JUSTICE 2 COMMITTEE

Wednesday 28 March 2001
(*Morning*)

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JUSTICE 2 COMMITTEE
5th Meeting 2001, Session 1

CONVENER

*Pauline McNeill (Glasgow Kelvin) (Lab)

DEPUTY CONVENER

*Mrs Lyndsay McIntosh (Central Scotland) (Con)

COMMITTEE MEMBERS

*Scott Barrie (Dunfermline West) (Lab)
Christine Grahame (South of Scotland) (SNP)
*Ms Margo MacDonald (Lothians) (SNP)
Euan Robson (Roxburgh and Berwickshire) (LD)
*Karen Whitefield (Airdrie and Shotts) (Lab)

*attended

WITNESSES

Simon Anderson (NFO System Three)
Inspector Paul Fleming (Strathclyde Police Force)
Dave Ingram (NFO System Three)
Becki Lancaster (NFO System Three)
Assistant Chief Constable David Mellor (Association of Chief Police Officers in Scotland)
Dr Joanne Neale (University of Glasgow)
Constable Nicholas Roberts (Strathclyde Police Force)
Constable Andrea Russell (Strathclyde Police Force)

CLERK TO THE COMMITTEE

Gillian Baxendine

ACTING SENIOR ASSISTANT CLERK

Fiona Groves

ASSISTANT CLERK

Graeme Elliot

LOCATION

Committee Room 1

Scottish Parliament

Justice 2 Committee

Wednesday 28 March 2001

(*Morning*)

[THE CONVENER *opened the meeting at 10:19*]

The Convener (Pauline McNeill): I formally open the fifth meeting of the Justice 2 Committee. I explained earlier the circumstances that led to the late start of the meeting, for which I offer my sincere apologies, so we will get down to business.

I report to the committee that the Parliamentary Bureau has agreed that the Justice 1 Committee and the Justice 2 Committee can work jointly on the budget process. The first joint meeting of the committees will take place immediately after this meeting. I wish to report back on other items but, given our late start, I will leave that until the end of the meeting.

I ask members of the committee whether they agree to take in private items 7 and 8. Item 7 is a continuation of our discussion of the proposed inquiry into the Crown Office and procurator fiscal service and item 8 is on the draft land reform bill.

Members *indicated agreement*.

Drugs and Driving

The Convener: Our main business today is the subject of drugs and driving, which was suggested by Margo MacDonald, who has just arrived. I thank her for that suggestion. The timing of our consideration of this subject is appropriate and we have a lot of important research to consider.

I will hand over to Simon Anderson, who will introduce his colleagues. We will have a presentation—members have been warned that we will be asked to provide a volunteer to take part in a demonstration.

Simon Anderson (NFO System Three): My name is Simon Anderson and I am a director of System Three. I am jointly responsible for the company's social research division. Members probably know System Three better for our polling activities, but our specialist social research unit does work for the public and voluntary sectors. My colleague Becki Lancaster is a principal researcher and Dave Ingram is a senior researcher. Both are based in our social research division.

We are not experts in the field of substance misuse, but we have carried out various pieces of research relevant to the study that we are here to discuss, including work on transport and road safety issues for the road safety campaign. Our work on substance misuse also includes analysis of data from the Scottish crime survey and other work on criminology.

Dave Ingram and Becki Lancaster did most of the work on the study and are much better placed than I am to talk about it. Dave will take members through the presentation.

Dave Ingram (NFO System Three): I will start by outlining the three issues that I am going to talk about this morning. First, I will set the scene by saying a little about the background. I will then talk about the methodology of our study and its strengths and limitations. That will provide the context in which to consider the drug-driving prevalence estimates.

On the background to the study, alcohol and drink-driving have been the traditional focus in relation to impaired driving—

The Convener: I am sorry to interrupt you, David, but could you sit down? You need to be closer to the microphone so that we can record what you are saying for the *Official Report*.

Dave Ingram: Sorry.

Although it was sensible to focus on alcohol and on drink-driving in the past, the belief has increased that other forms of impaired driving—

particularly the important issue of drug-driving—must be considered.

A literature review by Pavis and Akram for the road safety campaign and the Executive suggested that drug-driving was a problem and made two further important points. First, it claimed that previous work on the subject was of questionable quality—the prevalence estimates derived from the studies were open to question. Secondly, it found that almost no research had been conducted into drug-driving in Scotland. That is where the research conducted by System Three and the centre for drug misuse research at the University of Glasgow comes in. We examined the nature and extent of drug-driving in Scotland, in the hope of plugging that information gap and in order to help the work of the road safety campaign.

The brief for the part of the study undertaken by System Three was to estimate the prevalence of drug-driving among 17 to 39-year-old drivers in Scotland. We were as inclusive as possible: our survey was nationally representative and we carried out interviews throughout mainland Scotland and the Highlands and Islands. Moreover, any 17 to 39-year-old driver was eligible for inclusion—we did not focus on specific at-risk groups. Both those steps were necessary in bringing us to our general prevalence estimate.

Given that we were using a survey methodology and that the key aim was to uncover prevalence, a probability design was demanded by statistical theory. What that means, crudely, is that we took a random selection of households in Scotland, from which we interviewed one individual, who was selected at random. Therefore, the people to whom we talked should be broadly representative of the population as a whole. That approach allows us to say, "Our survey suggests this," and we can be reasonably confident that the same picture is true throughout Scotland.

The most important methodological point is how we conducted the interviews. When one is dealing with sensitive research topics, a key way of getting people to admit to illegal behaviour is to use self-reporting techniques. We did not use a pen-and-paper self-completion questionnaire. Instead, we used CASI—computer-assisted self-interviewing—with the interviewer simply handing over the CASI machine, which is a laptop computer with a touch-sensitive screen, to the respondent. The respondent then reads the questions off the screen and enters their answers into the machine. Evidence from the British crime survey in particular suggests that the CASI technique increases the rate of admission—it seems to encourage people to believe that the system is confidential and anonymous, which makes them more willing to admit the true extent of their behaviour.

It is also important to consider some of the study's limitations. The first set of limitations relates to sample coverage. This may seem obvious, but because the survey was a household survey—as a result of practical and budgetary constraints on the study—it excluded people who were not resident in private households. Groups such as homeless people and the prison population would not have been eligible for inclusion in the survey. It is possible that the drug-driving behaviour of those groups could vary from that of the population at large but, because they represent such a small proportion of the population, it is unlikely that their exclusion significantly affects the prevalence estimate.

Age is the second factor in the sample coverage limitations. We focused the study on 17 to 39-year-olds partly because of practical and budgetary constraints and partly because of what emerged from the literature review by Pavis and Akram. Their evidence suggested that drug-driving was more common in the under-40-year-old age group, so it made sense for us to focus the study on that group.

My final point on sample coverage is on non-response. As I said, we conducted the survey by selecting households, from which we then selected an individual. In some cases, we were unable to speak to that individual—they may have refused to take part in the study or we may have been unable to make contact with them—which raises the issue of non-response and whether the people to whom we talked were different from the people to whom we did not talk. Thankfully, in this study, non-response was not particularly significant, although we should bear it in mind.

The second set of limitations relates to the accuracy of reporting. Despite what I said about the use of CASI and the fact that it seems to encourage people to tell the truth, under-reporting is inevitable in any study. No matter what methodology is used, and no matter how the questions are desensitised, some people will not be willing to admit to what is illegal behaviour. Because of under-reporting, it is important that we treat the prevalence estimates as lower baseline estimates.

