number of samples being submitted for analysis.

CPS plans for producing legal guidance and training staff had been squeezed because the details of the offence and how it would operate were not clear until close to the introduction date. Some police forces did not complete initial training in the use of the DrugWipe device until four to six weeks after the introduction of the new offence.

Towards the end of the first year of operation of the new offence, police forces told us that defence teams had started to request large volumes of documentation, including details of analytical processes and procedures. This could have been problematic, but forces had found the advice provided by DfT and NPCC very helpful.

Costs associated with the new offence concerned police forces, and continue to concern them, as noted below. During the first year of the new offence, police forces had access to grants from DfT that could be used to offset costs associated with the new offence, such as those for:

- Training police officers in drug influence recognition and field impairment testing
- Saliva testing equipment
- Laboratory analysis costs.

We do not know how these costs will be met going forward.

4. What are the main risks to successful implementation that police forces and the CPS envisage?

Prior to its introduction, police forces were concerned about the cost of preliminary drug screening devices. This remains a concern, along with the cost of blood analyses. A range of costs per analysis were reported to us, from £250 to £385.

Officers were particularly concerned about blood analysis costs given that (as noted in several places in this report) where preliminary saliva tests are positive for THC (cannabis), some 30% result in blood analyses below the specified limit, so that the suspect cannot be prosecuted. Even where THC is present, forces have reported little success in reverting to a Section 4 charge even where impairment evidence was collected, as there appears to be a view that the defence will say that as the blood was below the Section 5A limit, the defendant could not have been impaired.

While forces had welcomed the grants towards these costs, they remained concerned that costs were high. Several forces noted that they would like to use preliminary drug screening for all collisions where officers attend, but as a result of the cost of the consumables, most forces tested only drivers in serious and fatal road traffic collisions, or collisions where drug awareness trained officers suspected drugs were a factor.

Police forces were concerned about 'B' samples for blood; specifically, that suspects might not keep the samples under appropriate conditions, and might then have them independently analysed resulting in different results from the 'A' sample. While few cases we were told about involved any use of the 'B' sample, some forces felt this remained an ongoing risk that had not yet been tested in court.

Police were also concerned that not all of the substances in the regulations could be screened for in the preliminary saliva tests, and that only one laboratory was accredited to test for all substances when the new offence was introduced; others could only test for two drugs, cannabis and cocaine (including the cocaine metabolite, benzoylecgonine). However, police forces recognised that evidence suggested that these two were the most common drugs involved in drug-driving. In the intervening year, the number of laboratories analysing for all relevant substances had increased and this risk was no longer considered important. However, some forces remain concerned that as officers come to rely on preliminary saliva screening devices, they may be missing users of other substances. One force felt that ketamine was a particular issue in its area, while another force felt that NPS use was increasing.

Several interviewees noted that while training stressed the importance of collecting impairment evidence, they thought that officers would come to rely on the use of preliminary drug screening devices and would arrest and investigate only for the new Section 5A offence, neglecting the Section 4 impairment offence. Forces remain concerned about this, as they have now observed a number of cases where blood could not be obtained, particularly for medical reasons, and where cases have therefore been subject to 'No Further Action' (NFA).

Some interviewees were concerned that positive preliminary drug screening might be followed by negative blood tests – especially if there are delays in obtaining blood samples – and that this might deter officers from using the new offence. While, as noted, a higher proportion of blood analyses have returned negative results than had been hoped, the offence is still being used.

CPS concerns were similar to those of the Police, chiefly relating to the potential for police officers to not routinely arrest and investigate for the Section 4 impairment offence alongside the new offence, together with concerns about the storage of 'B' samples by suspects, and opportunities for testing of 'B' samples. Prior to March 2015, CPS were also concerned that there had been some negative stories in the press, for example a story that one force would not be implementing the new

offence⁷⁰. However, evidence suggests that the force in question did start using the new offence, and its prosecutions per million population in its area during 2015 were above the median value for forces in England and Wales.

