

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

Proposed drugs and corresponding limits to be specified in Regulations using the power in section 5A of the Road Traffic Act 1988 (as inserted by the Crime and Courts Act 2013).

July 2013

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Foreword

By Stephen Hammond, Parliamentary Under Secretary of State for Transport



July 2013

Today we have launched the consultation on the Government's proposals for the controlled drugs and corresponding limits to specify in regulations for the new drug driving offence. I am delighted to have reached this stage so soon after the Crime and Courts Bill, which provided for the power to make these Regulations, received Royal Assent on 25 April 2013.

Earlier this year I met family members of a young girl killed by a drug driver in circumstances where the law was unable to prosecute the driver for 'causing death by careless driving when under the influence of drugs' due to the difficulties of proving impairment due to the drug. Meeting people who have been so deeply affected by inadequacies in the law makes me and the Government more determined to ensure others are not let down. The Government takes a zero tolerance approach to illegal drug use and in considering what drugs and limits to specify for the new offence, it is clear that a zero tolerance approach would send the strongest possible message that you cannot take illegal drugs and drive.

At the same time the Government has considered the position of those who legitimately and safely use medicines which may contain controlled drugs. We recognise that, for the purposes of drug testing, distinguishing between those drugs which do have medical uses and those which do not is complex. We are therefore proposing an approach that does not unduly penalise drivers who have taken properly prescribed or supplied medicines in accordance with the advice of a healthcare professional. So our zero tolerance approach will not involve setting limits at zero, as these could inadvertently criminalise patients, or people who have traces of drugs in their bloodstream through accidental exposure.

After taking account of responses received, Regulations containing the final proposals will then need to be approved by Parliament before they could become law. Regulations containing final proposals for Scotland will need to be approved by the Scottish Parliament.

STEPHEN HAMMOND

SUMMARY

Executive summary

- 1.1 The Review of Drink and Drug Driving Law by Sir Peter North, published in June 2010, concluded that there was “a significant drug driving problem” with an estimated 200 drug driving-related deaths a year in Great Britain. However, in 2011, around 41% of the prosecutions in magistrates’ courts for driving whilst impaired through drugs were withdrawn or dismissed. The comparable figure for exceeding the drink drive limit is just 3%.
- 1.2 Drug driving remains a primary concern for the public with 34% of people agreeing that drug driving is in the top three road safety issues most important to address¹.
- 1.3 This is why the Government included in a Bill in May 2012 a new offence of driving with a specified controlled drug in the body above the specified limit for that drug². The Bill, which is now the Crime and Courts Act 2013 (<http://www.legislation.gov.uk/ukpga/2013/22/contents/enacted>), received Royal Assent on 25 April 2013. Section 56 of the Crime and Courts Act 2013 inserted a new 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.
- 1.4 This consultation has been extended to Scotland at the request of the Scottish Government as they agree with the approach we are taking to the consultation for England and Wales. Any final policy proposal on the specific issue of drug driving in Scotland will be for the Scottish Government and will be taken within the wider context of Scotland’s national drugs strategy. The cost and benefit analysis set out in this document and impact assessment at Annex D relates to England and Wales only. If the Scottish Government decides to bring forward secondary legislation, the Scottish Government will produce a Business and Regulatory Impact Assessment that will set out the impact assessment, the effect the new offence and the limits proposed will have in relation to Scotland in due course.
- 1.5 The new offence will reduce the wasted time, expense and effort involved for the police, the Crown Prosecution Service (CPS) and the Courts when prosecutions fail under the existing offence in section 4 of the Road Traffic Act 1988 of driving under the influence of drink or drugs (known as “the

¹ TNS British Market Research Bureau 2011

² Controlled drugs are defined in the Misuse of Drugs Act 1971 (which extends to the whole of the UK) as being either a Class A, B, C or a temporary class drug. The Road Traffic Act 1988 (as amended by the Crime and Courts Act 2013) provides that, for the purposes of sections 3A to 10 of that Act, the term “controlled drug” has the meaning given by section 2 of the Misuse of Drugs Act 1971.

impairment offence”) due to the difficulty of proving impairment. The consultation seeks views on what drugs to specify, and what limits to specify for each of those drugs, in regulations, for the purposes of the new section 5A offence.

- 1.6 In spring 2012 the Department for Transport asked a panel of medical and scientific experts to provide advice on what controlled drugs impair driving and what limits (as a concentration in blood) should be specified for each. The Expert Panel produced their final report ‘*Driving Under the Influence of Drugs*’, which we published on 7 March 2013³.
- 1.7 We received a number of responses to the publication of the Expert Panel’s report, all of which welcomed the report. However, some questioned whether the recommended limits were too high, particularly for illegal drugs⁴ such as cannabis and cocaine – expressing the view that drivers may not exceed the limits proposed by the panel but still pose a very significant risk to the public.
- 1.8 In considering what approach to propose for each drug and what limit to set, we have weighed up the evidence about the use of the drug when driving; wider drugs policy; whether the drug is used medicinally; whether patients taking the drug are likely to be in a condition where they might drive; the findings and recommendations from the Expert Panel; plus the responses to the publication of the Expert Panel’s report.
- 1.9 After considering all of the above we propose to take a zero tolerance approach to the following 8 controlled drugs which are known to impair driving:

Cannabis	MDMA (Ecstasy)
Cocaine	Ketamine
Benzoylecgonine	Methamphetamine
Lysergic Acid Diethylamide (LSD)	6-monoacetylmorphine (6-MAM) (Heroin/Diamorphine)

- 1.10 Controlled drugs are governed by the Misuse of Drugs Act 1971. Because finding any of the controlled drugs listed above in a driver’s body is very likely to be due to drug abuse rather than any proper medicinal use, these controlled drugs are referred to in this consultation document as being illegal drugs with the exception of diamorphine, which can be used for medical purposes. The issue of 6-MAM and diamorphine is discussed on page 20. We believe that taking this tough approach to driving after taking these illegal drugs will serve as a strong deterrent to drug driving and will have benefits across Government and society as a whole. We consider that this approach will also have a greater potential to reduce the number of drug drivers and

³ Available at: <https://www.gov.uk/government/publications/driving-under-the-influence-of-drugs-2>

⁴ ‘Illegal drugs’ has no statutory definition but is commonly used to refer to controlled drugs and is more recognisable to the public in the context of those controlled drugs that have been obtained otherwise than through healthcare professionals (including but not limited to a prescription) and for a (diagnosed) medical treatment.

consequently will have the maximum impact in terms of improving road safety. It will bring about consistency in enforcement activities (in that it will be unlawful to drive with these drugs in the body at all in the same way that it is unlawful to possess or supply them at all), and will help to ensure that members of the public will receive greater protection against the potential harm of these drugs and their misuse.

- 1.11 In taking a zero tolerance approach to these drugs we are proposing to set the limits at a level that does not catch someone who has consumed a very small amount of the drug in question inadvertently. A tough approach will therefore not necessarily equate to setting limits at zero. Rather, it would involve setting a limit at the lowest level at which a valid and reliable analytical result can be obtained, yet above which issues such as passive consumption or inhalation can be ruled out – a ‘lowest accidental exposure limit’.
- 1.12 Setting higher limits would dilute the message to drug drivers, who would perceive such limits as meaning that it is “legal” to drive after taking certain amounts of illegal drugs.
- 1.13 In addition to the 8 illegal drugs listed above, we propose to take a road safety risk based approach to 8 controlled drugs that have recognised and widespread medical uses. The limits we propose to set follow the recommendations of the Expert Panel so as to avoid the new offence catching drivers who have taken properly prescribed or supplied drugs in accordance with the directions of a healthcare professional, or with any accompanying instructions given by the manufacturer (to the extent that these instructions are consistent with such directions).
- 1.14 In the majority of cases the limits recommended by the Expert Panel are above normal therapeutic ranges, (i.e. above the dosages expected to be seen when taken in accordance with the advice of a healthcare professional). There is one further controlled drug, namely amphetamine, which has some medical use in specific circumstances but is also often taken illegally. In this consultation we ask for views on what would be a suitable limit to set, and would consult further in due course on a specific proposal for such a limit. This is explained at pages 22-23.
- 1.15 We take the view that taking a risk based approach to controlled drugs with medical uses attempts to avoid the pitfalls of potentially arresting drivers who have taken properly prescribed or supplied medicines in accordance with the advice of a healthcare professional or, when relevant, with the written instructions provided with the medicine. Following the Expert Panel’s recommendations regarding limits for those drugs with recognised medical uses to a large extent avoids this risk. This would ensure that public resources are not wasted and would avoid potentially inconveniencing people who are taking such drugs legitimately. This is further discussed in the

Regulatory Options section, with detail on the preferred Policy Option 1 at pages 17-24.

- 1.16 This consultation, accompanied by an Impact Assessment at Annex D, therefore seeks views on the Government's proposed option. This is to set a zero tolerance limit (or 'lowest accidental exposure limit') for 8 controlled drugs which are mostly associated with illegal drug use, and to set Expert Panel recommended limits for a further 8 controlled drugs which have medical uses. We are also seeking views on what would be a suitable limit for amphetamine.
- 1.17 Once a proposed limit for amphetamine is settled upon, we will consult again on this later in the year.
- 1.18 It also provides 2 other options to offer a comparison with the preferred option:
- The second option, which is discussed at pages 24-25, follows the Expert Panel's recommendations to include 15 controlled drugs in the regulations with corresponding limits all based on a road safety risk approach.
 - The third option, which is discussed at pages 25-26, proposes a zero tolerance approach (that is, a lowest accidental exposure limit) for 16 controlled drugs.
- 1.16 We take the view that both of these 2 options are not viable for the reasons discussed in this consultation. The Impact Assessment at Annex D will also assist in considering the options.

Duration of consultation

- 2.1 The consultation period will last 10 weeks, beginning on 9 July 2013 and running until 17 September 2013.
- 2.2 In deciding on the length of time for which to consult, we have considered the Consultation principles guidance at **Annex A**. We have concluded that, as the Crime and Courts Act 2013 recently received Royal Assent and stakeholders are thus aware that the Government's proposals are likely to be imminent, 10 weeks should be a sufficient period in which to consider the proposals and respond.

The devolved administrations

- 3.1 Regulation-making power to specify limits for the offence is exercisable by the Secretary of State in relation to England and Wales. This is provided for in section 5A(8)(a) of the Road Traffic Act 1988 (as inserted by the Crime and Courts Act 2013).

- 3.2 As set out in the Executive Summary, the consultation is extended to cover Scotland for the purposes of receiving Scottish views on the three policy approaches outlined in the consultation. The regulation-making power to specify limits for the offence is exercisable by Scottish Ministers in relation to Scotland by virtue of section 5A(8)(b) of the Road Traffic Act 1988 (as inserted by the Crime and Courts Act 2013). Any final policy proposal on the specific issue of drug driving in Scotland will be for the Scottish Government in line with the Crime and Courts Act 2013, and will be taken within the wider context of Scotland's national drugs strategy.
- 3.3 The Road Traffic Act 1988 (with minor exceptions which are not relevant for present purposes) does not extend to Northern Ireland.

Consultation questions

- 4.1 When formulating a response to this consultation, it would be helpful if particular consideration could be given to the following questions:

Question 1.

Do you agree with the Government's proposed approach as set out in policy option 1? If not please provide your reason(s).

Question 2.

Do you have any views on the alternative approaches as set out in policy option 2 and 3?

Question 3.

We have not proposed specified limits in urine as we believe it is not possible to establish evidence-based concentrations of drugs in urine which would indicate that the drug was having an effect on a person's nervous system. Do you agree with this (i.e. not setting limits in urine)? Is there any further evidence which the Government should consider?

Question 4.

Is the approach we are proposing to take when specifying a limit for cannabis reasonable for those who are driving and being prescribed with the cannabis based drug Sativex (which is used to treat Multiple Sclerosis)? If not what is the evidence to support your view?

Question 5.

Do you have a view as to what limit to set for amphetamine? If so please give your reason(s).

Question 6

Are there any other medicines that we have not taken account of that would be caught by the 'lowest accidental exposure limit' we propose for the 8 illegal drugs? If so please give your reason(s).

Question 7

Are you able to provide any additional evidence relating to the costs and benefits associated with the draft regulations as set out in the Impact Assessment at Annex D? For example:

- i. Do you have a view on the amount of proceedings likely to be taken against those on the medical drugs proposed for inclusion under the approach in Policy Option 1? If so please give your reason(s).
- ii. Do you have a view on the methodology used to estimate the amount of proceedings? If so please give your reason(s).
- iii. Do you have a view on the methodology used to estimate the drug driving casualties baseline? If so please give your reason(s)
- iv. Do you have a view on the methodology used to estimate the casualty savings? If so please give your reason(s).
- v. Do you have a view on the methodology used to estimate those arrested on a credible medical defence under Policy Option 3? If so please give your reason(s).

Question 8

Does any business have a view on whether the Government's proposals will have any impact on them, directly or indirectly? If so please give your reason(s).

How to respond

5.1 The consultation period will run until 17 September 2013. Please ensure that your response reaches us before the closing date. If you would like further copies of this consultation document, it can be found at www.gov.uk/government/consultations/drug-driving-proposed-regulations or you can contact Martin Ellis at the Department for Transport (contact details below) if you need alternative formats (Braille, audio CD, etc).

5.2 Please send consultation responses to:

Martin Ellis
Road User Licensing, Insurance & Safety
Department for Transport
Zone 3/21, Great Minster House
33 Horseferry Road
London SW1P 4DR
Tel: 020 7944 6945; E-mail: roadsafetyenforcement@dft.gsi.gov.uk

- 5.3 When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear who the organisation represents and, where applicable, how the views of members were assembled.
- 5.4 A list of those consulted can be found at **Annex B** and we will seek to hold a briefing session with these stakeholders shortly after the launch of this consultation. These stakeholders have previously expressed the most interest or represent groups most affected by the policy proposal.
- 5.5 If you have any suggestions of others who may wish to be involved in this process, please pass the information to them or contact us.
- 5.6 We do not intend to acknowledge individual responses unless by request.

Freedom of Information Act 2000

- 6.1 Information provided in response to this consultation, including personal information, may be subject to publication or disclosure in accordance with the Freedom of Information Act 2000 (FOIA) or the Environmental Information Regulations 2004. If you want information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence.
- 6.2 In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.
- 6.3 The Department will process your personal data in accordance with the Data Protection Act 1998 and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.

What will happen next?

- 7.1 A summary of responses, including the next steps, will be published within three months of the consultation closing at www.gov.uk/government/organisations/department-for-transport. Paper copies will be available on request. The Department will then carefully consider those responses with a view to whether any changes are required to the draft regulations before they are laid before Parliament.

INTRODUCTION TO THE PROPOSALS

Reasons for introducing the new offence

Background

8.1 The new offence was created following Sir Peter North's Independent Review of Drink and Drug Driving Law, published June 2010⁵. Sir Peter reviewed the law on drug driving and procedure and set out a road map to improve the process of detecting, taking enforcement action against, and deterring drug driving. Stage three of this road map was the creation of a specific drug driving offence.

Evidence of a problem

8.2 'Impaired by drugs' was recorded by the police as a contributory factor in 54 road deaths, or about 3% of fatal road incidents in Great Britain in 2011⁶. This is about a third of the share of fatal accidents which had 'impaired by alcohol' assigned as a contributory factor.

8.3 It is likely that both these figures are substantial under-estimates, as the attribution of contributory factors is largely subjective, reflecting the police officer's opinion at the time of reporting; and as only those accidents where the police attended the scene and reported at least one contributory factor are included in the data.

8.4 It is difficult to establish the extent of this underestimate. Depending on the approach, figures ranging from 90 to 340 deaths per year⁷ can be calculated. For the purposes of assessing the impact of the new offence (Annex D), we estimate that drug driving causes 117 deaths and 515 serious injuries in England and Wales every year.

The existing drug driving offence

9.1 There is already an offence of driving whilst impaired through drink or drugs, in section 4 of the Road Traffic Act 1988 ("the 1988 Act").

9.2 In order to prove that an offence under section 4 has been committed, it is necessary to show that the accused person was driving, attempting to drive or in charge of a vehicle; the accused person was impaired so as to be unfit to drive; and the impairment was caused by drugs.

⁵ Report available at: <http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/report>

⁶ Contributory Factor Type: Report Accidents by Severity GB 2011 (Reported Road Casualties GB 2011), Department for Transport

⁷ See Impact Assessment at Annex F for more information on approaches.

- 9.3 Proving that the driver was impaired and that the impairment was due to a drug can be complex and requires an element of subjectivity. This can be seen by comparing the approximately 52,000 prosecutions brought in magistrates' courts in 2011 for the drink driving offence under section 5 of the 1988 Act with less than 2,700 prosecutions for driving whilst impaired through drink or drugs under section 4 of the 1988 Act⁸.
- 9.4 Further, of those section 4 cases (driving whilst impaired through drink or drugs) which were taken to court in 2011, around 41% were withdrawn or dismissed, compared to less than 3% of drink drive cases.
- 9.5 Work for the North review indicated that in a sample police force area (with above average experience of using the current drug driving enforcement regime) only 35% of positive preliminary tests led to successful prosecutions in 2008 and 2009.
- 9.6 The new offence will relieve the need for the police to prove impairment on a case-by-case basis where a specified controlled drug has been detected above the limit specified for that drug. In this respect, it brings the law on drugs into line with the law on drink driving – as there is a prescribed limit excess alcohol offence in section 5 of the 1988 Act (for which impairment does not need to be proved).