We wanted to know whether people were driving under the influence of drugs but, within the context of survey research, it was not possible to collect all the information necessary to assess whether someone was actually under the influence when behind the wheel. Instead, we assigned what we called effective time periods to the various drugs. For example, a respondent might be asked, "Have you ever driven within six hours of smoking cannabis?" We wanted a crude estimate of the average period that a drug, taken in average

quantity, would affect the average person. Such information allowed us to be a little more precise. It is important to bear in mind the limitations of the study when we consider the estimates of the prevalence of drug-driving. As I said, we should treat the estimates as lower baseline estimates.

10:30

The next slide shows two key measurements: the proportion of respondents who said that they had never driven under the influence of drugs and the proportion of respondents who said that they had done so in the past 12 months. The first column is labelled "Any" and gives the totals for any drug. It shows that 9 per cent of respondents said that they had driven while under the influence of drugs and that 5 per cent said that they had done so in the past 12 months. The other columns show the figures for cannabis, amphetamines and ecstasy; they demonstrate that the problem largely relates to people driving under the influence of cannabis. A total of 7 per cent said that they had driven while under the influence of cannabis and 4 per cent said that they had done so in the past 12 months. By contrast, the two other most commonly used drugs—amphetamines and ecstasy—both had figures of 2 per cent and 1 per cent for the two measurements.

An alternative way of examining the issue is not to consider drivers between the ages of 17 and 39, but to consider drivers between the ages of 17 and 39 who have ever used drugs. The next slide shows the figures for the latter group. The "Any" column shows that 27 per cent had driven while under the influence and that 16 per cent had done so in the past 12 months. Again, the columns for cannabis, amphetamines and ecstasy show that the problem is largely one of people driving while under the influence of cannabis. The slides suggest that, among drug takers, drug-driving is not an uncommon problem. However, we must bear in mind the limitations that I mentioned.

The survey also collected a range of demographic information about driving habits. We tried to come up with a risk profile in order to answer the question, "Who is most likely to drive while under the influence of drugs?" The answer in terms of demographics was young males who were not married and had no children—in other words, young males with what might be described as low levels of responsibility. The answer in terms of driving behaviour was people who had points on their licence, who were likely to break the speed limit and who were likely to drink and drive. That suggests that people who take general risks while driving—speeding, for example—are more likely to drive while under the influence of drugs. The answer in terms of alcohol and drugs, as might have been expected, was people who were regular and heavy drinkers and people who had been poly-drug users—people who have used more than one drug—either ever or in the past 12 months.

In summary, the risk profile shows that young males with low levels of responsibility and people who take other risks in their driving, or risks in their use of substances, are more likely to be drug-drivers.

The Convener: Thank you. That was pretty clear. Do you want to take questions now or to move on to your next presentation?

Simon Anderson: It might be sensible to discuss this part of the research first.

Mrs Lyndsay McIntosh (Central Scotland) (Con): I will start by saying that I am pleased to meet people from System Three, because I never see them when they are doing surveys.

I want to ask about the limitations of the survey. It was carried out in private households and so excluded, for example, students in halls of residence, nurses in hospital accommodation and perhaps armed forces personnel. Is that a seriously limiting factor?

Simon Anderson: It is a limiting factor. However, the survey considered prevalence estimates for the population as a whole, so we have to consider the numerical significance of those groups within the population. The issue arises for most household surveys—the Scottish household survey also excludes those groups.

There is good reason for thinking that there are likely to be higher levels of drug misuse among students, but the proportion of them who regularly drive may not be all that high. However, there is a case for considering that group separately. I do not think that the inclusion of students would significantly alter the prevalence rate for the population as a whole, but they are potentially a significant group in their own right.

Mrs McIntosh: So there is scope for further research.

Simon Anderson: Yes.

Mrs McIntosh: The survey points out that the prevalence of drug use and drug-driving is highest among young males and risk takers. Is there more research that could be done on this issue? Would a campaign that was focused on those groups have an effect in highlighting the dangers?

Simon Anderson: We are not especially well placed to answer a question on the effectiveness of campaigning, so I do not want to go too far down that line. However, we have done some research to evaluate specific interventions—young males are a difficult group to get messages across to. As the research indicates, most drug-driving is

done by that population group, so that group should be targeted, if that is what is required.

Mrs McIntosh: Topically, given this weekend's activities, the survey highlighted the fact that the major drug of choice is cannabis. Does that reflect a relatively relaxed attitude of the police towards the consumption of that drug or simply the fact that it is the most readily available drug? Before you answer, I should point out that the police are sitting at the back of the room.

Simon Anderson: On that basis—[*Laughter.*] Cannabis is the most readily available drug. Every study on prevalence shows that it is far and away the most widely used drug. I do not want to comment on any aspect of policing.

Mrs McIntosh: I will save that question for later.

Ms Margo MacDonald (Lothians) (SNP): I will start with a bitter in-joke. It sounds to me as if we could do with a commission to look into who takes drugs, when and under what circumstances they take them, and when they stop taking them. Your research covers the age group from 17 to 39. I would suggest that, within that age range, behaviour will be different and drugs will be used in different circumstances. When evolving policies, we need to consider that. In Edinburgh or any of the university cities, the statistics will be different from those in Ayrshire, for example. The drug of choice may also be different. Do you agree that, although you have made an excellent start and opened up a Pandora's box, we could do with rummaging a bit more?

Simon Anderson: Researchers always agree that—

Ms MacDonald: I do not mean just to make money for consultants. I genuinely believe that you have started the ball rolling.

Simon Anderson: Clearly, the survey is only a first take on the subject. The sample of 1,000 is too small to allow the figures to be broken down much beyond the basic demographic groups. It is certainly too small to allow any geographic analysis.

Ms MacDonald: Although that is absolutely required in the case of drug use.

Simon Anderson: I agree—but one would need very large sample sizes to be confident of differences between geographic areas. There is continuing discussion about the need for a national survey of drug misuse. It may well be possible to incorporate questions of drug-driving into that exercise.

Ms MacDonald: I want to ask about that. Later, we will ask the police how they evaluate driving under the influence. Did you have the opportunity to evaluate how users described being under the influence? I imagine that a high percentage of them said that although they had taken drugs, usually cannabis, they were not impaired. How did they evaluate the effect on themselves and their behaviour?

Becki Lancaster (NFO System Three): The respondents were asked whether they had driven in the specific time frame that Dave Ingram mentioned in the presentation rather than whether they felt impaired. They were also asked what impact they felt taking drugs had had on their driving on the most recent occasion on which they had driven after taking drugs. They were asked whether it made their driving worse or better. Opinions were split.

Ms MacDonald: Apart from wee white lies, how do you account for the difference between the 27 per cent who admitted to having driven having used drugs and the much smaller percentage—16 per cent—who said that they had driven having used drugs in the past 12 months? The figures do not correlate.

Simon Anderson: Drug misuse peaks in the 20 to 24-year-old age group. We considered people up to the age of 39.

Ms MacDonald: So that is the explanation.

Simon Anderson: The relationship between the percentage of people who have ever driven having used drugs and the percentage who have driven having used drugs in the past year will be closer for the youngest age group.

Scott Barrie (Dunfermline West) (Lab): I apologise for holding the committee up. I was at another committee meeting this morning to move amendments at stage 2 of a bill.

The first five categories of the risk profile could apply to me, which is slightly concerning. I have to inform the committee that the last three do not—well, maybe one of them does. How different is the risk profile of drug-drivers from that of drug misusers? Are they not exactly the same?

Simon Anderson: The profiles are similar. Population survey estimates from the Scottish crime survey show that drug taking peaks among 20 to 24-year-old males. There will be an interrelationship between the proportions. We are considering only current drivers. If more people in a certain section of the population take drugs, more of them will probably drug-drive.