Coroners

1. What did the forward planning done by coroners ahead of the new offence involved?

(this is addressed in item 3 below)

2. In putting these plans into place, which elements went well for coroners?

(this is addressed in item 3 below)

3. In putting these plans into place, which elements were difficult or raised concerns for coroners?

Coroners had not found it necessary to make any particular plans in relation to the new offence; the key activities related to circulating information to Coroners to ensure they were aware of the new legislation. As such, no views were expressed about what had gone well or not.

4. What are the main risks to successful implementation that coroners envisage?

There were no concerns envisaged for Coroners. However, it was noted that individual Coroners decide whether to take samples for toxicology, so that if police do not request a forensic post-mortem then toxicological samples may not be taken. Coroners face funding pressures, and priorities differ by area.

Laboratories

1. What did the forward planning done by laboratories ahead of the new offence involved?

The key task for laboratories was to achieve accreditation against the Home Office Centre for Applied Science and Technology (CAST) specification for analyses (ISO 17025) to allow them to carry out analyses of blood samples for the Section 5A offence. This required them to develop and validate methods, submit data to UKAS and go through the accreditation process.

2. In putting these plans into place, which elements went well for laboratories?

Most of the laboratories had been able to claim grant funding from DfT against the costs of achieving accreditation, which was welcomed. Three laboratories had been able to achieve the accreditation they aimed for in time for the introduction of the new offence, although they still felt that the process had been more rushed than they would have preferred.

Laboratories had also welcomed continued interaction with DfT throughout the year.

⁷⁰ <http://www.manchestereveningnews.co.uk/news/greater-manchester-news/gmp-not-enforcing-tough-new-8705484>

3. In putting these plans into place, which elements have been difficult or raised concerns for laboratories?

Two laboratories indicated that once the specification for analyses was issued, they had insufficient time to develop methods for all of the substances in the regulations, and so had sought accreditation (which they achieved) for THC, cocaine, and benzoylecgonine only. One laboratory had been unable to achieve accreditation in time for the introduction of the new offence.

Since the introduction of the new offence, the numbers of blood samples submitted for Section 5A analysis had increased. This had led to some capacity issues. At least one laboratory had managed this in part by subcontracting some analyses. In addition, the removal of the statutory option for alcohol had reduced the demand on laboratories for evidential analysis of blood samples for alcohol. Therefore, some laboratories had trained staff who had previously conducted alcohol analyses in Section 5A analysis of blood samples.

Laboratories felt that the level of Magistrates' technical understanding varied widely and that the use of statistics could be confusing to lay magistrates, particularly as many had seen very few Section 5A cases. Laboratories had also found that initially some police officers did not understand the difference between Section 4 and Section 5A analyses; however, this was not seen as an issue after a few months had passed.

Laboratories were concerned that not all police forces prioritised collection of blood from drug drivers, and felt that this should be done wherever practicable to minimise the time between saliva testing and blood collection.

4. What are the main risks to successful implementation that laboratories envisage?

Some laboratories raised concerns about 'B' samples similar to those raised by others – that they might not be stored appropriately and analyses might provide different results to those of 'A' samples. One noted that the different analyses might look for different substances. Concerns were also raised that as a new piece of legislation, it may be used a lot and laboratories might face high levels of demand and have insufficient capacity to turn analyses round quickly enough for legal processes. While there was little evidence that this had been an issue during the first year of the new offence, laboratories remain concerned about the custody of 'B' samples and how they might be used by defence teams.

Laboratories reported that they felt that defence teams were now starting to use tactics similar to some that had been used for alcohol, including demanding substantial data packs, challenging whether samples were contaminated, and talking about statistics as if they were problematic. They were concerned that lay magistrates would continue to be confused by statistics.