The Crime and Courts Act 2013

- 10.1 Section 56 of the Crime and Courts Act 2013 inserts a new section 5A into the 1988 Act and thus creates a new offence of driving, attempting to drive, or being in charge of a motor vehicle with a specified controlled drug in the body above the specified limit.
- 10.2 Section 5A of the 1988 Act provides the framework for the new offence. It creates an enabling power for regulations to specify the drugs to be covered by the offence and the corresponding limit for each drug. This consultation relates to the content of those regulations.
- 10.3 New section 5A also requires the regulations specifying the drugs and the corresponding limits to be the subject of a consultation and to be approved by both Houses of Parliament using the affirmative resolution procedure.
- 10.4 The power to specify a drug in regulations only applies in relation to drugs which are “controlled”, within the meaning of section 2 of the Misuse of Drugs Act 1971. Controlled drugs are generally sub-divided into “Class A”, “Class B” and “Class C” and are the subject of tighter legal controls to prevent their misuse.

⁸ Statistics available at <http://www.justice.gov.uk/downloads/statistics/criminal-justice-stats/2011/motoring-tables-1211.xls>

- 10.5 It will therefore not be possible to set specified limits in respect of drugs which are not controlled under the Misuse of Drugs Act 1971. However, if a person were to drive having taken a drug which was not controlled and there was evidence that their driving was impaired as a result of that drug, they could still be prosecuted for the existing drug driving offence in section 4 of the 1988 Act. This is because the definition of a drug for the purposes of section 4 is “any intoxicant other than alcohol”.
- 10.6 Section 5A allows limits for the drugs covered by the offence to be specified in either blood or urine. However, the Expert Panel on drug driving did not recommend setting limits in urine. This was because in their view it is not possible to establish evidence-based concentrations of drugs in urine which would indicate that the drug was having an effect on an individual’s nervous system, or could be related to increased road traffic accident risk for that individual. There is also no translation of the concentration of a drug in blood to a concentration of that drug in urine, for example there may be a time lag between the consumption of a drug and its appearance in urine.
- 10.7 On this basis, we do not propose to set limits in urine at this point. (While setting limits in urine may be feasible for those drugs for which we propose to take a zero tolerance approach, we consider that it would give rise to undue difficulty with enforcement if urine limits were set for some drugs but not others.) If new evidence became available which would enable the Government to set limits in urine, limits in urine could be set at a later date.

Q: Do you agree with this approach to setting limits in urine? Is there any further evidence which the Government should consider?

The medical defence

- 11.1 The new offence in section 5A of the 1988 Act contains a medical defence. This applies where the specified controlled drug, which the person has taken was prescribed or supplied for medical or dental purposes; where the accused person took the drug in accordance with any directions given by the healthcare professional who prescribed or supplied it, or with any accompanying instructions given by the manufacturer (to the extent that these were consistent with the advice of the healthcare professional); and provided that the accused person’s possession of the drug was not unlawful under section 5(1) of the Misuse of Drugs Act 1971.
- 11.2 The defence places an evidential burden on a person accused of committing the offence. This means that the accused person must simply put forward enough evidence to “raise an issue” regarding the defence that is worth consideration by the court. It is then for the prosecution to prove beyond reasonable doubt that the defence cannot be relied upon.

How the offence will work

- 12.1 The 1988 Act allows the police to require someone to provide up to three preliminary drug tests. The tests would be administered using a device which has been type approved by the Home Secretary. The Government is aiming to approve suitable devices for roadside use to facilitate the enforcement of the new offence. Such a device will use a sample of saliva to give a preliminary indication as to whether a person has a specified controlled drug in his or her body above the specified limit. A positive result on a type approved testing device will enable the police to require an evidential blood specimen to be provided without having to summon a medical examiner to authorise this.
- 12.2 In order to provide a secure basis for prosecution it is essential that the devices are consistent, accurate, precise and reliable. Type approval is only given following the satisfactory completion of operational and laboratory tests of devices against the requirements set in a specification drawn up by the Home Office's expert technical advisers. We intend to finalise (provisionally) and issue the specification shortly after the launch of this consultation. Manufacturers will be informed that the specifications may be changed, depending on the outcome of the consultation. However, it is necessary to give them provisional limits so that the development of the devices can be progressed.
- 12.3 Police officers are not entitled to conduct random drug testing. An officer may only administer a preliminary drug test if the officer suspects that a driver has a drug in his body or is under the influence of some drug, if the driver has committed a moving traffic offence, or if the driver has been involved in a road traffic accident.
- 12.4 A police officer would be entitled to administer up to three preliminary saliva tests when testing for drugs. The position prior to the Crime and Courts Act 2013 was that only one test could be taken. However this is likely to be insufficient for the purposes of the new offence, given that current drug screening technology can test for a limited range of drugs only using a single preliminary test. The new legislation thus enables three tests.
- 12.5 An officer would also be entitled to test a person at the roadside for both alcohol and drugs if they were unsure why the person was impaired. The order in which the tests were administered would be at the officer's discretion, although there are a number of factors, including the relative prevalence of alcohol as opposed to drugs, which might encourage a police officer to choose to administer a breath test first.
- 12.6 It would be open to a driver who believes that they are entitled to rely on the medical defence to raise the defence at any point in the investigation of the offence. In investigating the offence, an officer may also ask whether the

driver may have taken any medicine which could result in a positive drug screening result. As set out above, the driver has to provide evidence that they were taking the medicine legitimately in order to raise the defence. It will be for the police officer, taking account of all relevant circumstances, to decide whether it is appropriate to arrest a driver who asserts at the roadside that he is entitled to rely on the medical defence.

- 12.7 Where a preliminary drug test results in a positive result, the officer would be entitled to arrest a driver and require a blood sample to be taken. The driver could be bailed whilst the blood sample was analysed by a laboratory. If the laboratory results showed that the driver had a specified controlled drug in the body above the specified limit, the driver could be charged with the new offence.
- 12.8 Where a preliminary drug test does not result in a positive screening result because, while the drug was present, it was under the specified limit for the drug, the officer could consider whether there was evidence that the person's driving was impaired. If there was evidence of impairment, the officer could arrest the driver on the basis of the existing offence of driving while impaired by drugs under section 4 of the Road Traffic Act 1988.

Expert Panel report

- 13.1 In spring 2012, the Government announced the appointment of an Expert Panel on Drug Driving to provide technical advice for the purposes of the new drug driving offence. The Panel's Terms of Reference⁹ asked it to identify drugs to be included in the new offence; and to recommend limits for those drugs based on equivalence with particular blood alcohol concentrations.
- 13.2 The Panel was chaired by Dr Kim Wolff from King's College London. Other members were:
- Dr Roger Brimblecombe, Member of the Advisory Council on the Misuse of Drugs
 - Dr J. Colin Forfar, Commission for Human Medicines
 - Prof. Robert Forrest, Sheffield University
 - Hon. Prof. Eilish Gilvarry, University of Newcastle
 - Prof. Atholl Johnston, Queen Mary, University of London
 - Dr Judith Morgan, Driver and Vehicle Licensing Agency (DVLA)

⁹ Available at <https://www.gov.uk/government/publications/drug-driving-expert-panel-terms-of-reference-and-membership>

- Prof. David Osselton, Bournemouth University
- Dr Lily Read, Northamptonshire Healthcare NHS Foundation Trust
- Prof. David Taylor, King's College London and South London and Maudsley NHS Foundation Trust

Observer

- Dr Mark Prunty, Senior Medical Advisor with responsibility for Alcohol and Drugs, Department of Health

- 13.3** The Panel held meetings at regular intervals throughout 2012¹⁰. It used both epidemiological and experimental evidence in relation to blood drug concentrations and driving behaviour to assess the relationship between the use of a psychoactive drug and the potential to affect driving behaviour.
- 13.4** Rather than providing recommendations in relation to a comparable blood alcohol concentration, the Panel used scientific risk analysis, and in particular odds ratios¹¹ to support its conclusions. Account was also taken of data on blood specimens in suspected drug driving cases, as well as the pharmacokinetics and pharmacodynamics of a drug. The Expert Panel's report '*Driving under the influence of drugs*' was published on 7 March 2013¹². Its recommendations in relation to specific drugs are discussed at pages 24-25 of this consultation.

¹⁰ Minutes of panel meetings are available at <https://www.gov.uk/government/publications/driving-under-the-influence-of-drugs--2>

¹¹ That is, the ratio between the odds of an event (e.g. being seriously injured) occurring among those who tested positive for a drug and the odds of the same event occurring among those who tested negative for a drug.

¹² It is available at <https://www.gov.uk/government/publications/driving-under-the-influence-of-drugs--2>

The three regulatory options

Policy option 1

14.1 We propose taking a zero tolerance approach ('lowest accidental exposure limit') to 8 illegal controlled drugs and a road safety risk based approach to 8 controlled drugs which have medical uses. We are not proposing a specific limit in this consultation with regard to amphetamine. We will therefore carry out a further consultation on a proposed limit after considering the responses to this consultation. For the risk based limits we have followed the recommendations of the drug driving Expert Panel:

Drug	Threshold limit in blood
Amphetamine	TBC (following consultation)
Benzoyllecgonine	50µg/L
Clonazepam	50µg/L
Cocaine	10µg/L
Delta-9-Tetrahydrocannabinol (<i>Cannabis</i> & <i>Cannabinol</i>)	2µg/L
Diazepam	550µg/L
Flunitrazepam	300µg/L
Ketamine	20µg/L
Lorazepam	100µg/L
Lysergic Acid Diethylamide (<i>LSD</i>)	1µg/L
Methadone	500µg/L
Methamphetamine	10µg/L
Methylenedioxymethamphetamine (MDMA – <i>Ecstasy</i>)	10µg/L
6-Monoacetylmorphine (<i>Heroin</i> & <i>Diamorphine</i>)	5µg/L
Morphine	80µg/L
Oxazepam	300µg/L
Temazepam	1,000µg/L

14.2 This approach sends a clear message that you cannot take illegal drugs and drive but reduces the risk of patients taking commonly prescribed medicines being arrested.

14.3 The Expert Panel did not recommend Lysergic Acid Diethylamide (LSD) as a drug to include in the regulations as current usage in the UK is not high and data was not available to enable the Panel to propose a limit. However, the Panels' report goes on to say that "*the use of LSD is not likely to be compatible with the skills required for driving due to its severe psychomotor, cognitive and residual effects.*" Whilst use of LSD and driving may be extremely rare, we do not believe that the drug should be left out of the

regulations, particularly as the report states that LSD users should not be driving. As it has no recognised medical use we therefore propose to take a zero tolerance approach to this drug.

14.4 All of the drugs in the Table on page 17 are controlled drugs and are listed in Schedule 2 to the Misuse of Drugs Act 1971 or are not specifically listed in Schedule 2 but are still covered for the reasons set out below. These are:

- Methylenedioxymetamphetamine (MDMA) – This is captured by the phenethylamine generic definition in Schedule 2 Part 1 Paragraph 1(c);
- Benzoylcegonine – This is captured by the following phrase in Schedule 2 Part 1 Paragraph 1(a): ‘Ecgonine and any derivative of ecgonine which is convertible to ecgonine or to cocaine’;
- 6-Monoacetylmorphine – Morphine is listed in Schedule 2 Part 1 Paragraph 1(a) and 6-Monoacetylmorphine is an ester of morphine. Schedule 2 Part 1 Paragraph 3 states that: ‘Any ester or ether of a substance for the time being specified in paragraph 1 or 2 ‘not being a substance for the time being specified in Part II of the Schedule’;
- Lysergic Acid Diethylamide (LSD) - LSD is also known as lysergide. ‘Lysergide and other N-alkyl derivatives of lysergamide’ are listed in Schedule 2 Part 1 Paragraph 1(a).

14.5 In considering the approach to illegal drugs and driving the Government needs to take into account that drugs affect the whole of society and not just road users. From the crime impact on local neighbourhoods to the corrupting effect of international organised crime, drugs have a profound and negative effect on communities, families and individuals.

14.6 A zero tolerance approach to driving with illegal drugs in the body would accord with the Government’s wider drug strategy, which sets out how the Government seeks to bear down on those criminals seeking to profit from others’ misery; how it will protect young people by preventing drug use; and how recovery reforms will enable and support individuals to become free of dependence on drugs and reintegrate into their local communities and contribute to society. A zero tolerance approach to illegal drugs and driving therefore enables Government to link these various facets together. It thus ensures that we have a coherent and joined-up approach to tackling the crime and damage that drugs cause to society.

14.7 The European DRUID project research into driving under the influence of drink and drugs recommends, *“Issues of general drug and traffic safety policy must be distinguished precisely, but each law change within these two*

*fields must be made with respect to the other to ensure the entity of the legal system.*¹³

- 14.8 A substantial number of young people who are dependent on drugs are presenting for treatment. These individuals are likely to still be working and in stable housing; therefore those who may be learning to drive or have just started to drive. For young people, emotional and behavioural disorders are also associated with an increased risk of experimentation and misuse. They therefore need to consider the impact of taking drugs on their new found freedom to drive and a zero tolerance approach may act as a deterrent to these young people who may be prone to experimenting with drugs. The Crime Survey for England and Wales shows that the 16-24 age group are most likely to report driving under the influence of drugs. The majority of young people do not use drugs, but for those who do misuse drugs it can have a significant impact on their education, health, families and long term life chances.
- 14.9 Cannabis and alcohol are the most common substances used amongst young people. In 2011/12 around 20,000 people under 18 years accessed specialist support for substance misuse, 92% due to cannabis and alcohol. Taking a zero tolerance approach to illegal drug driving, in particular to cannabis, could be an important step in deterring young people from taking illegal drugs. It could also assist in creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so. Having a zero tolerance approach to illegal drugs and driving we believe will serve as a strong deterrent to drug driving and will have benefits across Government and society as a whole. This will include a reduction in the number of potential drug drivers and consequently have a positive impact on road safety. It will bring consistency in enforcement activities and members of the public will be protected against the potential harm of these drugs and their misuse.
- 14.10 Higher limits would also dilute the message to drug drivers who would perceive that it as being "legal" to drive on certain levels of illegal drugs. Indeed the DRUID Final Conference in September 2011 referred to a study in Germany that concluded, *"The more likely a person thinks a police stop will be, the more often the person decides against drug driving."*
- 14.11 During the Parliamentary debates of the Crime and Courts Bill and in correspondence from stakeholders, concerns were expressed that the new offence might discourage patients either from driving or from taking their medicine (for fear of being arrested, tested for, and charged with the new offence). We therefore looked at whether we could separate the drugs with recognised medical uses (where we take a risk based approach) from the drugs that are most associated with illegal use (where we take a zero

¹³ DRUID Final Conference 28 September 2011.

tolerance approach). We believe that this can be achieved but there are a number of complexities that arise which are discussed in detail below.

Heroin and Morphine

- 14.12** One of the key difficulties in taking this approach was to separate heroin misuse (in order to take a zero tolerance approach) from morphine (where a risk based approach is proposed). For the purposes of drug testing the body metabolises both heroin and opiate-based medical drugs into morphine.
- 14.13** Our scientific advice has identified that there is another metabolic marker for heroin/diamorphine consumption, 6-monoacetylmorphine (6-MAM), which stands apart from most other opiate based medicines. We believe that it is possible to set a lower limit for 6-MAM in order to tackle heroin use.
- 14.14** Diamorphine is used in the treatment of severe pain associated with surgical procedures, heart attacks or pain in the terminally ill and for the relief of dyspnoea in acute pulmonary oedema (shortness of breath due to fluid leaks into the lungs). Patients taking diamorphine are unlikely to be driving. If any were considering driving they should not do so if they feel drowsy, which is one of its side-effects. If they were not affected and they had taken their medicine correctly it would be possible for them to seek to rely on the medical defence if accused of the new offence.
- 14.15** Although 6-MAM has a longer half-life¹⁴ than heroin, it is still quite short. The precise time taken for a driver's body to metabolise 6-MAM to the point where it can no longer be reliably measured depends on the quantity taken and the driver's physical characteristics etc. The relatively short half life means that it is still possible that 6-MAM will have been metabolised (or to a level at which it cannot be reliably detected) before the police have been able to obtain an evidential specimen. We believe that it is still worth setting a limit in 6-MAM to send a clear message that the Government has a zero tolerance approach to driving with heroin in the body; and to catch any drivers who have misused it where it can be measured.
- 14.16** We propose setting a separate limit for morphine based on the Expert Panel's recommendation to be used for other drugs (morphine itself, dihydrocodeine and codeine in prescribed and over the counter medicines). These can be either prescribed and in most cases would be below the limit specified or if abused would therefore be over the limit and could be charged if no medical defence was provided. If a medical defence is provided then the police would have to revert to the existing section 4 impairment offence if their driving was thought to be impaired. The majority of opiates are metabolised into morphine before further breakdown, so a single morphine limit we believe would be sufficient.