Scott Barrie: If the risk profile for drug-drivers is similar to the profile for drug users, is it a separate issue? Is not it just another facet of the misuse of drugs?

Simon Anderson: We may be straying outside our areas of expertise. The two issues are related, but one might have more success persuading

people not to drive after taking drugs than persuading them not to take drugs.

Scott Barrie: Indeed. I was going to come to the conclusion that that is why it is different. Although the profile is similar, we are studying it for the reason that you have just mentioned. In your survey, was there any way of establishing whether people had considered that? The campaign on drink-driving has been successful, although its success may have reached a plateau. Drink-driving is now seen as unacceptable, whereas at one point it was relatively acceptable.

Simon Anderson: The qualitative study might have more direct relevance for the committee on that matter. We know from other work that we have done that young people tend to be much more likely to condemn drink-driving than drug-driving. That is a qualitative rather than a quantitative finding.

The Convener: I have some questions about what happens with the research. How is it translated into a campaign? Do you want to say something about that, or should we just fire away with questions on the subject?

Simon Anderson: Perhaps we should come back to that after Joanne Neale's presentation. The work that the centre for drug misuse research did was qualitative, so it gets much more into attitudinal data.

The Convener: Okay. I will come back to it after Joanne Neale's presentation.

10:45

Ms MacDonald: I may be anticipating the issues to which Joanne Neale will refer. If there is going to be a campaign, we must understand where we are starting from in respect of users' perception. Even people in the high-risk group know that drinking and driving is a no-no—that is established for drinking, but it is not established for taking drugs and driving. Is it possible to establish that it is as socially unacceptable to drive having taken drugs as it is to drive having taken alcohol unless you have determined what the acceptable limit of consumption is? It is relatively easy with alcohol, because people are either over the limit or they are not—when they go out, people know how much they can drink. The issue requires a lot more study if the research is to be used to move on and make policy.

Simon Anderson: The parallels are difficult, because with drug-driving the act of taking the drugs is illegal.

Ms MacDonald: Forget that for the moment. We are talking about perception.

Simon Anderson: I do not think that we are well placed to comment on that on the basis of this research.

Ms MacDonald: I have a factual question. I apologise if I missed this; it might be in the survey on recreational drug use and driving. I read that the percentage of people involved in road accidents is 18 per cent. That may have been police evidence. Was there a great difference between the number of accidents that occurred after drug use as opposed to after alcohol use?

Dave Ingram: We did not collect that information in the study.

Ms MacDonald: I apologise. It might not have been in your report. I have read quite a lot of reports now.

The Convener: Joanne Neale will now make her presentation.

Dr Joanne Neale (University of Glasgow): I am from the centre for drug misuse research at the University of Glasgow.

The main objective of the research that we conducted was to complement the System Three prevalence work, by providing a more in-depth, qualitative investigation of the links between recreational drug use and driving. We were interested in building up a more detailed and rounded picture of drug-driving. That includes not only who does it, but when they do it, why they do it and how they feel about it when they are doing it.

Our research has four elements, which are all documented in the main report. As we lack time today, I will concentrate on the study's main aspect, which was a series of 61 qualitative, in-depth interviews, conducted with individuals who were recruited from nightclubs around Scotland. The interviewees were screened to ensure that all were drivers and users of illegal drugs. About three quarters were male and one quarter were female. We sampled a group of people who we thought would be at high risk of drug-driving.

We wanted to find out how many had been involved in drug-driving. Our questioning revealed that about 85 per cent had driven a motor vehicle after using illegal drugs and that about 87 per cent had been a passenger of a drug-driver. Those percentages are much higher than those in System Three's report, which suggests that people who attend nightclubs have a high risk of drug-driving.

We wanted to find out what drugs were involved when clubbers drug-drove. Further questioning revealed that 72 per cent had driven after using cannabis, 32 per cent had driven after using ecstasy, 25 per cent had driven after using amphetamine, 11 per cent had driven after using cocaine and 8 per cent had driven after using

LSD. As with the System Three research and other international studies, we found cannabis to be the main drug involved in drug-driving.

That leads us to consider who the main risk groups for drug-driving are. Consistent with System Three's research, we asked our interviewees who they thought would be at risk. They told us that young people, especially young males, were particularly likely to drug-drive, because that population has a high incidence of drug use, is susceptible to peer pressure, is generally quite accepting of drug use and tends to behave in risky ways. The interviewees identified clubbers as another high-risk group, because clubbers accept drug use and tend to believe that drug taking is safe. Cannabis users were considered a high-risk group because cannabis use is widespread and the drug stays in the body for several weeks. The interviewees also thought that people who live in rural areas would be at high risk, because they tend to be dependent on cars.

We then asked our respondents to discuss how drug use affects driving. Their responses revealed that the effects of drugs on driving are complex and relate to three factors—the drug that has been taken, the individual and the situation. The variation by drug relates to the type of drug. Cannabis, for example, was often considered all right and quite safe—it was thought that it might sometimes enhance driving ability—but drugs such as ecstasy, amphetamine and, in particular, LSD were considered to have a more negative effect on driving.

The effects on driving also depend on the quantity and strength of the drug that is taken and on interactions with other drugs, such as prescribed medication, or with drink. The effects of drugs also vary by individual and depend on the individual's tolerance—how used they are to taking the drug—their body size and their general driving ability. If the individual is a poor driver, it is likely that their driving on drugs will be worse than that of someone who is a better driver. The effects on driving also depend on the situation—the time between taking the drug and getting in the car and driving, distractions from passengers, whether the driver was travelling late at night and was therefore tired and the driver's mood.

Another important question was why people drug-drive. Some of our interviewees told us that drug use and driving were everyday aspects of their lives, so they inevitably occurred together. Others said that they would drug-drive only if there were no alternative transport available that was convenient and cheap. Some people said that they drug-drove because they felt that it involved no danger—that attitude related mainly to cannabis-driving. Some said that they drug-drove because they felt that there was little chance of being caught or punished. Some said that they drug-drove because it was acceptable behaviour among their friends. A minority of people said that they smoked cannabis on a long journey because it prevented them from becoming bored.

There was much uncertainty about the law on drug-driving and the penalties that could result from it. Despite that, most of the respondents agreed that some penalties were necessary and acceptable. However, they also wanted more research to evaluate how dangerous drug-driving is. The interviewees felt that it should be recognised that people have different tolerance levels and so the effects of a drug on driving depend on how used someone is to taking that drug. They also highlighted the fact that current roadside testing techniques are problematic and need improved accuracy.

On the basis of our research, we can make recommendations on prevention strategies. It is important to target the right groups—young people, especially young men; clubbers; cannabis smokers and people who live in rural areas. Cannabis may need a different prevention strategy from that for other drugs, because cannabis is commonly described as okay to use before driving, as its effects are minimal, whereas people perceive driving on other drugs as more dangerous. Driving on cannabis also occurs frequently, whereas driving on other drugs occurs less frequently.

Greater dissemination of the facts about the law and penalties is needed, so that people who drug-drive know what the legal consequences of their actions may be. We need increased policing and more legal sanctions. That might stop drug-driving, especially among those who drug-drive simply because they feel that there is little chance of being caught. More public transport is needed, especially for people who travel home late at night and in the early hours of the morning, after leaving clubs. Such transport could take the form of minibuses or special coaches that would provide cheap transport between clubs and residential areas.