Policy stakeholders

1. What has the forward planning done by policy stakeholders ahead of the new offence involved?

DfT had done a considerable amount of planning, much of it associated with drafting legislation, consulting with stakeholders and getting legislation in place. This had involved working with other government departments as well as stakeholders outside government, to ensure that plans took account of policies related to drugs (generally illicit drugs and drugs generally used as medicines) within the Home Office and DH,

for example. DfT plans had included considerable consultation with external stakeholders and experts, given the number of substances included, and the different approaches taken – with essentially zero tolerance levels for generally illicit drugs, and risk-based levels for others.

DfT plans also included communications with a number of medical stakeholders, for example, the Medicines and Healthcare products Regulatory Agency (MHRA) which licenses drugs for use in the UK. The MHRA wrote to all market authorisation holders (essentially pharmaceutical companies) asking them to amend patient leaflets and summaries of product characteristics for those drugs included in the legislation to put flash warnings on packaging. DH also conducted work around medical communications, to make sure that clinicians are aware of their responsibilities in the event of conversations with patients about the effects of drugs on driving. A meeting of the Secretary of State's Honorary Advisory Panel on Drugs, Alcohol and Substance Misuse was also convened; this comprises experts who understand the effects of alcohol and drugs. Representatives of the Royal Colleges were also invited.

DfT plans also included working with DVLA, the Home Office and the Ministry of Justice to ensure that new offence codes were created and available to use when the new offence came into force, to allow for accurate monitoring and recording of offences.

Through its THINK! initiative, the DfT had planned an awareness raising campaign to fit in with their other road safety schedules and with the timescales for implementation of the new legislation and its first anniversary.

The Home Office Centre for Applied Science and Technology (CAST) had a key role. Its plans required production of specifications for preliminary drug screening devices, specifications for analyses by laboratories (against which laboratories are accredited), and type approval activities for preliminary drug screening devices submitted by manufacturers.

2. In putting these plans into place, which elements have gone well for policy stakeholders?

Policy stakeholders across government felt that good working relationships had been achieved, that communications interfaces worked well, and that sufficient time had been allowed to ensure that any concerns could be discussed. DfT and the Home Office felt that work to ensure that the legislation was coherent with The Home Office zero tolerance policy on illicit drugs had gone well, and that communications with medical stakeholders had gone well; meetings had been held with a wide range of stakeholders, actions had been agreed and implemented in a timely manner.

DfT policy staff felt that they had benefited from liaison with overseas administrations to discuss their experiences of introducing similar legislation. The experiences of Australian policy staff was particularly insightful. They advised that it was difficult to have everything in place at day zero, and that a practical approach was to ensure that minimum supporting arrangements were in place at the start, prior to developing additional analytical capacity and capability as time progressed.

DfT felt that use of the new offence had been very good. While some police forces had been slower to use the new offence, all were now using it, particularly since DfT had been able to provide grants to support its use – to pay for drug awareness and field impairment testing training, and for saliva testing equipment and evidential blood sample analyses. DfT was also pleased with the high conviction rate for the new offence.

Some overseas administrations had shown interest in the experience of introducing the new offence in the UK, and the World Health Organisation was engaging with DfT about what had been done. Plans for a drug driving rehabilitation course, or including an element of drug driving education in a wider drink and drug driving rehabilitation course had been welcomed by other departments.

CAST felt that a considerable amount had been achieved in a relatively short space of time, given that it is difficult to assess how long type approval processes will take.

From a wider Home Office perspective, policy staff were refreshing the drugs strategy and had been liaising with DfT as they were planning a section on drug driving, and saw the introduction of the new offence as a very positive story, in terms of good practice in cross-departmental cooperation and coherence with overall Home Office drugs strategy. It seemed the new offence had been used a lot more than some people had thought it would be.

DfT had been concerned that there might have been some adverse impact on patient groups – perhaps people being stopped and having to use the medical defence, or people not taking prescribed medicines through fear of being stopped. They had seen no evidence that this had happened. Our primary data collection found no examples suggesting that a medical defence would be raised⁷¹. Press coverage relating to the new offence had been mostly very positive.