¹⁴ Half-life means the rate at which a drug diminishes in the body, e.g. it may reduce by half in 60 minutes.

Cannabis and Sativex

- 14.17 The other medical drug we had to consider carefully was Sativex, as it is a cannabis plant based drug that has a licence for medical use in the UK where it is prescribed for the treatment of spasticity in multiple sclerosis (MS). In 2012 there were 4,977 prescriptions for Sativex, which the manufacturer GW Pharma estimates to represent around 1,500 people, of which possibly around 200 could be driving. For the purposes of roadside screening tests, the police would not be able to distinguish using a preliminary test between a driver taking cannabis and a driver taking Sativex. We want to ensure that MS sufferers who in the opinion of a doctor are able to drive safely can continue to do so without being deterred from either taking their medicine or from driving. We have therefore considered the position of MS sufferers being prescribed Sativex who may be driving.
- 14.18 The Multiple Sclerosis Trust defines spasticity as *“involuntary muscle stiffness and spasms as involuntary muscle contractions. Any muscle can be affected but spasticity and spasms tend to predominantly affect a person's limbs or trunk. People with spasticity describe their muscles as feeling stiff, heavy and difficult to move. When very severe it can be very difficult to bend a limb at all. If a limb becomes fixed in one position it is known as a contracture.”*
- 14.19 Sativex is issued under a European licence and prescribed under the supervision of a clinic and only after other treatments for spasticity has failed. The advice that comes with the drug reflects the fact that a number of different drug driving regimes are in operation in different countries, saying *“You must not drive or use machinery when you first start to take Sativex and until you are established on a stable daily dose. Once you are more used to taking Sativex and your dose is stable, you should still not drive or use machinery if Sativex causes effects such as sleepiness or dizziness that could impair your ability to perform these tasks. If you are not sure, do not drive or operate machines.”*
- 14.20 MS is a medical condition that must be notified to the DVLA. If a patient's doctor provides an opinion to the DVLA that the patient is safe to drive then the DVLA would notify the patient that a short-term driving licence will be issued up to three years. In the notification letter the DVLA proposes to provide the following advice:
- “If you are being treated with or start treatment with Sativex please be aware that Sativex is a cannabis based medicine and the Police will not be able to distinguish between an illegal drug and Sativex if any drug test is carried out. If you have any involvement with the Police in relation to driving you should therefore declare your use of prescribed Sativex and you may need to provide the Police with evidence that you have been prescribed Sativex.”*

- 14.21 We also propose to write to the Association of Chief Police Officers (ACPO) to make them aware of the above situation. It will be for ACPO to disseminate the information as they see fit to ensure that police officers are aware that some MS sufferers who are taking Sativex may be driving legitimately. Drivers taking Sativex will of course be able to seek to rely on the statutory medical defence. If in the view of the police officer their driving was not impaired, then we propose that these drivers should not be arrested nor any further action be taken against them.
- 14.22 We have also spoken to the manufacturer of Sativex, GW Pharma, and they have agreed there is a need to provide similar information via their patient information leaflet. Changes to medicines information must be made through the marketing authorisation via the Medicines Healthcare products Regulatory Agency (MHRA) and should be in line with the provisions of Title V of Council Directive 2001/83/EC.
- 14.23 We believe this approach to Sativex users is reasonable and will not deter them from taking their medicine in order to continue driving provided it is safe to do so.

Q. Is the approach we are taking to MS sufferers who are driving and being prescribed with the cannabis based drug Sativex reasonable? If not how can it be improved?

Amphetamine

- 14.24 The approach to take to proposing a limit for amphetamine is less clear. The Expert Panel recommended a limit at 600µg/L. However, drugs containing amphetamine are commonly used illicitly but also includes medicines used to treat conditions such as Attention Deficit Hyperactivity Disorder (ADHD). There is therefore a question as to whether to take a tough approach in line with drugs such as cannabis and cocaine or whether to specify a limit at which a road safety risk becomes unacceptable to ensure that patients are not unduly penalised.
- 14.25 Whilst ADHD is generally not found in the driving population because it is a condition associated with children and adolescents, diagnoses of adult ADHD is becoming more common. ADHD is a condition that has to be reported to DVLA if the person wishes to drive. A medical opinion must then be provided on whether the person is safe to drive.
- 14.26 Adult ADHD is a developing branch of medicine and there is a lack of available research evidence to determine either the road safety risk of prescribed drugs containing amphetamine on drivers with ADHD or the appropriate blood threshold limits for adults taking properly prescribed drugs containing amphetamine in accordance with the advice of a healthcare professional.

14.27 The Department received a number of responses after publishing the Expert Panel's report '*Driving under the influence of drugs*', some of which expressed a view that the limit of 600µg/L was too high. An expert group who advised the Department on the lowest accidental exposure limits for each of the 8 illegal drugs suggested a lower figure of 100µg/L, whilst France and the Netherlands have set it at 50µg/L.

14.28 There are therefore potentially 4 different limits which could be set in relation to amphetamine: the limit recommended by the Expert Panel (600µg/L), a lower limit of 100µg/L that would still not catch most people on standard dosages for the treatment of ADHD; a limit of 50µg/L in line with some other European countries; finally, a 'lowest accidental exposure limit'. We would therefore welcome views on the most suitable approach to take for amphetamine.

Q. Do you have a view as to what limit to set for Amphetamine? If so please express your reason(s).

14.29 As we are not proposing a specific limit in this consultation with regard to amphetamine, we will therefore carry out a further but shorter consultation on a proposed limit after considering the responses to this consultation.

Q. Are there any other medicines that would be caught by the 'lowest analytical exposure limit' we propose for the 8 controlled drugs that we have not taken account of?

Costs and benefits

14.30 In taking this approach we estimate the number of proceedings under a central scenario will be 8,800 per year. However, because we are not proposing to take a zero tolerance approach to those drugs most associated with medical uses we will not be arresting those who have a credible medical defence as the limits will be set at a level above most therapeutic ranges. For the small number of patients who may be arrested on higher doses of their medicines and for whom the separate offence of driving whilst impaired cannot be used then we believe it can be legitimate for the police to investigate further under the the new offence. The patient will be able to rely on the statutory medical defence if appropriate. If the statutory medical defence does properly apply, the police would still need to prove impairment due to the drug use if they wished to continue with any further action.

14.31 To enforce the new offence under this approach we estimate the police costs to be £74m over a 10 year period and criminal justice system to be £72m and CPS costs of £12m and costs to the offender of £12m. Overall the costs are £170m.

14.32 This option is likely to result in more casualty savings than in Policy Option 2. This is because the increased level of enforcement will act as a greater deterrent to drug drivers. The casualty savings are estimated at £153m over

a 10 year period and income from financial penalties and victim surcharges is estimated to be nearly £12m over this period.

14.33 This Policy Option therefore gives an overall net cost of £-5m. Whilst there is on the face of it a cost as discussed in the impact assessment the estimate of the casualty savings is uncertain and thus could potentially provide a net benefit of £93m. Overall there is less benefit than the next Policy Option (Option 2), as set out in the Executive Summary, but there is the potential for an economic benefit to society that is at this point unquantifiable. Once the new offence is in place we will aim to see the extent to which illegal drug taking is reducing. This is our preferred approach and we would welcome views.

Q. Do you agree with the Government's proposed approach as set out in policy option 1? If not please provide your reason(s).

Policy option 2

14.34 As stated earlier in this consultation document this option is not one we would propose to take. It is an option that takes the Expert Panel recommendation in full, specifying 15 controlled drugs and setting limits based on evidence of impairment to driving and in other cases on evidence of the increased odds of a road traffic accident and associated deaths and injuries ('odds ratio').

14.35 The Government is very grateful to Dr Kim Wolff and the Panel for the significant work undertaken in analysing a vast amount of research in this area and for making their recommendations. The Expert Panel's recommendations are based on the limits at which a road safety risk is most likely to be increased.

14.36 Whilst it may be the case that a road safety risk for an illegal drug may only be increased over a certain limit recommended by the Panel, we take the view that setting a permissible limit to drive on an illegal drug such as cannabis is contrary to the Government's approach to illegal drug use. It would therefore send out mixed messages to people who may be considering illegal drug use, i.e. "it's ok to drive on illegal drugs as long as you don't have too much of it".

14.37 The Government therefore does not propose to take this approach, but we have monetised the costs in the Impact Assessment in order to assist with the comparison. We estimate a central scenario of 5,700 proceedings each year and subsequently estimate the police costs over a 10 year period to be £47m and the criminal justice system to be £47m and CPS costs of £7.6m and costs to offenders of £7.6m. We estimate the casualty savings are £128m over a 10 year period plus income from financial penalties and victim surcharges of around £8m. This will give us a net benefit of £27m.

14.38 The costs of arrests and prosecutions are much lower than the other 2 options, but significant casualty savings can still be identified. As well as the mixed messages around permissible levels of illegal drug use, this option has little potential to benefit from the wider economic benefits that will arise from taking a zero tolerance approach, i.e. a 'lowest accidental exposure limit' to illegal drug use.

Policy option 3

14.39 This option takes a zero tolerance approach to all 15 controlled drugs and like the preferred policy option includes LSD. A zero tolerance approach would send the strongest possible message that you cannot take illegal drugs and drive. For those drivers who have taken properly prescribed or supplied drugs in accordance with the advice of a healthcare professional a medical defence is then available.

14.40 A zero tolerance approach may also have a strong deterrent effect to taking illegal drugs, which could have an enormous positive economic benefit to society. For example in 2003/04 Class A drug use was estimated to cost society around £15.4 billion through drug-related crime, health costs and social care costs associated with illegal drug use. It is difficult at this stage to monetise the potential impact of taking a zero tolerance approach in deterring those who may be prone to illegal drug use. Whilst this legislation is primarily aimed at improving road safety we cannot ignore the fact that any measure that could reduce illegal drug use should not be ignored particularly in the road safety context. If the amount of illegal drug users reduces it should consequently reduce the amount of drug drivers.

14.41 However, we believe that costs to the police and justice system would be higher (relative to policy options 1 and 2) as more people are likely to be arrested and charged. There would be increased costs to the police by arresting people who may be legitimately taking properly prescribed or supplied medicines in accordance with medical advice and where their driving may not be impaired. This could deter patients from taking their prescribed medicines with the resulting untoward effects of not taking the medicine. It might also deter healthcare professionals from prescribing the medicines a patient needs, for fear of the impact on the patient. There would be further costs, albeit relatively small, to the justice system where some drivers successfully claim the medical defence at the court stage.

14.42 The police will not be seeking to arrest people who are legitimately on medicines provided their driving is not impaired, but a zero tolerance approach to drugs with medical uses would inevitably result in some such people being arrested. We estimate a central scenario of 1,633 people who could rely on the medical defence could be arrested under this approach. In addition, a likelihood of 49 prosecutions per year where a successful medical defence is made giving additional costs to the criminal justice system of £64k and CPS of £68k over the 10 year period. There will also be

an additional cost to the police of attending court giving a total additional cost to the police of around £13m. This will mean over £13m of wasted additional public sector costs. In total this will increase police costs to £87m, with criminal justice system costs of £72m and CPS costs of £12m with costs to offenders of £12m.

14.43 We have also sought to monetise the costs to society of inconveniencing the patients taking medicines legitimately who would be arrested, which we estimate on this central scenario cost to be around £1.4m over a 10 year period. In addition to the increased costs and inconveniencing patients concerns were expressed during the Parliamentary debates and in correspondence from stakeholders, that the new drug driving legislation might discourage patients either from driving or from taking their medicines.

14.44 As stated in Policy Option 1, this option is likely to result in more casualty savings than Policy Option 2. This is because the increased level of enforcement will act as a greater deterrent to drug drivers. We therefore estimate the casualty savings will be approximately the same as option 1 at £153m over a 10 year period plus income from financial penalties and victim surcharges will be around £11m.

14.45 Given the significant increase in costs from more prosecutions; the increased costs of inconveniencing patients; additional costs to the justice system and more notably to the police of those with a successful medical defence, there is a much increased net cost under this approach of £-19m over a 10 year period. This has the least benefit and indeed the most cost of all the three policy options.

14.46 The Government believes it is important to send the strongest possible message to illegal drug drivers in taking a zero tolerance approach. However, we are not attracted to potentially arresting and inconveniencing so many patients who are taking their medicines legitimately and when their driving is not impaired. Nor are we attracted to incurring the increased costs and wasting over £13m of public resources over the 10 year period.

Q. Do you have any views on the alternative approaches as set out in policy option 1 and 2? If so please give your reason(s).

Impact assessment

15.1 The Impact Assessment at Annex D sets out in detail all the cost implications of each policy option for England and Wales and how they were estimated. It will assist in forming a view on the Government's preferred policy approach and on each of the other 2 possible policy approaches.

15.2 If the Scottish Government decides to bring forward secondary legislation, the Scottish Government will produce a Business and Regulatory Impact

Assessment that will set out the impact assessment, the effect the new offence and the limits proposed will have in relation to Scotland in due course.

Sentencing provisions and recording by DVLA

- 16.1 The penalties for the new drug driving offence are the same as those for the existing drink driving offence in section 5 of the 1988 Act and the existing impairment offence in section 4 of the 1988 Act.
- 16.2 A person found guilty of the new offence of driving or attempting to drive with a specified controlled drug in their body above the specified limit will be subject to a maximum penalty of 6 months imprisonment or a £5,000 fine or both. The person would also be disqualified from driving for a minimum of 12 months.
- 16.3 In cases where a person is accused of being in charge of a motor vehicle with a specified controlled drug in their body above the specified limit, the maximum penalty will be 3 months imprisonment or a £2,500 fine or both. The person may also be disqualified from driving or if not receive 10 penalty points on the licence.
- 16.4 DVLA and HM Courts and Tribunal Service will put in place new codes for recording the new drug driving offence. The primary function of the offence code is to enable appropriate endorsement of a driving licence when a driver has been convicted. In addition, the information recorded when licences are endorsed can be used to evaluate the effectiveness of the new offence by tracking numbers of convictions when the new measures come in to force; and by tracking which drugs were involved.
- 16.5 Additionally, the DVLA Driver Medical Casework system will produce the number of Medical Intervention cases being medically assessed for drug use. However, these are fundamentally different as they are based on third party notifications of drug use, as opposed to a driver actually prosecuted of driving while under the influence of drugs. Third party notifications can be from family members, GPs, police or other third parties who elect to report someone to the DVLA because of their drug use.

Addressing drug misuse

- 17.1 The Government is considering options for helping local criminal justice partners to tackle the drug misuse of drivers who use the Class A drugs that are most likely to lead to wider offending behaviour – currently heroin or cocaine/crack. The police have powers to require individuals arrested or charged with an offence (who test positive for heroin or cocaine/crack) to attend up to two assessments with a qualified drug worker. Such

assessments may lead to drug treatment or other support aimed at reducing the likelihood of reoffending. However, the Government is looking at how these powers can be applied as simply in relation to drug driving as for other offences.

High Risk Offenders (HRO) scheme

- 18.1 There is a rehabilitation scheme for drink drivers but with prosecutions against drug impaired drivers under the existing section 4 offence running at less than 5% of the level for drink drivers there is currently insufficient demand. The North report recommended extending the HRO scheme to drug driving. The Government response did not agree with this recommendation.
- 18.2 Dependency on impairing drugs is already covered by DVLA's medical licensing regime with published guidance for medical practitioners in the "At a Glance guide to the current medical standards of fitness to drive". This regime takes account of a range of evidence on drug dependency and it is not necessary to legislate to enable it to take specific account of drug driving convictions.
- 18.3 Drug driving is a more complex challenge than drink driving, due to there being a range of drugs and associated social problems. If there was proved to be sufficient demand for a similar national scheme then a syllabus suitable for all those likely to attend will have to be designed, with links into drug treatment services so that individuals get the help and support they need to get off drugs.
- 18.4 However, once the new offence has been fully implemented we will consider further the case for a rehabilitation scheme for those drug drivers that are not caught by other schemes. As part of the evaluation of the new offence we are therefore aiming to track the convictions for each drug and at what levels individuals are being convicted for in order to have a better understanding at what level and for which drugs may be appropriate to activate any possible future HRO scheme.

Communicating and evaluating the new offence

- 19.1 A communications plan will be developed prior to the new offence provisions and the related regulations being commenced, which is expected to be in summer 2014. A part of that plan will aim to launch a THINK! Campaign to deter drug driving alongside commencement of the new offence.
- 19.2 We will also be considering the communications to patients. The Department has liaised with the Medicines Healthcare products Regulatory Agency

(MHRA), an agency of the Department of Health. The MHRA has a communication role through the provision of accurate, timely and authoritative information to healthcare professionals, patients and the public. They are currently identifying the prescription medicines that would be affected by the new offence and will be contacting the manufacturers to include warnings in their patient information leaflets.