It might be a good idea to involve drug users in designing prevention campaigns, so that the message is credible and the tone is right. Many of us have mentioned the difficulty of getting the message across to people who are resistant to health education and Government messages. If those people are involved in designing the campaigns, we stand a better chance of getting the tone right. On a similar note, we should encourage drug users who refrain from drug-driving to get prevention messages across to their peers. Finally, we must change social attitudes to drug-driving. Many young people feel that drug-

driving is acceptable and have not questioned it. Attitudes to drink-driving have become more negative in recent years and there is no reason why we cannot change attitudes to drug-driving too.

The Convener: Some members will have been alarmed by some of the information that was uncovered and will want to pick up on several points. I have some questions on what you said about prevention strategies. You recommend different strategies for different drugs. Given that clubbers feel that cannabis is not as dangerous as other drugs, such as LSD, are you suggesting that a campaign might concentrate on cannabis users?

11:00

Dr Neale: The problem is quite pervasive. No one strategy will be sufficient—we need a range of strategies, which might include specific strategies for targeting cannabis. For example, cannabis-driving is likely to occur during the early evening, but it may occur during the day. It is a more regular day-to-day activity. The people who drive after taking cannabis are likely to span a much wider age range. People who drive after taking ecstasy, speed, amphetamines and LSD are most likely to drive from the early hours of the morning—after 2 am—up to midday. We are talking about late Friday night until midday Saturday and late Saturday night until midday Sunday. If we were to introduce a police crackdown, it would make sense to target those times of the day. However, while we would trace drivers who may be driving with a large degree of dangerous drugs in them, we would miss all the cannabis-drivers who are out in the middle of the afternoon, driving to the shops and so on. There is a need for two types of strategy; one, if used exclusively, would miss much of the population that we are concerned with.

The Convener: I appreciate what you are saying about targeting—we can perhaps raise that issue later with the police. However, if we are considering a public information campaign to make drug-driving socially unacceptable, in the way—as Scott Barrie said—that we have done with alcohol, should we target cannabis in particular? I ask that because what is striking about the research is the fact that a high proportion of cannabis users do not seem to think that cannabis-driving is dangerous.

Dr Neale: That is definitely the case. The problem is that people do not consider the effects of what they are doing. An awareness-raising exercise would be beneficial. As with drink-driving—there will always be a hard core of people who continue to drink and drive—there will always be regular cannabis users who decide to drive after taking the drug. However, we would pick up many people at the margins simply by raising their awareness and telling them, "You should think about the effects of driving within 12 hours of taking cannabis."

The Convener: You have drawn to our attention the need for other policies to be put in place—you mentioned public transport, for example. We would suggest that the Parliament's Transport and the Environment Committee—which may already be considering the issue—should pick up on the research.

Scott Barrie: Pauline McNeill touched on alcohol misuse. Has any comparison been made with attitudinal surveys of say, 20 years ago, on alcohol and driving? I note that some of the respondents said that there are different degrees of tolerance to drugs. It was always said about alcohol that person A could drink X number of units because they had a bigger build or had just eaten a meal—people were always trying to justify why they could drink a bit more than what was considered to be safe.

Dr Neale: We asked our respondents about their drink-driving behaviour. It was interesting that, although some of them had driven while drunk, their attitude towards drink-driving was different. They perceived drink-driving as very negative—after having done it they felt ashamed of it. They saw it as a major hazard. Their views were strongly anti-drink driving. On the whole it is something that they would not contemplate doing.

The drug users we spoke to were acutely aware of the tolerance issue. That should be borne in mind when prevention strategies are drawn up. If we put a simple message across—"Do not take drugs. Zero tolerance. Do not drive."—we will stop some people driving after taking cannabis, but a large number of drug users think, "I smoke cannabis several times a day. If I have one joint and drive my car, I will not be impaired." We need specifically to address that issue, because otherwise we will turn off a lot of people out there.

Scott Barrie: In the research, was there any examination of the misuse of prescribed medication?

Dr Neale: Yes. We asked the people we interviewed about driving on prescribed medication. It was clear from the interviews that the drug users we spoke to were quite aware of the sometimes contradictory nature of what they were saying. They would say, "I know that it sounds a bit odd that I am saying that drug-driving is okay and drink-driving is not." That came out especially when we asked them about whether they had ever driven under prescribed medication. For many of them it was not relevant—they had not been on prescribed medication. Others had been and despite being aware that they should not

drive if they were drowsy, had still done it. Again, they highlighted that by saying, "I'm being contradictory here. I'm saying that I know I shouldn't do it, but I've done it."

Mrs McIntosh: I was especially struck by a couple of things on the overheads. One that comes to mind is that the boredom of a long journey is a justification for taking drugs. As I am not in the age group for the study, I stick to the radio or a compact disc.

I was interested in your comment about targeting the right groups. How should that be done? I have visions of dealers handing out health education literature packs when people go to buy their supply of cannabis. We ought to have considered targeting those groups before now to get the message across.

Ms MacDonald: We need a commission—I told you that.

Mrs McIntosh: Well, possibly. Most of the respondents who use cannabis do not consider that they have a drug problem and have personal strategies to keep their drug consumption under control. Could the high profile afforded to the debate on the decriminalisation of cannabis have contributed to the perception among respondents that cannabis is a relatively safe drug?

Dr Neale: I cannot comment on whether the debate has contributed to that perception. I can say that many people think that cannabis is a safe drug. I am not sure to what extent the debate has added to that.

Mrs McIntosh: Perhaps we will find out later.

Ms MacDonald: I return to a question I asked the witnesses from System Three about how people evaluate whether the effects of their behaviour are very serious, serious, not so serious or negligible. You have talked about the rationale that is deployed—"I am a big person; it takes a lot to knock me over" and so on—but are there any accepted studies on the levels at which cannabis consumption affects behaviour, for example walking in a straight line, driving a car or operating machinery? Is there anything to which we can refer? It would be difficult to persuade someone who uses drugs but does not believe they have a drug problem not to drive. Although they believe that it is advisable not to drive after using cannabis, they think to themselves, "Och that was 10 hours ago. It'll be out of my system by now." Have any measurements been used in studies that could tell us what the facts are?

Dr Neale: The problem is that it is difficult to measure. There are guidelines, but they are subject to factors such as tolerance to the drug, which is very individual.

One of the interesting findings of our study, which has also been found in other research, is that people who have taken drugs feel that they are able to know when they have taken enough to be impaired. One might argue that they are already impaired, so they could not know that. When they talk about drink-driving, the feelings that they describe are of being out of control and of not being able to walk. When they talk about drugs-driving, they say that drug use and alcohol use have different effects and that they feel that they can take compensatory action—that they can pull themselves round when there is a need to do so. For example, they describe being stopped by the police, having to pretend to be normal and being able to pull it off in a way that would have been impossible if they had been drunk.

The Convener: Do you want to comment on that, Simon?

Simon Anderson: I think that Dave Ingram has sent some stuff to you about a recent Department of the Environment, Transport and the Regions study into the effects of cannabis use on driving ability. There are issues surrounding the extent to which cannabis affects drivers and the popular conception of the ways in which it affects them. Alcohol misuse is easier to deal with.

The Convener: Do you have any final comments to make in summary, before we move on?

Simon Anderson: I would like to ensure that the difference between the two elements of this study is clear. The percentages that Joanne Neale has been referring to are based on a qualitative sample of clubbers; they are not based on a general population sample. That is an important group as it contains high levels of drug misuse and, as Joanne Neale's research shows, those people are likely to take drugs and drive. However, of the sub-sample of the general population who had driven under the influence of drugs in the past year, just three of the 57 respondents to our survey had been going to or from a club, disco or rave. Most of those who were cannabis users were engaged in much more mundane activity of the kind that you have described. It is important not to lose sight of that part of the picture.

The Convener: Thank you for your evidence, which was most interesting. If we decided to take more evidence on the subject, would you mind returning to the committee?