3. In putting these plans into place, which elements have been difficult or raised concerns for policy stakeholders?

One stakeholder felt that an overall cross department programme with an identified critical path might have helped to see how everything fitted into the overall programme. All stakeholders felt that more time would have been useful, for example to ensure that more laboratory capacity was available to analyse blood samples for the whole range of substances in the regulations, at the introduction of the new offence. However, they also felt that on balance, it was better to have kept to the 2 March 2015 introduction date, with capacity to analyse for cannabis and cocaine (the two drugs addressed by analysing for THC, cocaine and benzoylecgonine).

There had been some practical issues reported by police forces – in particular, the equipment used for taking blood. (Police forces also told us this.) At present, blood is the only acceptable evidential matrix, and in a significant minority of cases (we estimate about 1 in 15), medical reasons such as collapsed veins mean that blood cannot be collected from someone who had produced a positive saliva test. DfT was looking at the use of more modern collection technology to assess its feasibility.

DfT also believed that there had been some issues once cases reached the courts. Where people had been charged with a Section 4 offence, if the levels were lower than the Section 5A specified limits, some magistrates were assuming that this meant the person was not unfit to drive, and so not guilty. They had also been told about a small number of cases where drivers had had their B' sample of blood analysed, resulting in lower levels of drugs than the prosecution analyses, probably due to unsuitable storage. However, the courts had given the defendants the benefit of the doubt in these cases. DfT was considering a change to the process so that the integrity of both samples could be maintained.

⁷¹ We asked if arrestees claimed at any point to be taking prescribed medication – we saw no cases where an arrestee had said they had been prescribed a drug specified in the regulations.

DfT were concerned that some senior police officers did not understand the potential benefits of roads policing in disrupting criminality generally. Roads policing officers do, but at the level where budget decisions are made on allocation of resources, roads policing is not considered in these terms. DfT had been told by several forces that the new offence had been of value – one force had stopped a car whose driver appeared to be under the influence of drugs, and on searching the vehicle found a large quantity of cash. Further investigations revealed they had stopped part of a major drugs distribution network. The Metropolitan Police had conducted some analysis and reported to DfT that of those stopped for drug-driving since the new offence had been introduced, about 70% have previous offences.

4. What are the main risks to successful implementation that policy stakeholders envisage?

Most of the potential risks had been addressed by February 2015 – there had, for example, been some risk that the secondary legislation might have a difficult passage through the House of Lords, because of their concerns on the potential impact on patients.

Operationally, the lack of an alternative to a blood sample is a risk – in some instances there are medical reasons that mean blood cannot be collected. There might be alternatives to blood samples at some point in the future; DfT had commissioned work on alternative evidential matrices.

CAST was carrying out some work to assess whether there might be any issues around the standard deviation associated with analysis results. For example, for blood alcohol analyses, there is a standard deviation of 2% in the accuracy of the forensic analysis and laboratory results are expressed with three standard deviations (6%) deducted from the level determined by analysis. This ensures that people who are close to the limit are given the benefit of the uncertainty in analysis results.

As noted earlier the storage and use of 'B' samples of blood remains a concern.

DfT expressed some concern that use of the new offence might receive lower priority over time. They were keen, therefore, to ensure that police forces shared experiences on its benefits regarding disruption of crime, and to explore ways of addressing some of the practical issues raised, such as looking at blood collection kits, other evidential matrices, and the use of 'B' samples of blood.

Medical stakeholders

1. What has the forward planning done by medical stakeholders ahead of the new offence involved?

Medical stakeholders interviewed represent a wide spectrum – from single issue bodies to those with wide membership. Forward planning has therefore varied widely. Most of the planning has been associated with ensuring a good understanding of the new offence, and planning communication strategies. In some instances, this meant ensuring that information was available when people asked for it, in others planning to send information out to those who would need it. Some forward planning has also involved plans to monitor queries and any additional workload. For example, the DVLA medical panel expects that communications to practitioners and on medicines will result in more drivers declaring medical conditions, which may result in additional work for them. They have reviewed the questionnaires they ask drivers to complete, and plan to monitor how the caseload varies.