- 19.3 We are also interested in working with healthcare professionals to explore other methods of explaining the new offence to patients. The aim is to support healthcare professionals to be able to provide, and to refer to sources of suitable advice. This will ensure that healthcare professionals are better informed in making patients aware of those medicines that have been or could be prescribed that could result in patients being arrested if they drive even if the medicine is not causing any impairment.
- 19.4 The Association of Chief Police Officers (ACPO) will be providing guidance to the police on the procedures officers should take when implementing the new offence.
- 19.5 The Department will monitor and evaluate the new section 5A offence. A specification is currently being developed for the development of roadside testing devices and will be issued to tenderers in due course.

THE REGULATIONS

Summary of the draft Regulations

- 20.1 The draft Regulations are at Annex C. They set out in a table each of the 17 controlled drugs and in each case (except amphetamine) the specified limit which is proposed. The regulations will therefore eventually “complete” the section 5A offence in the 1988 Act by providing the detail of the drugs to be covered by the new offence and the limit for each. Section 5A makes it an offence for a person to drive, attempt to drive, or be in charge of a motor vehicle on a road or other public place with a specified controlled drug in the body, if the proportion of the drug in the person’s blood exceeds the specified limit.
- 20.2 These Regulations specify the 17 controlled drugs for this purpose and the limit for each (except amphetamine) expressed as a concentration in blood.

Parliamentary scrutiny

- 21.1 The Regulations are subject to 'affirmative procedure', which means that they must be approved by both the House of Commons and the House of Lords before they can become law.
- 21.2 Following the completion of the consideration of the consultation responses and once the Government’s response to these has been published, we will aim to progress work on the Regulations with a view to the Regulations being made and the new offence provisions being commenced in mid 2014.

Annex A: Consultation principles

The consultation is being conducted in line with the Government's key consultation principles which are listed below. Further information is available on the Better Regulation Executive website at

<https://update.cabinetoffice.gov.uk/resource-library/consultation-principles-guidance>

If you have any comments about the consultation process please contact:

Consultation Co-ordinator
Department for Transport
Zone 1/14 Great Minster House
London SW1P 4DR
Email consultation@dft.gsi.gov.uk

Consultation Principles

- departments will follow a range of timescales rather than defaulting to a 12-week period, particularly where extensive engagement has occurred before;
- departments will need to give more thought to how they engage with and consult with those who are affected;
- consultation should be 'digital by default', but other forms should be used where these are needed to reach the groups affected by a policy; and
- the principles of the Compact between government and the voluntary and community sector will continue to be respected.

Annex B: List of those consulted

Action on Addiction
Add Action
Advisory Council on the Misuse of Drugs
Age UK
Alcohol Concern Cymru
Association of British Insurers
Association of Chief Police Officers (ACPO)
Association of Directors of Environment, Economy, Planning & Transport (ADEPT)
Association of Independent Multiple Pharmacies
Association of the British Pharmaceutical Industry
Automobile Association
BRAKE
British Generic Manufacturers Association
British Medical Association
British Pain Society
Chief Fire Officers
Driving Standard Agency
Driver Vehicle & Licence Authority (DVLA)
Drugscope
Focal Point
General Pharmaceutical Council
General Practitioners Committee
Highways Agency
Independent Healthcare Advisory Services
Independent Pharmacy Federation
Institute of Advanced Motorists
Liberty
Medicines & Health Products Regulatory Agency (MHRA)
Mental Health Foundation
MIND
MS Society
MS Trust
Napp Pharmaceuticals
National Attention Deficit Disorder Information and Support Service
National Pharmacy Association
National Pharmaceutical Association
National Rheumatoid Arthritis Society
Parliamentary Advisory Council for Transport Safety (PACTS)
Parliamentary Office of Science and technology
Pharmaceutical Services Negotiating Committee
Pharmacy Substance Misuse Advisory Group
Pharmacy Voice
Policy Connect
RAC Foundation
RoadSafe

Road Safety GB (Association of local authority road safety officers)
Royal College of Nurses
Royal College of Physicians
Royal College of Practitioners
Royal College of Psychiatrists
Royal Pharmaceutical Society of Great Britain
Royal Society for the Prevention of Accidents
The Alliance
The Alliance of British Drivers
The Company Chemists Association
The Law Society
The Patients Association
Transport for London
TTP Counselling
Turning Point
UK Adult ADHD Network
UK Psychiatric Pharmacy Group
Welsh Government
Young Minds

We propose to offer a briefing session to the above on 26 July 2013 in central London. If you have any suggestions of others who may wish to be involved in this session or in the consultation and wish to ensure they are aware of the process, please pass the information to them or contact us via the contact details listed on page 9.

As this consultation is extended to Scotland the following Scottish stakeholders have also been consulted:

Aberdeen City Alcohol & Drug Partnership
Aberdeenshire Alcohol & Drugs Partnership
Academy of Medical Royal Colleges and Faculties in Scotland
Alcohol and Drug Partnership
Alcohol Focus Scotland
BMA Scotland
BMA, Scottish General Practitioners Committee
Central Scotland Road Safety Partners
Community Pharmacy Scotland
Crown Agent
Crown Office and Procurator Fiscal Service
COSLA
Director of Public Health, NHS Greater Glasgow & Clyde
Drugs Strategy Delivery Commission (Scotland)
Dumfries and Galloway Road Safety Partners
Dundee Road Safety Partners
East Renfrewshire Alcohol & Drug Partnership
Faculty of Advocates
Fife Road Safety Partners

General Pharmaceutical Council, Scotland
Grampian Fire and Rescue Service
Grampian Road Safety Partners
Highland Alcohol & Drugs Partnership
Highlands and Islands Road Safety Partners
Judiciary for Scotland
Judicial Institute for Scotland
Lanarkshire Driver Trainers Association
Living Streets Scotland
Lothian Road Safety Partners
Miscarriages of Justice Scotland
National Forum on Drug Related Deaths
NHS Board Directors of Pharmacy Network
NHS Health Scotland
North East Scotland Transport Partnership
Police Scotland, national drugs coordinator
RCGP Scotland
ROSPA Scotland
Royal College of General Practitioners (Scotland)
Royal College of Nursing Scotland
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal Pharmaceutical Society (Scotland)
Scotland's National Naloxone Advisory Group
Scotland's Road Safety Framework
Scotland's Safety Camera Partnerships
Scottish Campaign Against Irresponsible Drivers
Scottish Court Service
Scottish Criminal Cases Review Commission
Scottish Drugs Forum
Scottish Families Affected by Drugs
Scottish Health Action on Alcohol Problems
Scottish Legal Aid Board
Scottish Medical and Scientific Advisory Committee
Scottish Police Federation
Scottish Prison Service
Scottish Recovery Consortium
Scottish Training on Drugs and Alcohol
Scottish Youth Parliament
Society of Chief Officers of Transportation
South Ayrshire Alcohol & Drug Partnership
Stirling Alcohol & Drug Partnership
Strathclyde Road Safety Partners
The Law Society of Scotland
The Royal College of Surgeons of Edinburgh
VMCL Ltd
Victim Support Scotland
West Dunbartonshire Alcohol and Drug Partnership

Annex C: Draft Regulations

Draft Regulations laid before Parliament under section 195(4) of the Road Traffic Act 1988, for approval by resolution of each House of Parliament.

DRAFT STATUTORY INSTRUMENTS

[2014] No. 0000

ROAD TRAFFIC, ENGLAND AND WALES

The Drug Driving (Specified Limits) (England and Wales) Regulations [2014]

Made - - - - - ***

Coming into force - - - - - ***

The Secretary of State makes the following Regulations in exercise of the power conferred by section 5A of the Road Traffic Act 1988⁽¹⁵⁾ and after consultation with representative organisations in accordance with section 195(2) of that Act.

A draft of these Regulations was laid before Parliament in accordance with section 195(4) of the Road Traffic Act 1988 and approved by a resolution of each House of Parliament.

Citation, commencement and extent

1.—(1) These Regulations may be cited as the Drug Driving (Specified Limits) (England and Wales) Regulations [2014] and come into force on [.....].

2. These Regulations extend to England and Wales.

Specified controlled drugs and specified limits for the purposes of section 5A of the Road Traffic Act 1988

3. The table below specifies the controlled drugs⁽¹⁶⁾ and, in each case, the limit in blood for the purposes of the offence in section 5A of the Road Traffic Act 1988.

Table

<i>Controlled drug</i>	<i>Limit [microgrammes per litre of blood]</i>
Amphetamine	[TBC]
Benzoyllecgonine	50
Clonazepam	50
Cocaine	10
Delta-9-Tetrahydrocannabinol	2
Diazepam	550
Flunitrazepam	300
Ketamine	20
Lorazepam	100

⁽¹⁵⁾ 1988 (c.52); section 5A was inserted by section 56(1) of the Crime and Courts Act 2013 (c.22).

⁽¹⁶⁾ Section 11(2) of the Road Traffic Act 1988 provides that the term “controlled drug” has the meaning given by section 2 of the Misuse of Drugs Act 1971 (c.38). The definition of “controlled drug” was inserted into the Road Traffic Act 1988 by section 56(2) of the Crime and Courts Act 2013.

Lysergic Acid Diethylamide	1
Methadone	500
Methamphetamine	10
Methylenedioxymethamphetamine	10
6-Monoacetylmorphine	5
Morphine	80
Oxazepam	300
Temazepam	1000

Signed by authority of the Secretary of State for Transport

Name
Parliamentary Under Secretary of State
Department for Transport

Date

EXPLANATORY NOTE

(This note is not part of the Regulations)

Section 5A(1) and (2) of the Road Traffic Act 1988 makes it an offence for a person (“D”) to drive, attempt to drive, or be in charge of a motor vehicle on a road or other public place with a specified controlled drug in the body, if the proportion of the drug in D’s blood or urine exceeds the specified limit for that drug. These Regulations specify the controlled drugs for this purpose and the limit for each expressed as a concentration in blood.

An impact assessment on the effect that the offence will have on the costs of business, the voluntary sector and the public sector is available from the Road User Licensing, Insurance and Safety Division, Department for Transport, Great Minster House, 33 Horseferry Road, London SW1P 4DR (telephone 020 7944 6945). It is annexed to the Explanatory Memorandum which is available alongside this instrument on the UK legislation website at <http://www.legislation.gov.uk>. (It concluded that there will be no effect on business and the voluntary sector.)

Annex D: Impact assessment

<p>Title: Drug Driving: Secondary legislation for England and Wales specifying the controlled drugs and the corresponding limits in blood for the new drug driving offence in section 5A of the Road Traffic Act 1988 (as inserted by the Crime and Courts Act 2013).</p> <p>Lead department or Agency: Department for Transport</p> <p>Other Departments or Agencies: Ministry of Justice, Home Office, Department of Health</p>	Impact Assessment (IA)	
	Date: 9 July 2013	
	Stage: Consultation	
	Source of intervention: Domestic	
	Type of measure: Secondary legislation	
Contact for enquiries: Martin.Ellis@dft.gsi.gov.uk		
Summary: Intervention and Options		RPC Opinion:

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as Two-Out?
£-5m	£0	£0	N/A Zero Net Cost

What is the problem under consideration? Why is government intervention necessary?

Driving under the influence of drugs contributes to or causes road deaths and injury and so is a problem in road safety terms. Although research suggests that the incidence of illegal drug driving is about half that of driving whilst under the influence of alcohol, very few proceedings (i.e. prosecutions) are brought against drug drivers (less than 2,700 in 2011, compared to 52,000 proceedings brought under the prescribed limit drink driving offence). Primary legislation has been enacted to create a new drug driving offence and Government is required to specify in secondary legislation the controlled drugs to be covered by the new offence and the limit for each. The new offence enables more effective enforcement action to be taken against drug drivers.

What are the policy objectives and the intended effects?

The overall policy objective 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 it is also our aim 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.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

There are no alternatives to regulation as Parliament has enacted primary legislation and this requires the Government to specify in regulations the drugs to be covered by the new offence and the limit for each. Three options are presented. Option 1 is the Government's preferred option.

Option 1: The new offence would cover 17 controlled drugs found in blood above a specified limit. For 8 controlled drugs most associated with illegal use limits in line with a 'zero tolerance approach', are proposed. For 8 controlled drugs most associated with medical uses limits in line with a 'road safety risk based approach', as identified by the DfT Expert Panel are proposed. The limit for a further controlled drug (amphetamine) would be determined following the consultation, or

Option 2: The new offence would cover 15 controlled drugs (excludes LSD and 6-MAM, included in Option 1) with limits based on a road safety risk based approach as recommended by the DfT Expert Panel; or

Option 3: The new offence would cover controlled drugs (excludes 6-MAM) with limits proposed in line with a zero tolerance approach.

Will the policy be reviewed? Yes		If applicable, set review date: 10/2016			
Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.		Micro No	< 20 No	Small No	Medium No
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)		Traded: £0		Non-traded: £0	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:


 Date: 8/7/2013

Summary: Analysis & Evidence

Policy Option 1

Preferred Government approach: Zero tolerance approach to 8 controlled drugs and a road safety risk approach to a further 8 controlled drugs with amphetamine limit to be decided following the consultation.

Description: New offence of driving with a controlled drug in the blood in excess of the specified limit for that drug (and related consequential amendments).

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2013	Time Period Years 2014-23	Net Benefit (Present Value (PV)) (£m) £-5m		
			Low: £-75m	High: £93m	Best: £-5m

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A	£18m	£146m
High	N/A	£24m	£195m
Best Estimate	N/A	£20m	£170m

Description and scale of key monetised costs by 'main affected groups'

The best estimates of the total monetised costs over the 10 year appraisal period for the Crown Prosecution Service (CPS), criminal justice system, police and offenders are around £12m, £72m, £74m and £12m respectively (Present Value). The criminal justice system costs include the costs of the courts, legal aid, prisons and probation. The police costs include the costs of screening suspects and preparation for prosecution.

Other key non-monetised costs by 'main affected groups'

1.) Police non-monetised costs: We have no estimate of the costs of the screening device, or the police undertaking less activity elsewhere. 2.) Non monetised costs to drivers: We have no estimate of the costs related to suspects who are not prosecuted, or time taken to provide a roadside drug screening test. 3.) Criminal Justice System non monetised costs: We have no estimate of Crown Court or remand costs as negligible.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	£9m	£72m
High	N/A	£35m	£288m
Best Estimate	N/A	£20m	£165m

Description and scale of key monetised benefits by 'main affected groups'

The best estimate of the total road casualty savings over the 10 year appraisal period following the introduction of the new offence is around £153m (Present Value). The savings are assumed to result from the offence acting as an effective deterrent to driving under the influence of drugs. The Exchequer is estimated to accrue total benefits of around £12m over the 10 year appraisal period as a result of income from financial penalties and victim surcharges (Present Value).

Other key non-monetised benefits by 'main affected groups'

1.) A zero tolerance approach to illegal drugs would assist the Government's wider drug strategy and may contribute to reducing illegal drug use. 2.) Cost savings of damage to vehicles are not monetised.

Key assumptions/sensitivities/risks

Discount rate (%)

3.5%

Due to the limitations of the available evidence, the costs and benefits of Policy Option 1 are subject to considerable uncertainty. To estimate the monetised costs and benefits, a number of assumptions have had to be made. Ranges have been generated to illustrate the scale of this uncertainty. For example, as evidence from other countries may not be directly applicable to England and Wales and the nature of the legislation precludes a trial period, we have included low, medium and high estimates for the number of proceedings brought against those suspected of committing the new offence. The estimates are very sensitive to the choice of assumptions, and should be interpreted as indicative estimates of the order of magnitude of these costs and benefits. Furthermore, there are a number of non-monetised costs and benefits. Therefore, there is considerable uncertainty over whether Policy Option 1 would result in a Net Benefit or a Net Cost.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: £0	Benefits: £0	Net: £0	N/A	Zero net cost

Summary: Analysis & Evidence

Policy Option 2

This road safety risk based approach to 15 controlled drugs is not the Government's preferred approach but is included to enable a comparison to be made with the preferred approach in Policy Option 1.

Description: New offence of driving with a controlled drug in the blood in excess of the specified limit for that drug (and related consequential amendments).

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2013	Time Period Years 2014-23	Net Benefit (Present Value (PV)) (£27m)		
			Low: £0.4m	High:£116m	Best:£27m

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A	N/A	£6m	£48m
High	N/A		£19m	£157m
Best Estimate	N/A		£13m	£109m

Description and scale of key monetised costs by 'main affected groups'

The best estimates of the total monetised costs over the 10 year appraisal period for the Crown Prosecution Service (CPS), criminal justice system, police and offenders are around £8m, £46.6m, £47.4m and £7.6m respectively (Present Value). The criminal justice system costs include the costs of the courts, legal aid, prisons and probation. The police costs include the costs of screening suspects and preparation for prosecution.