Simon Anderson: No.

The Convener: You would come back. Thank you very much.

I invite the next group of witnesses to join the committee. We welcome Assistant Chief Constable David Mellor and Inspector Paul Fleming of the Association of Chief Police Officers

in Scotland, and Constable Nicholas Roberts and Constable Andrea Russell from Strathclyde police force. I apologise for the fact that you have had to wait so long. I am sure that it will have been worth it—for us, anyway.

11:15

Assistant Chief Constable David Mellor (Association of Chief Police Officers in Scotland): I shall briefly introduce the quartet from the police service. I am David Mellor, the assistant chief constable of Fife constabulary. With ACPOS—the Association of Chief Police Officers in Scotland—I am responsible for a number of road policing issues, including drug-driving. I also have a wider interest in the issue of drugs as I chair Fife's drug and alcohol action team.

Paul Fleming is an inspector in Strathclyde police. He pioneered the police research into drugs and driving, which started back in 1997. His research led to the initiatives that have been taken throughout the UK for tackling drugs and driving. PC Nick Roberts was involved in the training of police officers in Aberdeen, which took place in March. Officers were trained to be trainers, to cascade down the training for officers to operate the field impairment test, which can be demonstrated in a short while if the committee wishes. He has used the techniques that he learned. PC Andrea Russell has also used those techniques and has given evidence of them in court cases. That is the expertise that my colleagues can provide.

Andrea Russell and Nick Roberts will be able to demonstrate the field impairment test, should the committee wish them to do so. I understand that a volunteer might be prepared to put their reputation on the line by participating in that test. I shall proceed with a few opening remarks, before we demonstrate the test—if you wish—and invite questions from the committee.

Tackling drug-driving is part of tackling drugs problems generally. The Scottish drugs strategy was published in 1999 and has four pillars: educating young people; protecting communities; treatment and rehabilitation; and stifling the availability of drugs. Tackling drug-driving is a very important element of that strategy.

The effects of alcohol on driving performance are well documented, although it is a little complacent—and I have been guilty of this complacency in recent years—to suggest that we have cracked the problem of drink-driving. The view prevailed that all we had left to tackle was a hard core of middle-aged men who just would not listen to the message we were putting across. However, in Fife, over the past year, we carried out a survey of people whom we detained for drink-driving and found that, contrary to our misconceptions, 50 per cent were under the age of 40. Although they were predominantly men, a significant number were female drink-drivers. There may also be a link between drink-driving and other risk-taking behaviour among young people. Although Dr Neale's study suggests that the people whom she surveyed strongly condemn drink-driving, the evidence in the Fife area shows that there is still a significant problem of drink-driving among young people.

The training on drug-driving, that was provided in Aberdeen earlier this month, was designed to equip our officers to carry out field impairment testing at the roadside, as the first step in assessing whether there is impairment due to drugs. The test was trialled satisfactorily in Scotland; Nick Roberts and Andrea Russell can talk about that as well. Margo MacDonald mentioned 18 per cent: it may have been the UK statistic for road accident fatalities involving people who had been using some form of illicit drug.

That is the end of my opening statement. We are happy to take questions, demonstrate the test or do whatever you like, within reason.

The Convener: Thank you very much. I cannot resist the temptation to ask committee members whether they would like to see the impairment test.

Members *indicated agreement*.

The Convener: Do we have a volunteer?

Scott Barrie: I will do it.

The Convener: I had a feeling that Scott would volunteer.

Assistant Chief Constable Mellor: As he fits so many of the criteria that the research employed, Scott Barrie is the ideal choice.

The Convener: We will have the test on the right of the table and I would like it to be in the *Official Report.* Members should remember to speak in such a manner as to enable it to be reported. They should therefore speak into the microphones. Recording such a demonstration will be a first for a parliamentary committee.

Ms MacDonald: The real test to worry about is the sanity test.

Inspector Paul Fleming (Strathclyde Police Force): Do you want me to provide a commentary?

Ms MacDonald: It would be useful if you would tell us what happens at a typical scene. I know that Strathclyde police is ahead of other forces in the implementation of roadside tests and so on. You could explain what would lead an officer to decide that they were going to stop a certain driver and what would happen after that.

The Convener: A commentary would be useful in helping us to understand the demonstration.

Inspector Fleming: Nick Roberts will demonstrate the pupil examination first. He will check for certain signs that can be attributed to drug consumption—some drugs, such as opiates, will constrict the pupils while others, such as amphetamines and cocaines, will dilate the pupil. Using a small gauge, we examine the size of the person's pupils.

Constable Nicholas Roberts (Strathclyde Police Force): I will run through the test from beginning to end. Feel free to stop me at any point if you have questions.

Prior to the test, there is an introduction and a caution. The test is the final step in the roadside examination, after we have assessed the shortcomings in the person's driving ability. While interviewing the driver, we look for the signs of drug use and ask pertinent questions. That process will allow us to decide whether we want to proceed with the field impairment test.

Ms MacDonald: Would you first test for alcohol misuse?

Constable Roberts: Yes, we rule that out initially. If the person shows signs of alcohol misuse, the test that I am about to demonstrate will be dropped and we will follow the alcohol procedure through to its conclusion. If the alcohol test shows that the person has drunk less than the prescribed limit but impairment is still present, we will revert to the drug-driving system, although we would not run the test that I am about to perform.

Inspector Fleming: It is important to realise that the legislation that we are operating under—sections 3 and 4 of the Road Traffic Act 1988—relates to impairment through both drink and drugs.

Ms MacDonald: If you notice erratic driving, you would stop the car.

Inspector Fleming: We teach officers a package of responses. The keystone of the process is the person's driving. Did the person go through a red light? Are they weaving about? Are they driving too slowly? That is the starting point and the techniques that we are discussing follow from that.

Constable Roberts: I will run through the introduction.

Mr Barrie, to assess whether your ability to drive is impaired, I would like you to perform a series of tests. The tests are simple and will enable me to make a judgment as to whether your ability to drive is impaired. I must caution you that you are not required to participate. If you do, the results of the tests may be used in evidence. Part of the evaluation is based on your ability to follow my instructions. If you do not understand any of the instructions, please tell me so that I can clarify them. Do you understand?

Scott Barrie: I understand.

Constable Roberts: Do you agree to participate in the test?

Scott Barrie: I do.

Constable Roberts: I am going to examine the size of your pupils by comparing them to a gauge that I am holding up at the side of your face. All I require you to do is to look straight ahead and keep your eyes open. Do you understand?

Scott Barrie: I understand.

Constable Roberts: Are you wearing contact lenses?

Scott Barrie: Yes. Is that a problem?

Constable Roberts: It is not a problem, but I would record that fact to ensure that I had asked. It does not affect the test.

The next step is for me to record the size of each pupil against the gauge, which will give me an accurate indication of the size of the pupil, which will be recorded as constricted, normal or dilated.

Inspector Fleming: It is important that we realise that, under various lighting conditions or due to emotions such as fear or excitement, the pupil size might change. We teach officers to be aware of the fact that such factors must be taken into consideration, particularly during the hours of darkness or in bright sunlight.

Ms MacDonald: What if the officer is wearing contact lenses?

Mrs McIntosh: Did Mr Barrie pass?

Constable Roberts: I did not really do the test.

Scott Barrie: Of course I passed.

Mrs McIntosh: I just wanted that fact on the record, Scott.

Constable Roberts: Mr Barrie, please stand with your heels and toes together with your arms by your side. Maintain that position while I give you the remaining instructions. Do not begin until I tell you to. When I tell you to, tilt your head back slightly and close your eyes. When you think that 30 seconds have elapsed, bring your head forward, open your eyes and say, "Stop." Do you understand?