Several medical stakeholders noted that doctors need to balance the need for patient confidentiality with the public interest. We were told that the GMC has reviewed and reworded guidance for doctors, to provide them with more reassurance that considering road safety is part of the public interest.

2. In putting these plans into place, which elements have gone well for medical stakeholders?

Some stakeholders thought that communications with DfT had worked well, as DfT had been helpful, responsive and had supported their internal communication plans. Stakeholders had received fewer queries than they had thought they might, and so believed that communications strategies had worked well (both their own and wider publicity). One stakeholder had contacted DfT in response to a query following an article they had published, after the introduction of the new offence and found DfT remained helpful and supportive.

One medical professional noted that the new offence provided a good 'anchor point' to discuss the potential problems of impaired driving; while able to discuss the medical defence, they found the new offence useful in terms of pointing out the potential dangers of impaired driving, and for drawing comparisons with drink-driving. This professional's view was that the new offence had highlighted the issue across the medical community, particularly in specialist areas such as pain medication, and made practitioners focus more on adverse effects of medication.

3. In putting these plans into place, which elements have been difficult or raised concerns for medical stakeholders?

Some stakeholders felt that doctors might still be unsure of how to advise patients, whether the doctors themselves should inform DVLA that patients were taking medicines listed in the regulations, and whether to advise patients that they should not drive.

Some stakeholders, notably smaller third sector organisations, felt they would have benefited from a more systematic programme to communicate and consult with them about the new offence, the medical defence and how it would work, and to provide materials they could use with patient groups. It is noteworthy that some stakeholders felt that DfT had done a lot of work 'to get the message out there'.

4. What are the main risks to successful implementation that medical stakeholders envisage?

Medical stakeholders were not all clear about how the medical defence would work, in particular, what advice to give to patients about how to demonstrate they had a bona fide prescription for their medicine. Some stakeholders thought that there was still a need for more guidance for medical practitioners, in terms of how they should advise patients, and what their responsibilities were.

Experience of the offence one year after it was introduced, seems to suggest that that initial concerns relating to medical defence had not been realised.

5. How did medical stakeholders expect patients to respond to the new offence?

Some stakeholders were concerned that patients might ask for different drugs – ones not listed in the regulations – and that this might lead to increased prescription costs. Some also noted that some patients might either stop driving, or stop taking their

medicine, or might adjust when they took their medicines. Some noted that while some medicines are impairing, some patients would be less impaired drivers taking their medicine before driving than not taking it (e.g. methadone users, ADHD patients taking amphetamine-based medication).

Those we spoke to (both medical and others) had seen no evidence to suggest that this risk had been realised. One noted that prior to the introduction of the new offence, discussions with patients on mixed sustained and quick release medication had suggested that some deliberately avoided quick release medication when they knew they would be driving, and that the proportion of conversations including such comments did not appear to have changed since the new offence had come into force.

6. How do medical stakeholders expect healthcare professionals to respond to the new offence?

Stakeholders felt this was an area that was not clear. As noted, the GMC was understood to be rewording guidance to doctors, and so more doctors might be expected to highlight the potential impairing effects of some medicines, and advising against driving if affected. Some stakeholders expected healthcare professionals to raise queries with their professional bodies, both technical queries (e.g. what dose of codeine would be within the limits?) and queries relating to legal responsibilities to patients.

Those we spoke to a year after the offence was introduced had noted some queries of this nature, but very few, and they had tailed off very quickly.

7. Are there any wider consequences anticipated by medical stakeholders?

One stakeholder noted that the limits in the regulations were consistent with limits for opioid analgesics above which medical consensus is that benefits no longer outweigh risks, and that this might be helpful for doctors discussing dosages with chronic pain patients, in terms of advice about driving while taking such medicines. It could act as a helpful lever to reduce high doses being taken by some patients.