Other key non-monetised costs by 'main affected groups'

1.) Police non-monetised costs: We have no estimate of the costs of the screening device, or the police undertaking less activity elsewhere. 2.) Non monetised costs to drivers: We have no estimate of the costs related to suspects who are not prosecuted, or time taken to provide a roadside drug screening test. 3.) Criminal Justice System non monetised costs: We have no estimate of Crown Court or remand costs as negligible.

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	N/A	£6m	£48m
High	N/A		£33m	£274m
Best Estimate	N/A		£16m	£136m

Description and scale of key monetised benefits by 'main affected groups'

The best estimate of the total road casualty savings over the 10 year appraisal period following the introduction of the new offence is around £128.5m (Present Value). The savings are assumed to result from the offence acting as an effective deterrence to driving under the influence of drugs. The Exchequer is estimated to accrue total benefits of around £8m over the 10 year appraisal period as a result of income from financial penalties and victim surcharges (Present Value).

Other key non-monetised benefits by 'main affected groups'

Cost savings of damage to vehicles are not monetised.

Key assumptions/sensitivities/risks

Discount rate (%)

3.5%

Due to the limitations of the available evidence, the costs and benefits of Policy Option 2 are subject to considerable uncertainty. To estimate the monetised costs and benefits, a number of assumptions have had to be made. Ranges have been generated to illustrate the scale of this uncertainty. For example, as evidence from other countries may not be directly applicable to England and Wales and the nature of the legislation precludes a trial period, we have included low, medium and high estimates for the number of proceedings brought against those suspected of committing the new offence. The estimates are very sensitive to the choice of assumptions, and should be interpreted as indicative estimates of the order of magnitude of these costs and benefits. Furthermore, there are a number of non-monetised costs and benefits. Therefore, there is considerable uncertainty over the extent of the Net Benefit in Policy Option 2.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: £0	Benefits: £0	Net: £0	N/A	Zero net cost

Summary: Analysis & Evidence

Policy Option 3

This zero tolerance approach to 16 controlled drugs is not the Government's preferred approach but is included to enable a comparison to be made with the preferred approach in Policy Option 1.

Description: New offence of driving with a controlled drug in the blood in excess of the specified limit for that drug (and related consequential amendments).

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2013	Time Period Years 2014-23	Net Benefit (Present Value (PV)) (£m) £-19m		
			Low: £-82m	High: £71m	Best:£-19m

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A	N/A	£18m	£154m
High	N/A		£24m	£217m
Best Estimate	N/A		£22m	£184m

Description and scale of key monetised costs by 'main affected groups'

The best estimates of the total monetised costs over the 10 year appraisal period for the Crown Prosecution Service (CPS), criminal justice system, police and offenders are around £12m, £72m, £87m and £12m respectively (Present Value). The criminal justice system costs include the costs of the courts, legal aid, prisons and probation. The police costs include the costs of screening suspects and preparation for prosecution. In addition, the best estimate of the total monetised costs to drivers who have a credible medical defence over the 10 year appraisal period is around £1.4m (Present Value).

Other key non-monetised costs by 'main affected groups'

1.) Police non-monetised costs: We have no estimate of the costs of the screening device, or the police undertaking less activity elsewhere. 2.) Non monetised costs to drivers: We have no estimate of the costs related to suspects who are not prosecuted, or time taken to provide a roadside drug screening test. 3.) Criminal Justice System non monetised costs: We have no estimate of Crown Court or remand costs as negligible.

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	N/A	£9m	£72m
High	N/A		£35m	£288m
Best Estimate	N/A		£20m	£165m

Description and scale of key monetised benefits by 'main affected groups'

The best estimate of road casualty savings over the 10 year appraisal period following the introduction of the new offence is £153m. The savings are assumed to result from the offence acting as an effective deterrence to driving under the influence of drugs. The Exchequer is estimated to accrue total benefits of around £11m over the 10 year appraisal period as a result of income from financial penalties and victim surcharges (Present Value).

Other key non-monetised benefits by 'main affected groups'

1.) A zero tolerance approach to illegal drugs would assist the Government's wider drug strategy and may contribute to reducing illegal drug use. 2.) Cost savings of damage to vehicles are not monetised.

Key assumptions/sensitivities/risks

Discount rate (%) 3.5%

Due to the limitations of the available evidence, the costs and benefits of Policy Option 3 are subject to considerable uncertainty. To estimate the monetised costs and benefits, a number of assumptions have had to be made. Ranges have been generated to illustrate the scale of this uncertainty. For example, as evidence from other countries may not be directly applicable to England and Wales and the nature of the legislation precludes a trial period, we have included low, medium and high estimates for the number of proceedings brought against those suspected of committing the new offence. The estimates are very sensitive to the choice of assumptions, and should be interpreted as indicative estimates of the order of magnitude of these costs and benefits. Furthermore, there are a number of non-monetised costs and benefits. Therefore, there is considerable uncertainty over whether Policy Option 3 would result in a Net Benefit or a Net Cost.

BUSINESS ASSESSMENT (Option 3)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: £0	Benefits: £0	Net: £0	N/A	Zero net cost

Evidence Base

Problem under consideration and rationale for intervention

Road Casualty Problem

1. Driving is a complex task and the capacity to drive safely may be impaired in a variety of ways due to drugs. In 2010 the Government commissioned a review of the legal framework governing drink and drug driving in Great Britain. The report, the North review,¹⁷ set out the ways in which different drugs have an adverse effect on the behaviours and skills required to drive safely. It describes how depressant drugs can for example slow response times and recall, lower alertness and lead to more errors. Hallucinogens and drugs that cause sedation have adverse effects on driving performance. Stimulants may improve reaction time, but can negatively affect critical judgement, increase impulsiveness, lead to more errors and disrupt sleep patterns.
2. 'Impaired by drugs' was recorded by the police as a contributory factor in 54 road deaths, or about 3% of fatal road incidents in Great Britain in 2011¹⁸. For England and Wales, it is estimated to be 49. This is about a third of the share of fatal accidents which had 'impaired by alcohol' assigned as a contributory factor (149). The North Report considered both these figures to be substantial under-estimates, as the attribution of contributory factors is largely subjective, reflecting the police officer's opinion at the time of reporting; and as only those accidents where the police attended the scene and reported at least one contributory factor are included in the data.
3. The official provisional estimate for drink drive related road deaths in 2011 is 254¹⁹ for England and Wales. If the under-reporting of the 'impaired by drugs' contributory factor in police data on road traffic incidents (STATS19²⁰) is in the same proportion as for the 'impaired by alcohol' contributory factor, the figure of road deaths related to drug impaired driving would be about 85, i.e. approximately a third of 254. However, the Department considers that it is likely that the

¹⁷ North Report of the Review of Drink and Drug Driving Law (published in June 2010),

<http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/>

¹⁸ Contributory Factor Type: Report Accidents by Severity GB 2011 (Reported Road Casualties GB 2011), Department for Transport. To produce an estimate for England and Wales, we have adjusted the figures by a reduction of 9.44% to take account of Scotland's proportion of the GB population.

¹⁹ Reported Road Casualties GB 2011 - <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2011>. The England and Wales figures are taken from these statistics but are not published separately.

²⁰ Reported Road Casualties GB 2011 - <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2011>

under-reporting of drug impairment in the STATS19 contributory factor system is greater than for drink, because the practical difficulties of testing for drugs are greater.

4. The European Commission funded project 'Driving under the Influence of Drugs, Alcohol and Medicines' (DRUID)²¹ conducted between 2007 and 2009 suggests that the prevalence of illegal drugs²² in the general driving population is about 55% that of alcohol. Assuming that this relationship also translates to impairment, the prevalence of drug impaired driving safety problems can be estimated to be roughly half that of drink driving. If this held in England and Wales this would suggest that there were about 140 road deaths related to illegal drugs and impaired driving in 2011
5. Work by Tunbridge et al²³ suggested that illicit drugs could be present in about 18% of road fatalities in 2000. If sustained, in 2011, this would equate to around 310 deaths in England and Wales (i.e. about 18% of 1,722), far higher than police estimates, but no assessment can be made of the actual impairment at the time of driving.
6. Estimating the casualty savings of increased drug driving enforcement for the purpose of this Impact Assessment is therefore problematic for two main reasons:
 - current and historic data on the impact of drug driving on casualties is known to be unreliable;
 - it is difficult to determine the deterrence effect of increased levels of enforcement on the incidence of drug driving.
7. Nevertheless, it is necessary to make some estimate of the impact of new drug driving legislation on the annual number of people killed, seriously and slightly injured over the appraisal period.
8. Estimating the number of drug driving casualties is difficult because:

²¹ DRUID, Driving under the Influence of Drugs, Alcohol and Medicines, Main DRUID Results, 6th Framework Programme, 2011. This report estimates the prevalence of illicit drugs (1.90%) and prevalence of alcohol (3.48%) in the driving population across Europe.

²² 'Illegal drugs' has no statutory definition in the UK but is commonly used to refer to controlled drugs (under the Misuse of Drugs Act 1971) and is commonly understood as meaning drugs that have been obtained otherwise than through healthcare professionals (including but not limited to a prescription) and for medical treatment of a diagnosed condition.

²³ Tunbridge RJ, Keigan M and James F (2001) The incidence of drugs and alcohol in road accident fatalities. TRL Report 495. Crowthorne: TRL.

- Coroners' data does not indicate whether drugs were instrumental in causing an accident. It is also only a measure of the drugs in the system of those who died in an accident;
- Since 2005 the police have indicated whether they believe drugs to have been a contributing factor in an accident. This data²⁴ is considered to be a significant underestimate of the true impact of drug driving, as it is based only on the police officer's assessment at the scene of an accident;
- The type of drug, the size of the dosage and the length of time a drug has been in a driver's body and their physiology all have a bearing on the degree to which a driver is affected. That a driver is found to have consumed a drug is not necessarily an indication that their driving was impaired. This is in contrast to alcohol where the link between consumption and impairment is well established and understood. (In other words, the prescribed limit for the excess alcohol offence in section 5 of the Road Traffic Act 1988 is set at a level where it can reasonably be said that the average driver would be impaired; it is not possible to determine such a limit for drugs);
- Police have not had the resources to properly test drivers for drugs, resulting in underestimates of incidence of drug driving.

9. For these reasons it is difficult to establish an estimate of the number of casualties of drug driving for a baseline forecast for the appraisal period. We have therefore employed a wide range, in which the lowest and highest estimates are likely under and over estimates, and the central estimate is uncertain.

Low estimate of drug impaired driving casualties (based upon data 2006-2011)

10. The lowest estimate is the number of casualties reported in accidents in which drugs was recorded by police as a contributing factor. This is likely to be an underestimate for the reasons outlined above. To attempt to alleviate some of the uncertainty we have employed an average of the number of casualties for drug driving

²⁴ Contributory Factors in Road Casualties Great Britain 2011
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/10241/ras50007.xls

from 2006 until 2011 (data is only available from 2005 and 2012 is not yet available). This methodology is used to estimate the low baseline to take forward from the beginning of the appraisal period in calculating the casualty savings.

High estimate of drug impaired driving casualties (based upon data 2007-2011)

11. To arrive at an upper estimate we have applied the proportion of drug drivers in the driving population as estimated by DRUID to the number of casualties recorded in accidents in which a driver is over the legal alcohol limit (i.e. 55%). This figure is likely to be an over estimate as it assumes drivers impaired by drugs are at the same risk of having an accident as drink drivers and DRUID demonstrates that drink driving is more dangerous than drug driving. Whilst relatively small concentrations of alcohol are known to impair driving, drugs impair drivers to differing degrees and in different ways. The DRUID study included drivers who had consumed a range of drugs above a minimum threshold that was set at a level that does not necessarily imply the driver is impaired. DRUID do not estimate how many drivers drive with concentrations of drugs above a threshold known to be dangerous.
12. Although the upper estimate has the advantage of a being based on a plausible relationship between the consumption of alcohol and drugs and driving it also makes the assumption that the same factors that formulate trends in drink driving and drink driving accidents have a similar impact on drug driving. The most significant factor in recent years is the impact of the economic recession on driving, driving behaviour and drink driving in particular. If we are to assume drug driving follows a similar trend to drink driving then we also assume that there is a similar relationship between the economy and drug consumption behaviour and driving whilst under the influence of drugs. Whilst such a relationship is plausible it is not nearly as well understood as with drink driving. In times of recession people tend to visit pubs, restaurants and bars less frequently. This is known to influence the incidence of drink driving and casualties; there is little evidence that drug driving is similarly affected.
13. To attempt to compensate for any subsequent potential downward bias in drug driving casualties we have used as the basis of our forecast the average number of casualties between 2007 and 2011. The relative accuracy of drink driving statistics (coroner's data and

positive breath tests) suggests an average of three years would in normal circumstances be reasonable and provide a reliable basis for casualty forecasts over the next five to ten years. However, the downturn in the UK economy is likely to have been a significant factor in the dramatic fall of overall casualties and drink driving casualties from 2008²⁵ to 2010 and the weaker (or at least less well established) relationship between drug driving and the economy we feel that an average over a longer period of time may assist in mitigating some of the impact of the recession. We have therefore included casualty statistics for 2007.

Central estimate of Drug impaired driving casualties (based upon data 2007-2011)

14. For similar reasons we are wary of assuming too close a relationship between drink driving casualties and drug driving casualties for our central estimate. However, there is little other basis for establishing a central baseline. We have therefore opted to assume that drug driving fatalities are one third of drink driving, which is purely an illustrative assumption. Serious and slight injuries are assumed to share the same ratios to fatalities as with the lower estimate. Whilst we cannot claim that choosing 33% of the drink driving casualties (2007-2011) as the basis for our estimate is grounded in strong evidence, it is an illustrative example and closer to the lower estimate (and so less likely to be an over estimation). We cannot stress enough, however, the sensitivity of the outcome of the analysis to the baseline estimate of the number of drug driving casualties.

15. In addition, to obtain a forecast of the possible casualty savings over the ten year appraisal period we have adopted the following approach:

- TRL forecasts²⁶ up until 2025 were used to estimate the annual reduction in road traffic casualties for the do nothing scenario;

²⁵Department for Transport (2011) *Strategic Framework for Road Safety* and Broughton, J. (2009) *Post-2010 Casualty Forecasting*, TRL.

²⁶http://www.trl.co.uk/online_store/reports_publications/trl_reports/cat_road_user_safety/report_post-2010_casualty_forecasting.htm

- The same rate of change was then applied to estimates for 2011 described above up until 2025 to produce the baseline forecast;
- A further percentage reduction from this baseline was then calculated to arrive at potential average casualty savings under each policy option.

16. Casualty savings were then given monetary values using values provided by Webtag.

Table 1: Drug impaired driving casualty estimates on three baseline estimates

	Casualties (England and Wales) ²⁷									
	Deaths			Serious			Slight			Total
Drink Drive (2007 -2011 averages)	304			1,338			9,182			10,824
Estimates	Low	Mid	High	Low	Mid	High	Low	Mid	High	
Drug Impaired (2011)	52	117	192	229	515	778	683	1,536	2,244	

Q. Do you have a view on the methodology used to estimate the drug driving casualties baseline? If so, please give your reason(s).

Level of Enforcement

17. 2011 Ministry of Justice returns indicate that there were far fewer proceedings²⁸ brought related to drug impaired driving than for drink driving. There were about 52,000 proceedings brought to Magistrates' Courts in England and Wales²⁹ for the specific offence of driving with alcohol above the prescribed limits (under section 5 of the Road Traffic Act 1988). There were fewer than 2,700 proceedings related to the impairment offence of being unfit to drive through drink or drugs (under section 4 of the 1988 Act), which is the main offence available to proceed against drug drivers prior to the new offence being introduced. This is less than 5% of the drink drive proceedings.

18. Given drink and drug driving are issues of a similar nature (albeit the prevalence of drink driving may be about double that of drug

²⁷ Reported Road Casualties Great Britain by region (i.e. England and Wales)

²⁸ We have used the term 'proceedings' to mean those prosecutions brought to court.

²⁹ Ministry of Justice, Court proceedings database

driving), the enforcement action related to drug driving appears disproportionately low.

Effectiveness of Enforcement

19. Approximately 41% of the proceedings at Magistrates' Courts in England and Wales for impairment (due to drugs or drink but nearly always drugs) were withdrawn or dismissed in 2011 (compared to about 3% for the prescribed limit drink drive offence)³⁰. The North review indicated that in a sample police force area (with above average experience of using the current drug driving enforcement regime) only 35% of positive preliminary tests led to findings of guilt at court in 2008 and 2009.
20. The existing offence used to prosecute drug impaired drivers requires impairment of their driving to be established case by case, as well as the impairment being due to drugs. This differs from the approach taken to the prescribed limit drink driving offence, where the evidence required is simpler to obtain.
21. Given that the current system is hindering effective enforcement, Government intervention is required to address this, improve driver compliance with required driving standards and, in doing so, improving road safety.