Scott Barrie: Yes.

Constable Roberts: Tilt your head back. Close your eyes. Begin.

Inspector Fleming: This test is known as the Romberg test. The officer has got Mr Barrie to stand in what we call a start-up stance, with his heels and toes together and his arms down by his side. It is a lot easier for people to stand with their legs open and their arms at their side. However, when someone has an impairment—which could be due to a number of factors including drugs—they might start to raise their arms or step away from the position that they have been put in.

Scott Barrie: Stop.

Inspector Fleming: When the person is estimating 30 seconds, the officer is checking for how well they keep their balance.

The estimation of the length of 30 seconds is important as research has shown that a person who is under the influence of drugs such as stimulants that speed up the internal body clock might think that 10 or 15 seconds was 30 seconds. People who have been using opiates or depressants, which slow down the system, might estimate that one minute or 90 seconds was 30 seconds. That is not a definitive test and we would not arrest someone on that basis, but it indicates that something is not quite right.

Ms MacDonald: I assume that blood pressure can affect that, too.

Inspector Fleming: Yes.

Constable Roberts: The doctor to whom you will speak later might talk about that. At the time, however, we would simply record the time that the person estimated rather than make a final judgment.

Mrs McIntosh: Can we have the results of Mr Barrie's test?

Constable Roberts: Yes. As we are looking for clues, we record factors such as the ability to follow instructions, swaying, raising of hands or stepping. The only obvious problem, which was not technically a clue but which would be recorded, was that he did not follow the instructions correctly and started before he was instructed to. I would record that, but it is not a make-or-break error.

Mrs McIntosh: How was his estimate?

Constable Roberts: The estimate was bang on.

Mrs McIntosh: I will tell you why I am curious about that. While Scott Barrie was counting, you were talking to us and I think that that might have distracted him.

Constable Roberts: It did not. His timing was spot on.

Ms MacDonald: Can you not count and listen at the same time, Lyndsay?

Mrs McIntosh: I can and I did.

Ms MacDonald: Constable Roberts, you should test her.

Constable Roberts: For the next test we have to find a line or imagine one. This room has a beautifully lined carpet but we will imagine a line just in front of Mr Barrie. I will demonstrate what to do while I explain the test.

Mr Barrie, please put your left foot on the imaginary line and place your right foot in front of your left foot, touching heel to toe, with your arms by your side. Maintain that position while I give you the remaining instructions and do not begin until I tell you. When I tell you to, take nine heel-to-toe steps along the line. On each step, the heel of the foot must be placed against the toe of the other foot. On the ninth step, leave the front foot on the line and turn around using a series of small steps with the other foot. After turning, take a further nine heel-to-toe steps along the line. During the test, keep your arms close by your sides, watch your feet at all times, count the steps out loud and do not stop walking until the test is complete. Do you understand?

Scott Barrie: Yes.

One, two, three, four—

Constable Roberts: Keep your arms by your side.

Scott Barrie: —five, six, seven, eight, nine. I cannot remember whether I was supposed to turn at the end.

Ms MacDonald: We will get him a good human rights lawyer.

Scott Barrie: One, two, three, four, five, six, seven, eight, nine.

Constable Roberts: That is fine, thank you. This is a good opportunity to stress that there is no pass or fail. I challenge anybody to come up here and not register some clues. I did this with my wife last night: she registered some clues and I am fairly positive that she was fairly sober. You would expect some clues to be recorded during the testing. We have demonstrated a few of the clues that we would record and use in our analysis in the totality of the procedure. There is no pass or fail for any of the tests. A person can do dreadfully in one test and perfectly well in another, and still we would permit them to go on their way. It is about the totality of the process.

11:30

Ms MacDonald: Yes, but he got three and a half out of 10 for that, which will bring down his average score. Is the process as formulaic as that, or is it about the impression that you get?

Constable Roberts: No. All I do is record the clues, such as raising of the hands, swaying and turning in the wrong manner, which comes under the guise of inability to follow instruction.

Ms MacDonald: But we knew that about Scott Barrie.

Constable Roberts: We record those and have them in front of us so that we can make a decision at the end, but we do not say that because an individual got three tests wrong, or three indicators were present, we will arrest him and take away his liberty. We do not do that; it is the whole process that matters.

Ms MacDonald: Re-education is called for here. Are there any more tests?

Constable Roberts: Yes, there are a couple of tests. With permission, I will abbreviate the next test, because it involves standing on your leg for 30 seconds.

Mrs McIntosh: Oh please, let us see that.

Scott Barrie: I can do that.

Constable Roberts: Please stand with your heels and toes together, and with your arms by your sides. Maintain that position while I give you the remaining instructions. Do not begin until I tell you to. When I tell you to, I want you to raise your right foot approximately 6in off the ground, keeping your leg straight and your toe pointing forward. Look at my feet and see how I am doing that. Keep looking at your foot. Keep your arms at your side, and count out loud in the following manner: 1,001, 1,002, 1,003, until I tell you to stop. Do you understand?

Scott Barrie: I understand.

Constable Roberts: Have you a medical condition or disability to prevent you from doing this test?

Scott Barrie: No.

Constable Roberts: Raise your right foot and begin.

Scott Barrie: Okay: 1,001, 1,002, 1,003, 1,004, 1,005, 1,006, 1,007, 1,008, 1,009, 1,010, 1,011, 1,012, 1,013, 1,014, 1,015, 1,016, 1,017, 1,018, 1,019, 1,020, 1,001, 1,002, 1,003, 1,004, 1,005, 1,006.

Constable Roberts: That is fine, thank you. I would then repeat the test using the other leg.

Ms MacDonald: These are pretty hard tests. Do we have figures on how different age groups respond to them?

The Convener: Can we get through the tests first and deal with that later?

Constable Roberts: The final test is a finger-to-nose test. Cannabis affects your depth perception and spatial awareness, and this test, in which with your eyes closed you try to touch the end of your nose, can highlight that. A fairly common symptom of cannabis use is that you stop before you get to your nose and have to start fishing for it.

Please stand with your heels and toes together and with your arms by your sides. Extend both arms forward, palm side up. Make fists, extend both index fingers and lower your hands by your sides. Maintain that position while I give you the remaining instructions and do not begin until I tell you to. When I tell you, I want you to tilt your head back slightly, close your eyes, and raise your arms slightly forward. I will then say either left or right, at which time put the relevant hand directly in front of you and touch the tip of your nose with the tip, not the pad, of your index finger. After touching your nose, lower the hand until I tell you the next hand to use. Do you understand?

Scott Barrie: I understand. This is when you wish you were Gérard Dépardieu.

Constable Roberts: Tilt your head back slightly, close your eyes and raise your arms slightly forward: left; right; left; right; right; left. That is fine, thank you. That is the conclusion of the test.

The Convener: Thank you. That is what happens to you if you are late for this committee. [*Laughter.*] Thank you Scott, and thank you Constable Roberts.

Inspector Fleming: It is important that you realise that although these tests are contrary to what police officers are used to doing, they are serious. Inevitably, when you demonstrate them, there is a giggle and a laugh factor—there is no doubt that that will happen—but the tests that we are proposing to use and which we have described are used by our police surgeons, albeit in a controlled environment.

A number of factors are taken into account at the roadside. Ms MacDonald mentioned age. A person's performance in each test will be influenced if they are overweight, if they are suffering from an illness or injury, or if they are fatigued because they have been driving for a long time. The keystone indicator is driving—that is the first thing—and thereafter drug influence recognition, for which we can identify certain signs and symptoms for six drug categories.