APPENDIX D – BESPOKE FORM USED FOR PRIMARY DATA COLLECTION ON SUSPECTS STOPPED AND SALIVA TESTED

Drug-driving data record

Custody/Niche ref:

Age: Gender (M/F): Ethnicity Code: Police Force Code:

INITIAL ACTION (INCIDENT)

Date and time of initial stop: / Road Traffic Collision? (tick if yes)

	Tick if done	Test result	Drug detected	Time of test
FIT test at roadside?	<input type="checkbox"/>	Performed as instructed? <input type="checkbox"/> Performed poorly? <input type="checkbox"/>		<input style="width: 40px;" type="text"/>
Breathalysed at roadside?	<input type="checkbox"/>	<input style="width: 60px;" type="text"/>	<input style="width: 60px;" type="text"/>	<input style="width: 40px;" type="text"/>
Saliva test (drug screen) at roadside?	<input type="checkbox"/>	<input style="width: 60px;" type="text"/>	<input style="width: 60px;" type="text"/>	<input style="width: 40px;" type="text"/>
Device: Drager 5000 (station) <input type="checkbox"/> Drager 5000 (mobile) <input type="checkbox"/> Drug wipe (mobile) <input type="checkbox"/> Other (specify): <input style="width: 100px;" type="text"/>				

Arrested? (tick if yes) If no, why not? (eg went to hospital, dealt with by summons)

Arrested for: Section 4 alcohol and/or drugs Section 4 drugs Section 5A drugs Section 4 alcohol Section 5 alcohol Failure to provide Other:

STATION SCREENING

Offences driver was told they were being investigated for at station:

Section 4 alcohol and/or drugs Section 4 drugs Section 5A drugs Section 4 alcohol Section 5 alcohol Failure to provide Other:

	Tick if done	Test result	Drug detected	Date of test	Time of test
Breathalysed at station?	<input type="checkbox"/>	<input style="width: 60px;" type="text"/>		<input style="width: 60px;" type="text"/>	<input style="width: 40px;" type="text"/>
Saliva test (drug test) at station?	<input type="checkbox"/>	<input style="width: 60px;" type="text"/>	<input style="width: 60px;" type="text"/>	<input style="width: 60px;" type="text"/>	<input style="width: 40px;" type="text"/>
Device: Drager 5000 (station) <input type="checkbox"/> Drager 5000 (mobile) <input type="checkbox"/> Drug wipe (mobile) <input type="checkbox"/> Other (specify): <input style="width: 100px;" type="text"/>					
Referred to healthcare professional(hcp)?(tick if yes) <input type="checkbox"/>		hcp was Doctor: <input type="checkbox"/> Nurse: <input type="checkbox"/> Other (specify): <input style="width: 100px;" type="text"/>			
Impairment assessed by hcp? <input type="checkbox"/>		hcp's decision: drug-related condition? <input style="width: 100px;" type="text"/>		<input style="width: 60px;" type="text"/>	<input style="width: 40px;" type="text"/>

Blood sample requested? (tick if yes)

Who took (or attempted to take) sample? Doctor: Nurse: Other:

Blood provided? (tick if yes) Time of sample:

If NO, why not? (reason given):

Urine sample provided? (tick if yes)

1st sample time (hh:mm)

2nd sample time (hh:mm)

Laboratory: LGC Randox ROAR Other Test kit ref / barcode:

Medical defence Did driver claim to be on prescription medication at any stage? (tick if yes)
 If YES, which drugs did driver indicate:

Disposal Tick charges: Section 4 alcohol and/or drugs Section 4 drugs Section 5A drugs Section 4 alcohol Section 5 alcohol Failure to provide Other:

Please specify any other disposal:

NOTE: please use the back of this form to add any additional information and to record any problems, e.g. technical issues with screening device, or a doctor or other healthcare professional was not available.