Aims and Objectives

22. The overall aim of these proposals is to improve road safety by reducing the risk arising from drug driving. To achieve this overall aim, it is also our objective to:
 - Deter people from taking illegal drugs in the first place and those who abuse their medication; and
 - Enable more effective enforcement to be taken against those who persist in taking illegal drugs and those who abuse their medication and continue to drive; and
 - Increase the efficiency of enforcement action against drug drivers.

Proposal Options in Context

23. The North Review's recommendations in relation to drug driving law proposed a five step strategy to improve the law and the regime for drug testing. This comprised:

³⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/162619/motoring-tables-1211.xls.xls

1. improving the current drug testing process;
2. preliminary screening tests;
3. a specific prescribed limit drug drive offence;
4. drug screening at the roadside;
5. evidential saliva testing.

24. The new offence of driving with a specified controlled drug³¹ in the body above the level specified for that drug, which was introduced in the Crime and Courts Act 2013 by inserting a new Section 5A in the Road Traffic Act 1988 (“1988 Act”) enables the third step of the strategy to be implemented. It is described in detail below. Work on steps 1 and 2 have been proceeding. In respect of step 2, drug screening equipment for THC, the active ingredient for cannabis, was type approved by the Home Secretary on 30 December 2012 for use in preliminary screening tests for drugs at police stations. This device can be used initially when enforcing the existing drug driving offence (in section 4 of the Road Traffic Act 1988).

25. Planning work is underway in relation to drug screening equipment for use at the roadside (step 4). Type approval work is planned so the equipment can be available to enable the objectives for the new offence to be achieved. To enable the final specification for manufacturers to develop the devices clarity on the specified limits is required.

26. The new offence can be introduced without roadside screening equipment being available. However, the objectives for the new offence would only be partially achieved if this equipment were not available. Both the benefits and costs in this Impact Assessment assume the availability of roadside screening equipment. Step 5 is a longer term plan and is not included in this assessment.

The new specific drug driving offence

27. The Crime and Courts Act 2013 created a new offence for use across Great Britain by inserting a new offence in section 5A in the 1988 Act of driving with a specified controlled drug in the body in excess of the limit specified for that drug. It is already an offence to drive whilst impaired by drugs (under section 4 of the 1988 Act), and this will remain in place alongside the new, more specific offence. The penalty options for the new offence are the same as those for

³¹ Controlled drugs are defined in the (UK wide) Misuse of Drugs Act 1971 as being either a Class A, B, C or a temporary class drug.

the existing offence of driving with an alcohol concentration above the prescribed limit (under section 5 of the 1988 Act).

28. The new section 5A offence includes a regulation-making power (exercisable by the Secretary of State for Transport in relation to England and Wales and by the Scottish Ministers in relation to Scotland) to specify which controlled drugs are covered by the offence, and the specified limit in relation to each. These regulations are subject to the affirmative resolution procedure in Parliament³², and there is a requirement to carry out a public consultation before making them³³. The objective of the new offence is to improve public safety on roads.
29. Different specified limits can be set for different controlled drugs. The North review of drink and drug driving law advised that a new specific offence should be developed, and identified eight drugs or categories of drug which should be considered for inclusion. The exact drugs and limits involved are proposed under the different policy options below following technical advice from the DfT Expert Panel. The panel began work in April 2012 and their report and recommendations were published on 7 March 2013 recommending limits to be set for 15 different controlled drugs³⁴.
30. The primary legislation provides a defence if a specified controlled drug is taken in accordance with the advice of a healthcare professional. The impairment offence (section 4 of the 1988 Act) will continue to be used to deal with those whose driving is impaired by specified controlled drugs where they have not been taken in accordance with the advice of a healthcare professional, e.g. abused. The impairment offence would also continue to be used to deal with those whose driving is impaired by drugs which are not specified for the purposes of the offence.
31. Consequential amendments made by the Crime and Courts Act 2013 in relation to the new offence also make provision so that if a person has a specified controlled drug in the blood or urine in excess of the specified limit for that drug, and causes death by careless driving, that person can be charged with the offence of causing death by careless driving when under the influence of drink

³² By virtue of the amendment to section 195 of the Road Traffic Act 1988 made by subsection (3).

³³ By virtue of section 195(2) of the 1988 Act.

³⁴ Expert Panel report 'Driving under the influence of drugs' is available at <https://www.gov.uk/government/publications/driving-under-the-influence-of-drugs-2>.

or drugs (under section 3A of the 1988 Act). More substantial penalties are available for that offence than for the offence of causing death by careless driving (under section 2B of the 1988 Act), which is currently used if it cannot be proven that the person was impaired by drugs at the time of causing the death.

32. The primary legislation also provides for a maximum of three preliminary saliva or sweat screening tests to be taken to check for drugs. Preliminary testing for drugs would use saliva testing, while evidential testing for drugs would be through blood samples. Saliva or sweat tests would not be evidential tests, in contrast to breath tests for alcohol, which can be – and are the most frequently used – type of evidential test for the offence of drink driving. It is envisaged the new offence would apply to those driving with any of 17 controlled drugs proposed found in blood above a certain limit.

New Offence and Regulations

33. For the offence to be put into operation, regulations need to be made specifying the controlled drugs covered by the offence and the specified limits for each. This Impact Assessment sets out the Government's proposals by setting out in Policy Option 1 the preferred approach. For 8 controlled drugs most associated with illegal use limits in line with a 'zero tolerance approach' are proposed. For 8 controlled drugs most associated with medical uses³⁵ limits in line with a 'road safety risk based approach' as identified by the DfT Expert Panel are proposed. There is one further controlled drug, amphetamine, which we also propose to include in the regulations and thus apply a limit to. While amphetamine has significant medical uses, it is also often taken illegally so we are asking for views in the consultation on a possible limit to set. A limit for amphetamine will, therefore, be determined following consideration of the responses to the consultation and a further but shorter consultation on the proposed limit will be undertaken.

34. In taking a zero tolerance approach to those drugs most associated with illegal use we are proposing to set limits at a level that do not catch those who have inadvertently consumed very small amounts of a drug. The approach will therefore not necessarily equate to setting limits at zero, but at the lowest concentration at which a valid and reliable analytical result can be obtained, yet above which issues such as passive consumption or inhalation can

³⁵ Controlled drugs associated with medical uses are those where the amount of prescriptions issued each year runs into the many thousands.

be ruled out – a ‘lowest accidental exposure limit’. These limits were obtained from an expert advisory committee convened by the Home Office in May 2013. The committee includes some members of the DfT Expert Panel and toxicologists with extensive experience in the field of forensic science. The 8 illegal drugs for which a zero tolerance approach is taken are:

Cannabis	MDMA (Ecstasy)
Cocaine	Ketamine
Benzoylecgonine	Methamphetamine
Lysergic Acid Diethylamide (LSD)	6-monoacetylmorphine (6-MAM) (Heroin/Diamorphine)

35. The road safety risk based approach would apply the same limits for the other 8 controlled drugs as those recommended by the Expert Panel.
36. Two other policy options have also been analysed in order to show a comparison to the preferred approach. We take the view that both of these approaches are not viable for the reasons sets out in this Impact Assessment.

Policy Option 1: A zero tolerance approach to 8 illegal controlled drugs and a road safety risk based approach (Expert Panel recommendation) to 8 controlled drugs. A further controlled drug, amphetamine, to be determined following the consultation.

37. The Government has a zero tolerance approach to illegal drug use, and in considering the specified drugs and their limits, it is clear that a zero tolerance approach for the new drug driving offence would send the strongest possible message that you cannot take illegal drugs and drive. At the same time the Government must consider the position of those who legitimately and safely use medicines which may contain controlled drugs. We recognise that for the purposes of drug testing, distinguishing between those drugs that do have medical uses and those that do not is complex. We must ensure that the new offence would not unduly penalise drivers who have taken properly prescribed or supplied drugs in accordance with the advice of a healthcare professional. A medical defence is available to those on properly supplied medicines that are taken in accordance with the advice of a healthcare professional. **Table 2** sets out the proposed limits for the 8 controlled drugs subject to the

zero tolerance approach and 8 controlled drugs subject to the road safety risk based approach.

Table 2: Limits for a zero tolerance approach to 8 illegal controlled drugs and a road safety risk based approach (Expert Panel recommendation) to 8 controlled drugs.

Drug	Threshold limit in blood
Amphetamine	TBC (following consultation)
Benzoyllecgonine	50µg/L
Clonazepam	50µg/L
Cocaine	10µg/L
Delta – 9 – Tetrahydrocannabinol (<i>Cannabis & Cannabinol</i>)	2µg/L
Diazepam	550µg/L
Flunitrazepam	300µg/L
Ketamine	20µg/L
Lorazepam	100µg/L
Lysergic Acid Diethylamide (LSD)	1µg/L
Methadone	500µg/L
Methamphetamine	10µg/L
Methylenedioxyamphetamine (MDMA – <i>Ecstasy</i>)	10µg/L
6-Monoacetylmorphine (6-MAM – <i>Heroin & Morphine</i>)	5µg/L
Morphine	80µg/L
Oxazepam	300µg/L
Temazepam	1,000µg/L

Proceedings

38. We have provided analysis for the above scenario. The introduction of the new criminal offence – of driving with a specified controlled drug in the body above the specified limit for that drug – will create a new set of offenders. Because this offence is new, there is considerable uncertainty regarding the forecast increase in the number of drug-driving offenders. This is primarily due to a lack of evidence regarding the prevalence of drug-driving, currently and into the future, and enforcement levels in the future. There is also a degree of uncertainty on the immediate availability of roadside screeners and which drugs they will be able to screen.

39. In the Impact Assessment of the primary legislation published in May 2012³⁶, we estimated that there will be approximately 8,200 proceedings brought per annum due to the new offence, which was based upon a road safety risk approach to both illegal drugs and drugs most associated with medical uses. We believe this estimate was high as discussed in Policy Option 2 where a road safety risk based approach to both medical and illegal drugs is considered.
40. For the purposes of the current Impact Assessment we have taken an alternative approach to arrive at estimates for the number of proceedings brought against drivers who test positive for illegal drugs and for those that test positive for drugs most associated with medical use under Policy Option 1. Clearly we expect there will be more proceedings under this approach where the limits will be much lower for the illegal drugs than where the limits are proposed at a higher level for a road safety risk based approach.
41. For this approach we first estimate the number of drivers who can reasonably be expected to be tested for drugs. The legislation only allows the police to test drivers who have committed a moving traffic offence (such as having a defective tail light), who have been involved in a road traffic accident or who are driving erratically. Based on informal discussions with the police it is most likely that they would first test for blood alcohol content using a breathalyser test as the test is more straightforward, cheaper and there is no opportunity for the suspect to raise a medical defence. According to the latest available data for England and Wales (2010) around 649,000 drivers underwent a breathalyser test and were not above the prescribed blood alcohol limit³⁷.
42. If the test proves that the suspect's blood alcohol content is below the prescribed threshold the police will then have the option of conducting a preliminary roadside drug screening test. If the suspect provided a positive alcohol test the police would be unlikely to also check for drugs unless a road traffic accident where personal injury took place, because the sanctions for the drink driving offence is the same as the drug driving offence. For the purposes of this Impact Assessment, the estimates of the number of proceedings are therefore solely based on the number of drivers who have tested negative for alcohol. Determining the proportion of drivers who have

³⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98433/ia-drug-driving-offence.pdf.

³⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/10266/ras51016.xls

tested negative for alcohol, but who may have drugs in their system requires an estimate of the prevalence of the use of controlled drugs among the UK driving population. Unfortunately, there has been no such study in the UK. However, a European Commission funded project, 'Driving under the Influence of Drugs, Alcohol and Medicines' (DRUID)³⁸ measured the prevalence of alcohol and other drugs in the driving population in thirteen European countries (the UK did not participate)³⁹. The survey involved roadside surveys in which participants were randomly selected, stopped and asked to contribute saliva and/ or blood samples for analysis. In total over 48,500 drivers of passenger cars and vans in thirteen European countries provided samples. The overall prevalence of illegal drugs in the driving population in these European countries was 1.9% and drugs with medicinal uses (benzodiazepines and medicinal opioids) was 1.3%. This represents a split of around 60% illegal drugs and 40% drugs with medicinal uses.

43. There are some difficulties applying the DRUID results to the UK. First, as the DRUID report makes clear, there are substantial variations in the prevalence and nature of drug use between countries. There is no guarantee that the averages are consistent with the drug use among the driving population in the UK. Secondly, participants in the survey were randomly stopped and were not involved in situations or exhibiting driving behaviour that would necessarily have prompted action by the police. The proportion of drug users stopped by the police might therefore be higher than the proportion of drug users in the general driving population.

44. The Centre for Applied Science and Technology (CAST) made available to the Expert Panel on drug driving data relating to cases, predominantly from England and Wales, of road traffic accidents or impairment witnessed by the police, followed by an assessment by a forensic physician⁴⁰. The data included 3,616 blood samples and provided prevalence by drug types. Illegal drugs accounted for 62% whilst the controlled drugs with medicinal uses (Benzodiazepines and the opiates) accounted for 38% of the total. The DRUID study breakdown of 60% illegal drugs to 40% controlled drugs with medicinal uses is very similar to the CAST breakdown of 62% / 38% and whilst it is still an assumption it should provide some confidence in the figures given the consistent findings. In the absence of more

³⁸ http://www.druid-project.eu/cln_031/nn_111632/Druid/EN/about-DRUID/about-DRUID-node.html?__nnn=true

³⁹ DRUID Deliverable 2.2.3 data collected 2007-2009 (Houwing et al 2011).

⁴⁰ page 28 of *Driving under the influence of drugs*.

UK specific data, we have used the DRUID results to estimate the prevalence of drug driving in the UK.

45. Therefore, assuming that 1.9% of drivers might be on controlled drugs associated with illegal use, it is estimated that 12,331 drivers that underwent a breathalyser test and were not above the legal blood alcohol limit in 2010 might be on controlled drugs associated with illegal use. (i.e. 1.9% of 649,000). 1.3% of drivers on controlled drugs with medical uses would equate to around 8,437. If we then attempt to apply the CAST ratio of 62% for illegal drugs then the figure would increase slightly to around 12,900 ($8,437 + 12,331 = 20,768$ and $62\% \text{ of } 20,768 = 12,876$). As these estimates are uncertain we have taken a mid point of 12,600 (i.e. $12,876 - 12,331 = 554/2 = 272.5 + 12,331 = 12,603.5$, rounded to 12,600).
46. We cannot be sure that the police would go on to carry out a screening test on them all and subsequently take proceedings, particularly as the drivers have just provided a negative breath test and may not show signs of drug use especially if low level drug use. However, whilst the police would not want to arrest those who had taken a controlled drug in accordance with the advice of a healthcare professional and could provide a credible medical defence, they would seek to arrest those likely to be driving on illegal drugs. We would therefore expect police to be more likely to carry out a drug screening test on those suspected to have illegal drugs in their system as opposed to medical drugs. Whilst there are uncertainties, from informal discussions with the police and agreed with Ministry of Justice analysts, we have assumed a range of 60-80% rather than the 10-30% range we have assumed are likely to be screened on medical drugs (see Policy Option 3).
- 60% of 12,600 = 7,560
 - 70% = 8,820
 - 80% = 10,080.
47. We therefore propose a range of 7,600-8,800-10,100 and therefore a central scenario of **8,800** proceedings. There may be a small number of proceedings against those on controlled drugs associated with medical drugs that are over the specified limit. As the proposed limits are at a level where the chances of having a road traffic accident increases and in the vast majority of cases above the normal therapeutic doses it would only be those who are either (a) on high prescribed doses but represent a road safety risk,

where the police are more likely to charge them under the existing section 4 impairment offence; or (b) where the suspect is unable to provide a credible medical defence, i.e. obtained illegally. We believe the range is sufficient to accommodate the small number of suspects who fall under (b). This range has been discussed informally with the police, prior to being included in this new assessment. However, we would welcome views on whether our estimate that there will be a small amount of proceedings against drivers on controlled drugs with medical uses is correct.

Q. Do you have a view on the amount of proceedings likely to be brought against those taking medical drugs proposed for inclusion under this approach? If so please give your reason(s)

Q. Do you have a view on the methodology used to estimate the amount of proceedings for this approach? If so please give your reason(s)

48. To extend the analysis to cover the 10 year appraisal period we have made two further assumptions:

- the number of proceedings per annum, (7,600, 8,800, 10,100) remains constant throughout the appraisal period; and
- the number of offenders charged under the existing impairment offence will be unchanged.⁴¹

49. The detailed cost estimates have been produced on the basis that the extra proceedings relate to the new offence (or associated failures to provide samples). The existence of the new offence is also likely to result in some cases that would have been taken forward under the existing impairment offence instead proceeding under the new offence. For the detailed cost estimates it has been assumed that the net change in the impairment offence numbers is zero. However the cost estimates would be very similar if there were a net change in the number of proceedings under the impairment offence, provided the overall increase in the total proceedings under all the offences was the same.