Secondly, during the interview with the person we look for clues in their demeanour, for example the way they speak and behave. Thirdly, we ask the person to participate in field impairment tests. We ask them to participate at the roadside because that is closest to where the offence has been committed.

The difficulty is that once the officer has decided

that the person is to be arrested, there can be a delay of between an hour and a half and two hours from the initial stop to the police surgeon doing the examination. The example of cannabis was cited; the impairment effects of cannabis are short term. A lot of the time individuals are not found to be impaired by the police surgeon, but they quite evidently were impaired at the roadside. Roadside testing is a way of better articulating the evidence to the court, so that the court can make up its mind based on all the circumstances. It is a way of enhancing the procedure, not changing it. The police surgeon is still an integral part of the system.

When I was in America, I found that the police surgeon had been excluded from the process. Specially trained police officers known as drug recognition experts conduct a medical examination as well as the tests that have been described. We do not suggest that the police surgeon should be removed from the process, because if the impairment is not drug-induced—if it is due to illness or injury, for example—we are looking for the police surgeon to identify its cause. Once the police surgeon has made their assessment, we can get a biological sample if the person agrees.

The Convener: I know that members wish to ask a number of questions, so I suggest that we do so for the next 10 or 15 minutes. The first set of questions will be to ensure that we have asked everything about roadside testing. I want to spend some time getting the witnesses' views on how we use qualitative research, because they are the practitioners and it is important to get their views on the record. We can deal after that with any other matters. What did the police do prior to roadside tests?

Inspector Fleming: There has been a piecemeal approach. Officers have made assessments based on an individual's driving. An untrained officer will look at the individual, and the usual phrases that one will hear from that officer are, "The person's eyes were glazed, their speech was slurred and they were unsteady on their feet." That usually amounts to all the evidence on a person's driving that is presented to a court.

Thereafter, the police officer has a difficulty. He must make a subjective assessment of what he knows and what he has seen and decide whether to arrest that individual. At the moment, the culture tends to be that police officers rely on the roadside breath test machine to determine alcohol levels. If we use the breath test machine and the result is not positive, we go back to old powers that we used in days gone by, although officers are not particularly conversant or comfortable with those powers. Officers then try to make an assessment. The idea is to enhance and improve the officer's assessment at the roadside.

The Convener: Given the quality of testing in the past, do you have information about the rate of conviction in the past?

Inspector Fleming: Unfortunately, I do not.

The Convener: Do you have a general impression of whether there was a low conviction rate? Did the fact that there was not a proper and recognised roadside test hold you back?

Inspector Fleming: Anecdotally, my general impression is that, once we have gone through the procedure, and the police surgeon has agreed with the officer's assessment and we have a biological sample, there is a high conviction rate. Difficulty arises where there is a time differential between the initial assessment and the police surgeon arriving. The surgeon might by that time not agree that there is impairment, or the surgeon might not find a condition that is due to a drug. If we do not get a biological sample, a conviction is open to challenge because there is no scientific evidence.

The Convener: Earlier, Margo MacDonald asked the researchers about not having measures to assess when intake has been exceeded. Do you have a view on that?

Inspector Fleming: As far as police officers are concerned, enforcement would be far easier if there were set limits for drugs, as for alcohol. However, I have spoken to researchers and toxicologists and it is very difficult—if not impossible—to set limits. However, that field is outwith my expertise.

The Convener: Do you feel that we should set limits rather than enforce total abstinence of a particular drug?

Assistant Chief Constable Mellor: That would be a very interesting debate in terms of the Misuse of Drugs Act 1971. The debate concerns whether any level of illicit drugs is acceptable and whether setting a limit higher than total abstinence sends out a mixed message or a message that is inconsistent with the current strategy of enforcement through that act.

Ms MacDonald: I appreciate that the answer to my question will be subjective and anecdotal, but I believe that Constable Russell has given evidence in such a case in court. This may seem strange, but how were you questioned, Constable Russell?

Constable Andrea Russell (Strathclyde Police Force): I was questioned on the method of our training, what was in the tests and what signs of drugs I saw in each person with whom I had dealt. I was asked how I formed conclusions from the tests.

Ms MacDonald: We could do with some research on that. We need, perhaps, to examine

cases in Scottish courts over the last two or three years.

Constable Russell: The problem in the past has been that both driving while unfit through drink and through drugs come under the same category and have been banded in the same area.

Inspector Fleming: The tests and subjects with which Andrea Russell was involved were within a specified period. We have not been using those techniques. During June and July 1999, a number of officers in Strathclyde and in five other forces in England and Wales were trained in the techniques for the purposes of evaluation. The Transport Research Laboratory published a report on the evaluation. I think that the techniques were used in Scotland over five weeks.

Thereafter, we stopped using the techniques, because we wanted to see the results as cases went through the courts system, as well as the Transport Research Laboratory evaluation of the techniques. The techniques have not been used since the summer of 1999, although we are now starting to introduce training in them now.

Ms MacDonald: We shall see what we can learn from that. What about the wipes? I have read about them.

Inspector Fleming: Again, that is slightly outwith my area of expertise, although I have been involved on the periphery. There are a number of devices that will detect whether a person has a substance in their system. The preferred option for the police would be the sweat device or the saliva device. There are other devices to examine samples of urine, but it is not particularly useful to use them at the roadside. However, I sound a note of caution about the sweat and saliva devices. They can be useful to an officer at the roadside, but all that those devices will say is that a person has a particular drug in their system. They do not say whether that person's ability to drive is impaired, which is a road safety issue. The devices must be used hand in hand with judgment about impairment and the amount of the substance in the driver's body.

11:45

Ms MacDonald: If somebody takes Distalgesic, it could impair their driving and their judgment on stopping at lights and so on. Could they be prosecuted under the same legislation that catches people for careless or reckless driving?

Inspector Fleming: The same legislation applies to all drugs, prescribed or illicit. If a person's ability to drive is impaired, he or she is unfit to drive.

Ms MacDonald: Are penalties, roughly speaking, the same for somebody who miscalculates a dose of analgesic for pain relief?

Inspector Fleming: Under the present system, the penalties are exactly the same. If an offence has been committed and it is demonstrated that the person was unfit to drive, the cause of that unfitness is irrelevant, whether it is a prescribed drug or an illicit substance.

The Convener: We must remind ourselves that road traffic legislation is a reserved matter and that we cannot change it. However, we can consider in more depth what assistance we could give to a potential change in the law of the UK.

Using the existing law or a new law, how could you get the maximum evidence so that you could achieve a higher conviction rate for on-the-road drug users?

Assistant Chief Constable Mellor: We must monitor closely the Scotland-wide implementation of the field impairment test. As Paul Fleming said, there were trials at six sites in the UK, including Strathclyde, for a short period in the summer of 1999.

This time around, we are in a stronger position to go forward and achieve greater success all the way through the process—including getting a conviction in court—because we have worked closely with Mirian Watson at the Crown Office to iron out a number of legal and procedural issues. We are therefore in a stronger position to overcome any challenges to the validity of the tests or the procedure that is followed, both at the roadside and subsequently at the police station.

There is merit in evaluating carefully how the work goes when we implement it across Scotland, starting in June. We hope to coincide with the safer Scotland campaign on drugs later in the year, and there will be a media release. As members will have seen when we demonstrated the test, there is a difficulty in getting the media to take the issue 100 per cent seriously, because there is a giggle factor in the tests. We will have to work out a media strategy that will ensure that the key road safety messages get across.

It is important to evaluate from June the use of the field impairment test throughout Scotland. It will be used on a voluntary basis and, if it proves to be successful, it would be helpful to be able to use it other than on a voluntary basis, although we found that the majority of people who were asked to perform the test during the trials complied fully.