⁴¹ There may be a certain transfer of cases between the existing impairment offence and the new specific drug offence, and vice versa. There may also be interactions with the prescribed limit drink driving offence.

50. The new offence is assumed to operate in the same manner as the existing prescribed limit drink drive offence, such that offenders will be charged under one of the following:

- Driving or attempting to drive with a specified controlled drug in the blood above the prescribed limit
- Being in charge of a motor vehicle with a specified controlled drug in the blood above the specified limit
- Failing to provide a specimen for analysis or laboratory test (evidential test).
- Being in charge of a motor vehicle and failing to provide a specimen for analysis or laboratory test (evidential test).

51. Given the similarity between the drug and drink driving offences, we have assumed that the distribution of proceedings among the 4 above-mentioned scenarios will be the same as that for the drink-driving offence.⁴² Table 3 shows the estimated annual distribution of proceedings brought among the different offence scenarios based on the central case of an estimated 8,800 proceedings. The distinction between the different offence scenarios affects our analysis because those drivers who fail to provide a specimen for analysis or laboratory test will not accrue the associated costs.

Table 3: Total Additional Completed Proceedings by Offence Types per Annum (Central Scenario)

Offence Type	Proceedings
Driving or attempting to drive with a specified controlled drug in the blood or urine above the specified limit	8212
Being in charge of a motor vehicle with a specified controlled drug in the blood or urine above the specified limit	324
Driving and failing to provide specimen for analysis or laboratory test	165

⁴² The distribution of drink-drivers among the offence types is from MoJ 2010 Data

Being in charge of a motor vehicle and failing to provide specimen for analysis or laboratory test	99
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Casualties

52. The key objective for the new offence is to contribute to improving road safety. It is expected to reduce the number of drug-related road casualties.
53. Elvik et al⁴³ identify an average effect of road user information and campaigns on drink driving prevalence of 19%. For road safety campaigns more generally, campaigns with enforcement resulted on average in a 13% reduction in accidents, compared to campaigns on their own having very little effect.
54. Without this legislation there would be no reasonable prospect of a substantial, effective and sustained increase in enforcement against drug driving, due to the section 4 offence being so complex to operate. With the new offence in place, the expectation is that effective enforcement against drug drivers would be possible and that it would be accompanied by campaigns, as is planned.
55. Shults et al (2001)⁴⁴ identified nine US studies on the effect of changes to drink driving laws. These studies met the criteria for inclusion in a NICE 'Cochrane' study.⁴⁵ The studies indicated a median change in alcohol-related motor vehicle fatalities of 9% as a result of changes in the law. The studies also considered changes to fatal crashes following increased drink driving enforcement (via selective or random breath testing) with reductions of about 20% to 26%.
56. Using this international evidence on the impact on drink driving would suggest a range of change as a result of changing the law and associated enforcement of between 10% and 20%. However, drug driving is a far more complex behaviour than drink driving, involving a great variety of drugs, some obtained legally and others illegally.

⁴³ The Handbook of Road Safety Measures: Rune Elvik, Alena Høy, Truls Vaa and Michael Sørensen

⁴⁴ Shults RA, Elder RW, Sleet DA et al. (2001) Reviews of evidence regarding interventions to reduce alcohol-impaired driving (Brief record). American Journal of Preventive Medicine 21 (4 supplement): 66–88

⁴⁵ 'Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths' (Centre for Public Health Excellence, Amanda Killoran, Una Canning, Nick Doyle, Linda Sheppard; March 2010)

57. DRUID⁴⁶ adapt a 'dose response' model used by Elvik (2001)⁴⁷ to estimate the impact of increased enforcement of drink driving laws on casualty rates. Elvik suggests "that increased enforcement increases the expected cost of crime (the deterrence effect), particularly through increases in the perceived risk of being caught, such that some potential drunk / drugged drivers end up with a different decision – *not* to drive when having taken drugs, medicines or alcohol (or *not* taking drugs, medicines or alcohol because of the need to drive) instead of driving under the influence (reducing prevalence, and thus, attributable fatalities/injuries)." Applied to drink driving the model assumes a diminishing return to increased enforcement: a doubling of enforcement (the 'dose') will lead to a 3.5% reduction in the number of injuries, a tripling to 5% and so on. Applied to drug driving the level of enforcement is defined as a combination of police activity (the number of drug tests per 100,000 inhabitants) and the effectiveness of testing equipment, and so the likelihood of generating 'false negatives' (those with drugs in their system but who test negative).

58. Having established a baseline as set out in paragraphs 5-11 we then need to consider the impact of the enforcement of the new offence. We have adapted DRUID's approach to estimate possible casualty savings following the new legislation in the following way:

- a. Because the effectiveness of the legislation is derived from both a more efficient process by which police arrest and charge suspects and improved testing equipment we have not solely used an estimate of the improved efficacy of testing equipment. Instead we assume that changes in the number of proceedings brought against drug drivers will serve as an indicator of increases or decreases in the level of enforcement. We believe this to be an effective alternative as it signals both an improvement in the means by which police can identify drug drivers and their efforts to do so and is a concrete measure of the effectiveness of such efforts.

⁴⁶ DRUID, 'Cost-benefit analysis of drug driving enforcement by the police' 2011 page 13, http://www.druid-project.eu/cdn_31/nn_107548/Druid/EN/deliverables-list/downloads/Deliverable_3_3_1.templateId=raw.property=publicationFile.pdf/Deliverable_3_3_1.pdf

⁴⁷ Elvik, R. 2001. "Cost-benefit analysis of police enforcement." Working Paper 1, Enhanced Safety Coming from Appropriate Police Enforcement (ESCAPE), Project funded by the European Commission under the Transport RTD Programme of the 4th Framework Programme. Institute of Transport Economics, Oslo, Norway.

- b. Given the above assumption, estimating changes in the level of enforcement is, therefore, relatively straight forward. However, it should be noted that the results are sensitive to the choice of the measure of enforcement that is used. We assume police will continue to bring proceedings against drivers who are 'impaired' by drugs (currently 2,700 people per year). Therefore, under the central scenario, it is estimated that the actual level of enforcement will rise from 2,700 to 11,500 (2,700 + 8,800), an increase of 4.25.
- c. The precise relationship between changes in the level of enforcement and casualty reductions is subject to uncertainty. We use the relationship between changes in the level of enforcement and casualty reductions identified in Elvik (2001). As Elvik found casualty savings to diminish with every increase in enforcement, we assume that there are fewer casualty savings the greater is the increase in the number of proceedings:

59. **Table 4** sets out the ratio of the level of enforcement and the percentage of the casualty reduction whilst **Table 5** sets out the low, central and high estimates on the rate of the increase in enforcement and annual % fall in casualties:

Table 4: Level of enforcement and annual percentage casualty reduction

Increase in Enforcement	Annual percentage fall in casualties
x 2	3.5%
x 3	5%
x 3.75	5.5%
x 4	6%
x 4.25	6%
x 4.75	6.2%
x 5	6.4%

Table 5: Estimated increase in enforcement and annual % fall in casualties

	Proceedings	Increase in Enforcement	Annual % Fall In Casualties
High	10,100	x4.75	6.2%
Central	8,800	x4.25	6.0%
Low	7,600	x3.75	5.5%

60. Based on this our Best estimate is that there will be approximately 61, 237 and 640 less fatal, serious and slight casualties respectively over the appraisal period as a result of the introduction of the new offence as based on our best estimate of 8,800 proceedings resulting in an increased factor of enforcement of 4.25 we estimate an annual 6% fall in casualties. We can therefore provide a range of casualty savings based upon the estimate of proceedings.

Table 6: Estimated Casualty Reductions, total over appraisal period for all 3 scenarios

	Fatal			Serious			Slight		
	Low 7,600	Central 8,800	High 10,100	Low 7,600	Central 8,800	High 10,100	Low 7,600	Central 8,800	High 10,100
Casualties baseline	52	117	192	229	515	778	683	1,536	5,244
Casualty Reduction	24	61	104	96	237	367	286	640	2,476

61. However, as noted above, the actual size of the deterrence effect - the reaction of motorists - is uncertain particularly as some of those drivers who are drug dependent may not be deterred as they may not act rationally or behave in a way that is driven by legal rules. The assumptions for the magnitude of the deterrence effect are discussed above. The estimates presented in this Impact Assessment are very sensitive to these assumptions and should therefore be treated as indicative estimates of the order of magnitude of these potential savings. The key factors which determine the deterrence effect and which may be subject to change over the appraisal period are:

- the level of Police enforcement activity;
- the number of drugs which will be included in the regulations and screened for;

- the limits for the drugs which are specified in the regulations; and
- to a lesser extent, the costs/penalties associated with the new offence.

Q. Do you have a view on the methodology used to estimate the casualty savings? If so, please give your reason(s)

Unit Costs

62. **Tables 7 and 8** estimate the costs incurred by the Criminal Justice System and Police, respectively, for each drug-drive suspect. When applying the criminal justice and police unit costs to the forecast on proceedings above, we have made several assumptions and need to bear in mind a number of risks. These assumptions and risks are:

- Sentencing: We have assumed that sentencing outcomes for the new specific drug driving offence (and its different scenarios) will be the same percentage as for the prescribed limit drink driving offence. There is however a risk that magistrates or judges will sentence some drug drivers more harshly due to the illegality of the possession of Class A drugs.
- Interactions: We have assumed that the new drug driving offence will not affect drink driving enforcement. Specifically, the rate of enforcement of drink driving offences will remain unchanged, as will the allocation of justice system and police resources.
- Additional cases: We are assuming that the additional cases will not displace any existing cases in either the Magistrates court or the Crown Court. Similarly we have assumed that there will not be a significant displacement of police activity (i.e. the police undertaking less other activity) in the estimates of police costs.
- Legal aid: We have assumed that the offences in question will have the same average Legal Aid costs and eligibility as all other summary motoring offences. In reality these more serious motoring offences could have higher Legal Aid eligibility⁴⁸.
- Police costs: We have estimated the police costs by multiplying time spent arresting, preparation and attendance in court by the hourly rate⁴⁹ of a police officer and the number of proceedings. In line with Wehtag guidance the hourly police resource cost is equal to the gross wage rate plus non-wage labour costs. The mean gross hourly wage for police officers ranked sergeant and below

⁴⁸ This was advised by Ministry of Justice due to the limitations of the evidence available.

⁴⁹ Hourly rate is derived from information supplied by the Home Office in May 2013.

(£18.35) was multiplied by a mark-up of 21.2%⁵⁰. We have not considered the true opportunity costs of police time, as it is unrealistic to determine how police forces will decide to re-allocate resources in response to the new legislation.

- Imprisonment/community orders: A risk is that the cost of imprisonment/community orders might be higher than the standard unit costs, as it may be that if we are dealing with offenders with a drug dependency, this may require more expensive community orders to tackle the dependency or higher prison costs. The Government is considering options for helping local criminal justice partners to tackle the drug misuse of drivers who use Class A drugs that are most likely to lead to wider offending behaviour – currently heroin or cocaine/crack. The police have powers to require individuals arrested or charged with an offence (who test positive for heroin or cocaine/crack) to attend up to two assessments with a qualified drug worker. Such assessments may lead to drug treatment or other support aimed at reducing the likelihood of reoffending. However, the Government is looking how these powers can be applied as simply in relation to drug driving as for other offences. We have, therefore, not provided those costs in this assessment.
- Remand: We have not included the potential increase in remand costs from those charged with the new offence or any of the amended offences. We believe that any increase in remand costs would be extremely small given the very small percentage (0.2%)⁵¹ of people remanded in custody for these offences.
- HM Courts and Tribunal Service (HMCTS) Costs: We have not taken into account the Crown Court costs where defendants have been committed for trial or committed for sentence as very few defendants under existing drink driving and drug impaired driving offences go to Crown Court.
- Breaches: We are not including any potential consequences of breaches (including potential custodial sentences) of the additional suspended sentences as suspended sentences where conditions are imposed or probation orders are extremely low for drink and drug driving offences.

⁵⁰ 21.2% is the figure recommended by Webtag and derived from the 2000 Labour Cost Survey. (http://www.dft.gov.uk/webtag/documents/expert/pdf/u3_5_6-vot-op-cost-120723.pdf)

⁵¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203847/3-court-proceedings-dec12.xls

- Fines: 75% payment rate is now the assumption used. Until recently the data available on the 'payment rate' of financial penalties was limited and based on the ratio between the value of fines imposed in one year and the value of receipts in the same year. This rate fluctuated yearly. The ratio of the value of fines collected to the value of fines imposed was around 65% in 2009/10, around 75% in 2010/11 and around 85% in 2011⁵². These can only be treated as approximate payment rates as not all the fines collected in a year will have been imposed in that year. Given this, we assume a baseline payment rate of around 75%.
- Victim Surcharge: We have assumed that 70% of those fined also paid a victim surcharge⁵³.

Table 7: Unit cost - Criminal justice system costs⁵⁴

Type of Cost	Unit Cost	Unit Cost	Percent of those charged that result in cost	Cost per case
Legal Aid⁵⁵	Cost of a legal aid trial in the Magistrates Court	£511	We assume 4% of drug drive cases are eligible for legal aid.	£511
HMCTS⁵⁶	Cost per sitting day.	£1,358	We have assumed 11 cases will be held per day, which is approximately 29 minutes per case. 100% of cases will be tried at a Magistrates' Court.	£121
CPS⁵⁷	Cost per defendant in a Magistrates' Court	£143	We have assumed 100% of cases are tried in Magistrates' Courts	£143
Probation / Community Sentences⁵⁸	Cost per offender per year	£3,000	We have assumed that 21% of drug drive cases result in a community service	£3,000
Prison⁵⁹	Cost per Offender per Year	£28,000	We have assumed 3% of offenders go to prison for about 6 months, half of their custodial sentence.	£14,000

⁵² Information provided by Ministry of Justice

⁵³ Information provided by Ministry of Justice

⁵⁴ With the exception of prison costs, the victim surcharge and community sentence costs (all 2013) have been uprated from 2010-11 prices to 2013 prices using GDP per capita growth and the GDP deflator.

⁵⁵ Source: Crime Lower report by the Legal Services Commission

⁵⁶ Ministry of Justice

⁵⁷ Ministry of Justice Cost Benefit Framework

⁵⁸ Ministry of Justice Cost Benefit Framework

⁵⁹ NOMS management accounts addendum (2011)

Average fine⁶⁰	Average fine in Magistrates' Court	£259	We assume around 70% of defendants are fined, and 75% of these pay the fine.	£241
Victim Surcharge⁶¹	Value of Victim Surcharge, applied to all fines.	£20	We assume 70% of those fined pay a Victim Surcharge.	£20
			Total Expected Cost per Case	From £264 to £14,775 ⁶²

Table 8: Unit Costs - Police costs⁶³

	Description	2013 Prices and Values
Forensic Medical Examiner	Forensic Medical Examiner (FME) call out charge for taking blood sample at Police Station.	£103
Blood Test Kit	Cost per suspect	£6.73
Lab Test Analysis	Cost of examining specimen	£200
Custodial Costs⁶⁴	Custodial cost per suspect per hour	£200
Police Costs	Cost of on duty policeman/woman (below sergeant) per hour	£22

⁶⁰ Ministry of Justice

⁶¹ Victim and Witness Consultation Response (available online at: <https://consult.justice.gov.uk/digital-communications/victims-witnesses/results/ia-victim-witness-combined.pdf>)

⁶² The actual cost of a case will vary. The lowest estimate is HMCTS and CPS costs only. The highest is Legal Aid, HMCTS, CPS and Prison Costs.

⁶³ Information provided by the Home Office and updated to 2013 prices using GDP deflator.

⁶⁴ This is an estimate of the costs involved in the charging of a suspect and include factors, such as duty Custody Sergeant.

63. **Table 9** contains an estimate of how police costs are then distributed across their activity⁶⁵. This assessment of police costs is used again when we consider the cost implications of Policy Option 3 where arrests of those with a credible medical defence are considered where a zero tolerance approach to drugs associated with medical use is proposed.

Table 9: Police costs in relation to arrests and prosecutions

Procedure	Police Time (hrs)	Police Costs (£)
Arrest Time	0.5	11
Police Station Investigation	1.5	33
Booking in with Custody Officer	0.5	11
Case File	1.5	33
Extra Hour Investigating Medical Defence	1	22
Time at Court	3.75	83
Witnessing Police Officer		
Arrest	0.5	11
Police Station Investigation	0.5	11
Write-up Notes	0.45	10
Other Costs		
Forensic Medical Examiner		104
Blood test kit		7
Lab Test Analysis		200
Custodial Costs		408
Total Police Time (before court)	6.45	142
Total Police Time (including court)	10.2	224
Total Costs (before court)		861
Total Costs (including court)		943

64. **Table 10** contains the value of preventing a casualty for different levels of severity. Casualty values have been up-rated over the appraisal period in line with GDP per capita⁶⁶. We have not included costs that are not specific to casualties as damage only accidents are not comprehensively reported to police⁶⁷. If such costs were included potential cost savings could be substantially higher.