We need to look at drug-driving as part of the drugs strategy, because we have a significant and growing problem with the misuse of drugs in Scotland. As the researchers said, it might be easier to persuade people not to drive while taking drugs than it is to persuade them to abstain from drugs altogether. However, we must ensure that

that is linked to all other developments. We have an excellent drugs strategy, and we have £100 million over the next three years to develop various elements of that strategy, including some criminal justice elements such as drug treatment and testing, and the possibility of experimenting with drugs courts. We must ensure that our work on traffic is tied into the rest of the criminal justice process. Of course, we also need the science to catch up, so that we can begin to consider the other types of test to which we referred.

Scott Barrie: I have one question, which may have been answered while I was trying to listen to what I was supposed to do when you demonstrated the tests. Everybody will think that I never listen to instructions.

Will you be testing at random, or would the driver have to have drawn themselves to the attention of the police in the first place, by driving erratically or by going through a red light, for example?

Inspector Fleming: I cannot emphasise enough that that is the start point of the process. We do not envisage using the techniques as a random screening test at the roadside.

Mrs McIntosh: Does an officer's evidence have to be corroborated in court by a colleague?

Constable Russell: It has to be corroborated by somebody. I was involved in several court cases and most of the tests were done with a colleague who was also trained in the technique. Both of us got the same findings when we did the test. On one occasion outwith the trial period for the pilot scheme, I gave evidence on a drug-driver on whom we could not conduct the roadside tests because the pilot scheme was over. That driver showed all the obvious signs of heroin use, and the court heard my evidence, along with medical evidence from the doctor.

Mrs McIntosh: What happened to the guys who did not comply?

Constable Russell: They all complied. They all did the test for us willingly.

Inspector Fleming: If they do not comply, we revert to what we do at the moment. The officer must make an assessment. We hope that the drug influence recognition training, which covers the signs and symptoms that can be attributed to each drug grouping, will make officers better informed to make such decisions. At the moment, I do not feel that all officers have had the training to make such decisions as well as they ought.

The Convener: Do you have any further points?

Assistant Chief Constable Mellor: We have agreed with the Crown Office that the corroborating officer does not need to be trained in the use of field impairment testing. In order to monitor carefully the implementation of field impairment testing from June onwards, we are not training everybody, but only a selected number of officers. That way, we can ensure that we keep a tight control on the testing and that we monitor it carefully. The corroboration must come from another officer who has observed the test, but he or she does not need to have had the training.

I was interested in the presentation that preceded ours. That research gives some excellent pointers, both for policy and for further research. I got the impression that committee members were interested in the possibility of some form of campaign. ACPOS certainly recognises that campaigns are a very important element in tackling the drugs issue.

However, young males are a particularly difficult group of people to influence. We need to be much more sophisticated in the way that we get our messages across. We need to look at young males as a specific group, because they have often been left out of campaigns in the past. The largest group of victims of crime is young males, yet young males think of themselves as invulnerable—as people who do not need to listen to either personal safety or road safety advice. We need to do a lot of work to get across quite subtle messages to that group in schools, prior to them becoming young adults.

One of the elements of the research, which certainly attracted my interest, was the idea of defining the type of person who takes risks. We might be able to adjust what we do in schools so that we look at all risk-taking behaviour, including drink-driving, drug-driving and speeding. At the moment, there is an emphasis on doing risky things, some of which—such as going on roller coasters—are quite fun. However, many such activities have significant negative impacts and we should perhaps look at the possible use in schools of a form of intervention in relation to risk-taking behaviour.

The Convener: I thank the witnesses for their presentation, and for making it so interesting for the committee. We will probably want to return to the subject when we are drawing up our report. We will see where we want to go from here.

Members might be interested to know that we have received a letter from John S Oliver of the department of forensic medicine and science at the University of Glasgow. Mr Oliver writes to advise us that, as he is an expert in the topic, he should be called to give evidence. Members can discuss whether they think that is appropriate when we decide where we want to go from here. Do any members have objections to our taking further evidence on the subject from witnesses, including Mr Oliver?

Ms MacDonald: There are a number of university folk who should be invited to give evidence.

The Convener: If members have other suggestions about experts or people in the field for the committee to invite, will they please let the clerk or me know of those suggestions.

Subordinate Legislation

The Convener: I propose that we move speedily on, so that we stay on time for a finishing time of 12.30 pm. Members will note that there are three negative instruments for our consideration under item 4: the Discontinuance of Legalised Police Cells (Portree) Rules 2001 (SSI 2001/64); the Police Grant (Scotland) Order 2001 (SSI 2001/74); and the Gaming Act (Variation of Fees) (Scotland) Order (SSI 2001/83). Negative instruments do not require the minister to be here to answer questions, but we can note the instruments and/or make comments on them. Do members have comments on the Discontinuance of Legalised Police Cells (Portree) Rules 2001 (SSI 2001/64)?

Scott Barrie: The order sounds like a good idea.

Ms MacDonald: It seems to make sense.

The Convener: It seems pretty straightforward.

Do members have comments to make on the Police Grant (Scotland) Order 2001 (SSI 2001/74)?

Scott Barrie: For the record, I want to say that committee members who served on the then Justice and Home Affairs Committee will remember that the Police Grant (Scotland) Order 2000 caused considerable comment when it was discussed, because committee members perceived that the police service was underfunded. We should at least note the 7.9 per cent increase that is taking place in the police grant this year, given that we exercised a considerable amount of time criticising the Executive for underfunding the police service last year. This year, the Executive has made a considerable increase in the police grant.

Ms MacDonald: Is not that a redistribution of the grant?

Scott Barrie: The grant has increased.

Ms MacDonald: I think that the increase went to the Grampian and Highlands forces.

The Convener: It is fair to say that committee members have said that they want that topic to be a future topic of discussion. Members may therefore wish to pick that up at a future meeting, using the note of today's discussion as guidance.

The final order—the Gaming Act (Variation of Fees) (Scotland) Order (SSI 2001/83)—is quite straightforward.

Ms MacDonald: I ask members to excuse me, as I have to leave soon for another appointment at 12 noon.

Proposed International Criminal Court Bill

The Convener: In their committee papers, members will find a note from the clerks, which relates to item 5. A list of possible witnesses has been suggested. Do members have additions or objections to make to the names that are found on the list? The bill is the first that the committee has been asked to consider.

Ms MacDonald: I do not know some of the people who are named and cannot therefore comment on all the suggestions that have been made.

The Convener: If members feel that anybody is missing from the list, will they please let me know and we can deal with those suggestions.

As members do not have other comments to make on the subject of international criminal courts, we will move on.

European Document

12:00

The Convener: Item 6 is an on-going item for the committee as, although the decision is unwritten, we have agreed to take an interest in certain European legislation. Members will recall that when Peter Beaton gave evidence to the committee, in private and public session, he asked us to consider whether we wished to make comments in advance of his next visit to Brussels, where he will represent the Scottish Executive. The minutes of the private session include members' comments on the Council regulation on the mutual enforcement of judgments on rights of access to children. As Peter Beaton's next meeting in Brussels takes place tomorrow, I propose that we put those comments in a letter to him, prior to that meeting. It is important to demonstrate that we intend to take a positive role in the scrutiny of European legislation.

Under this heading, I would like to say that I will report on the conveners' trip to Brussels when we have more time. A number of items arise from that visit that link into what we have been saying about the need to look at European regulations that have a direct impact on legislation that the Justice 2 Committee scrutinises.

As agreed, we move into private session for consideration of items 7 and 8.

12:02

Meeting continued in private until 12:24.

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