⁶⁵ As advised by the DfT police liaison officer

⁶⁶ DfT Webtag 3.4.1 [The Accidents Sub-Objective](#)

⁶⁷ DfT Webtag 3.4.1 [The Accidents Sub-Objective](#)

Table 10: Value of Preventing a Casualty⁶⁸

Casualty Severity	2013 Prices and Values
Fatality	£1,775,393
Serious	£199,508
Slight	£15,374

65. The unit costs in Tables 7 and 8 have been up-rated over the 10 year appraisal period using the forecast GDP per capita growth rate.⁶⁹ We used the forecast GDP per capita growth rate for two reasons:

- we have assumed that the primary determinant of the unit costs is staff costs; and
- the index is a measure of income growth.

66. In order to translate the unit costs from Tables 7 and 8 into the final appraisal figure we have in some cases simply multiplied the estimated proceedings by the unit cost, e.g. Police costs x amount of proceedings. For Criminal Justice System costs it is a combination of Magistrates Court costs, prison costs, community sentences and legal aid.

Appraisal

67. Due to the limitations of the available evidence, the costs and benefits of Policy Option 1 are subject to considerable uncertainty. To estimate the monetised costs and benefits, a number of assumptions have had to be made. Ranges have been generated to illustrate the scale of this uncertainty. The estimates are very sensitive to the choice of assumptions, and should be interpreted as indicative estimates of the order of magnitude of these costs and benefits. Furthermore, there are a number of non-monetised costs and benefits. Therefore, there is considerable uncertainty over whether Policy Option 1 would result in a Net Benefit or a Net Cost.

68. Costs to Offenders: There is the possibility of costs to offenders, in addition to the fine and victim surcharge, such as a driving ban, imprisonment or community service. Whilst these represent real

⁶⁸ DfT Webtag 3.4.1 [The Accidents Sub-Objective](#), Table 1

⁶⁹ DfT Webtag 3.5.6: [Values of Time and Operating Costs](#), Table 3a

costs to offenders, they are not included as part of this cost benefit analysis⁷⁰. There is also the possibility that there will be indirect costs to employers; however we have no evidence on this issue. If businesses would like to comment on this treatment of indirect costs (for example if they view that this proposal places indirect costs on to them), please respond to the consultation.

69. One In Two Out (OITO): We do not believe that the Government's preferred proposed approach will have a direct impact on business. There may be indirect costs (as discussed above); however, these do not fall within the remit of OITO.

Q. Does any business have a view on whether the Government's proposals will have any impact on them, directly or indirectly? If so please give your reason(s).

70. **Table 11** shows the ranges of estimates that have been generated. The Best estimates are discussed in more detail below.
71. Based on the above central assumptions on the number of proceedings (8,800 per annum) and the casualty savings (6% reduction per annum), the Best estimate of the Net Benefit of the new offence under this Option is approximately £-5m (Present Value) over the appraisal period 2014-2023. The Best estimates of the total benefits and costs over the 10 year appraisal period are approximately £165m and £170m (Present Value) respectively.
72. Casualty savings are estimated to account for the vast majority of the total benefits of this option, with a Best estimate of the total benefits over the 10 year appraisal period approximately £153m (Present Value). The casualty savings arise due to the assumed reduced prevalence of drug-driving as a result of the introduction of the new offence and amendments and more effective enforcement.
73. The total costs have been grouped under three main headings: police costs, CPS costs and criminal justice costs. The Best estimate of the total police costs over the 10 year appraisal period is approximately £74m (Present Value). Police costs include the costs associated with enforcing the offence of driving with a specified controlled drug in the body above the specified limit for that drug. The Best estimates of the total CPS costs and the criminal justice

⁷⁰ This treatment has been chosen in discussions with Ministry of Justice

costs over the 10 year appraisal period are approximately £12m and £72m (Present Value) respectively.

74. The Police costs in Table 8 are likely to be an underestimate of the true costs because we have neither an estimate of the unit cost of the screening device nor a forecast for the number of screening devices, which will be used annually. In addition, we have no estimate of the number of screening tests, which will not result in court proceedings.
75. We have not monetised the time costs for drivers as a result of this policy [on the grounds of proportionality]. This includes the time costs for those drivers who provide a negative roadside test - this time is expected to be negligible; the time costs for suspects that are taken to a police station but not charged, e.g. because their evidential blood limit is below the threshold; and the time costs for suspects that are taken to court but cases are withdrawn or dismissed (for drink driving offences it is 3% and we expect a similar proportion for the new drug driving section 5A offence).
76. We have assumed that all court costs and other relevant criminal justice system costs will fall at the Magistrates courts. We have not taken into account crown courts as very few (1%-2%) are expected to go through the crown court. Therefore the overall costs to the Criminal Justice System may be a slight underestimate.
77. This option seeks to take the benefits of a zero tolerance approach to illegal drug users but not the costs that would arise due to the arrest of those on properly prescribed or supplied medicines that are taken in accordance with the advice of a healthcare professional who may produce a positive preliminary screening test if a zero tolerance approach is taken (see Policy Option 3).
78. Table 11 sets out all the costs and benefits of our preferred policy option. It assumes a road safety risk based approach to amphetamine. Under this approach it is assumed that there would be no costs associated arresting and seeking to prosecute those that are able to provide a credible medical defence as explained when consider Policy Option 3 where this issue arises. This is because the limits for those controlled drugs most associated with medical uses are specified at a higher level, i.e. a road safety risk level that is above most normal therapeutic ranges (i.e. the doses normally seen when taken in accordance with the advice of a healthcare professional). The low, central and high casualty

estimates apply to the three scenarios, i.e. low to 7,600 proceedings, central to 8,800 proceedings and high to 10,100 proceedings.

Table 11: Total Costs and Benefits of Option 1 over the 10 year appraisal period (Present Value): Zero tolerance approach to 8 illegal controlled drugs and a road safety risk based approach (Expert Panel recommendation) approach to 9 controlled drugs

		Total 2014-23 (7,600 proceedings)	Total 2014-23 (8,800 proceedings)	Total 2014-23 (10,100 proceedings)
BENEFITS				
Casualty Savings		£61,500,000	£153,100,000	£274,100,000
Exchequer	Fines	£9,500,000	£11,000,000	£12,700,000
	Victim Surcharge	£600,000	£700,000	£800,000
Total Benefits		£71,600,000	£164,800,000	£287,600,000
COSTS				
Police Costs		£64,000,000	£74,200,000	£85,100,000
CPS Costs		£10,100,000	£11,800,000	£13,500,000
Criminal Justice System		£62,100,000	£71,900,000	£82,500,000
Offender Costs		£10,100,000	£11,800,000	£13,500,000
Total Costs		£146,300,000	£169,700,000	£194,600,000
Net Benefits		£-74,700,000	£-4,900,000	£93,000,000

79. The Best estimate is that there is a Net Cost as a result of this Policy Option and is estimated to have less benefit than estimated in Policy Option 2, which is considered next. However, we believe that whilst Policy Option 2 achieves the aim of protecting public safety, this Policy Option has the potential to provide society with wider benefits in taking a zero tolerance approach to illegal drugs that are not captured in Table 11. However, given the uncertainties around casualty savings and costs and thus the vast range, there could still be a considerable net benefit.

80. In considering the approach to drug driving the Government also needs to take account that drugs matter to the whole of society and not just road users. From the crime impact on local neighbourhoods to the corrupting effect of international organised crime, drugs have a profound and negative effect on communities, families and individuals. A zero tolerance approach to illegal drug driving would assist the Government's wider drug strategy⁷¹, which seeks to bear down on those criminals seeking to profit from others' misery; and

⁷¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98030/impact-assessment.pdf

sets out how it will protect young people by preventing drug use and how recovery reforms will enable and support individuals to become free of dependence on drugs and reintegrate into their local communities and contribute to society. A zero tolerance approach to illegal drugs and driving therefore enables Government to link these various facets together and ensures that we have a coherent and joined-up approach to tackling the crime and damage that illegal drugs cause to society.

81. The total annual economic and social cost of Class A drugs was estimated to be around £15.4 billion in 2003/04 through drug-related crime, health costs and social care costs associated with drug use⁷². Drug use in the UK remains too high. According to the Crime Survey for England and Wales, 8.9% adults in 20011/12 used an illegal drug which is just over 3 million people⁷³.
82. A substantial number of young people who are dependent on drugs present themselves for treatment. These individuals are likely to still be working and in stable housing; therefore those who may be learning to drive or have just started to drive. For young people, emotional and behavioural disorders are also associated with an increased risk of experimentation and misuse.⁷⁴ They therefore need to consider the impact of taking drugs on their possible new found freedom to drive and a zero tolerance approach may act as a deterrent to these young people who may be prone to experimenting with drugs. The Crime Survey for England and Wales shows that the 16-24 age group are most likely to report driving under the influence of drugs⁷⁵. The majority of young people do not use drugs, but for those that misuse drugs it can have a significant impact on their education, health, families and long term life chances.
83. Cannabis and alcohol are the most common substances used amongst young people⁷⁶. In 2011/12 around 20,000 under 18 years accessed specialist support for substance misuse⁷⁷, 92% due to

⁷² The economic and social costs of Class A drug use in England and Wales, 2003/04. Home Office Online Report 16/06.

⁷³ Home Office. (2012). *Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales*. <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112/>

⁷⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98030/impact-assessment.pdf

⁷⁵ <http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2011/rrcgb2011-05.pdf>

⁷⁶ Home Office. (2012). *Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales*: <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112/>

⁷⁷ Department of Health/National Treatment Agency. Statistics from the National Drug Treatment Monitoring System (NDTMS). Statistics relating to young people England, 1 April 2011– 31 March 2012

cannabis and alcohol. Taking a zero tolerance approach to illegal drug driving in particular to cannabis could be an important step in deterring young people from taking cannabis. It could also assist in creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so. Having a zero tolerance approach to drug driving may, therefore, serve as a stronger deterrent to drug driving and may have benefits across Government and society as a whole. As the Elvik model suggests an increased perception that drivers are more likely to be caught is likely to lead people to a different decision, i.e. not to drive if taken drugs or not to take drugs in order to drive. It will also bring consistency in enforcement activities and that members of the public will be protected against the potential harm of these substances and their misuse.

84. The Crime Survey for England & Wales 2011/12⁷⁸ also shows that it is not just the 'hard pressed' in society who take illegal drugs but is prevalent across all social groups from 'moderate means' to 'wealthy achievers'. Driving a car is likely to be a regular occurrence for this group and with 7% of this total group (i.e. 'wealthy achievers', 'urban prosperity', 'comfortably off' and 'moderate means') reporting the use of cannabis and 2.4% reporting the use of powder cocaine (the 2 drugs that are most prevalent in drug driving cases), it is possible that a zero tolerance approach may have a stronger deterrent effect to drug driving and thus reduce the likelihood of drug driving in the first place. A significant number of illegal drug users may, therefore, need to consider their drug use against losing the convenience of driving a car and gaining a criminal record as well as a fine and possible imprisonment.
85. Aligning a zero tolerance approach to drug driving to the overall drug strategy may add to the benefits of that strategy. This includes a reduction in demand for prison places; reduction in drug related crime; reduction in costs of re-offending and crime through effective rehabilitation; reduction in costs to health and social care services; savings in transfer and welfare payments; and improvements in health and employment outcomes for offenders through effective rehabilitation. The misuse of drugs imposes a cost on society greatly in excess of the perceived cost to the individual.

[http://www.nta.nhs.uk/uploads/yannualreport-statisticalreport\[1\].pdf](http://www.nta.nhs.uk/uploads/yannualreport-statisticalreport[1].pdf)

⁷⁸ <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112-tabs/illicit-use-tabs?view=Binary#D.09!A1>

86. It is difficult to monetise the potential impact of taking a zero tolerance approach to illegal drug driving in deterring those who may be prone to illegal drug use. Some of those who are drug dependent may not be deterred as they may not act rationally or behave in a way that is driven by legal rules. This, therefore, makes it difficult to monetise the extent to which the approach will act as a deterrent to drug use and there is no attempt here to do so, but the post implementation review will consider if the current surveys see a downward trend in illegal drug use. The Government takes the view that a zero tolerance approach to illegal drugs is likely to have a greater deterrent effect to drug use than Policy Option 2. Whilst we are unable to monetise it in this assessment we believe that it is worth taking a strong approach to seek to deter those from taking illegal drugs in the first place.

87. The consultation of which this Impact Assessment accompanies and should be read in conjunction with this assessment asks specific questions and some of the issues that arise in taking the Government's proposed approach. These are:

Question 1.

Do you agree with the Government's proposed approach as set out in policy option 1? If not please provide your reason(s).

Question 2.

Do you have any views on the alternative approaches as set out in policy options 2 and 3?

Question 3.

We have not proposed specified limits in urine as we believe it is not possible to establish evidence-based concentrations of drugs in urine which would indicate that the drug was having an effect on a person's nervous system. Do you agree with this (i.e. not setting limits in urine)? Is there any further evidence which the Government should consider?

Question 4.

Is the approach we are proposing to take when specifying a limit for cannabis reasonable for those who are driving and being prescribed with the cannabis based drug Sativex (which is used to treat Multiple Sclerosis)? If not what is the evidence to support your view?

Question 5.

Do you have a view as to what limit to set for amphetamine? If so please give your reason(s).

Question 6

Are there any other medicines that we have not taken account of that would be caught by the 'lowest accidental exposure limit' we propose for the 8 illegal drugs? If so please give your reason(s).

Question 7

Are you able to provide any additional evidence relating to the costs and benefits associated with the draft regulations as set out in this Impact Assessment? For example:

- i. Do you have a view on the amount of proceedings likely to be brought against those taking medical drugs proposed for inclusion under the approach in Policy Option 1? If so please give your reason(s).
- ii. Do you have a view on the methodology used to estimate the amount of proceedings? If so please give your reason(s).
- iii. Do you have a view on the methodology used to estimate the drug driving casualties baseline? If so please give your reason(s)
- iv. Do you have a view on the methodology used to estimate the casualty savings? If so please give your reasons(s).
- v. Do you have a view on the methodology used to estimate those arrested on a credible medical defence under Policy Option 3? If so please give your reason(s).

Question 8

Does any business have a view on whether the Government's proposals will have any impact on them, directly or indirectly? If so please give your reason(s).

Policy Option 2 – A road safety risk based approach (Expert Panel recommendation) for 15 controlled drugs

88. The Expert Panel made a recommendation to specify limits for 15 controlled drugs, which is in line with the North Review recommendations, and is based upon an odds ratio of having a road traffic collision approach. An odds ratio approach in determining a threshold is reached after considering the ratio between the odds of having the event, (e.g. a road traffic collision) among those positive for a given drug and the odds of those having the event among those tested negative for that substance. The previous Option included a zero tolerance approach to LSD and 6-MAM, which the Expert Panel did not make any recommendation upon. This is why this Option only proposes 15 controlled drugs as opposed to the 17 proposed in Option 1.

Proceedings

89. The original Impact Assessment for the primary legislation⁷⁹ under a road safety risk based approach estimated there would be 8,200 proceedings. In order to attempt to verify these estimates we looked at the number of proceedings brought in Western Australia (WA) after the introduction of a drug driving offence based upon a deemed impairment level where roadside screening is carried out as this could be based on actual cases where a similar road safety risk based approach was taken. A similar justice system applies as opposed to say looking at drug driving in France where a different justice system is used. As this was a recent state where a new drug driving offence similar to a road safety risk based approach was introduced and the justice system is very similar, we believe could be used to see if the earlier estimate was reasonable.

90. Between 1 July 2011 and 30 June 2012 there were 520 proceedings in WA. If we then adjust that to the population for England and Wales (c56.1m) based upon the last UK census and Western Australian population (c2.5m) data⁸⁰ that would produce a figure of nearly 12,000 proceedings ($56.1/2.5 = 22.44$; $520 \times 22.44 = 11,669$). However, drug driving fatalities are around 30% more prevalent in Australia⁸¹ as a whole than they are in England and

⁷⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98433/ia-drug-driving-offence.pdf

⁸⁰ <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>

⁸¹ <http://www.parliament.qld.gov.au/documents/explore/ResearchPublications/ResearchBriefs/2007/RBR200704.pdf>.

Wales. This is often attributed to the greater prevalence of stimulants taken by long distance truck drivers in order to keep awake and alert. If we make that adjustment for England and Wales we then come to a figure of around 8,200 ($11,669 - 30\% (3,501) = 8,168$), which is very close to the original estimate of 8,200. However, WA police conduct random testing and when looking at the level of positive breathalyser tests⁸², it is at a level 4.66 times more than in England and Wales. If we apply the original figure of 12,000 and divide by 4.66 it would produce a figure very close to 2,500 ($11,669/4.66 = 2,504$). As there is a potential range of around 2,500 additional proceedings through to the original estimate of 8,200 a best estimate is therefore in the middle at 5,700. We therefore propose for this approach, in order to monetise, to use a range from 2,500 to 8,200 and thus a central scenario of 5,700.

91. This is a different approach to calculating the number of proceedings to the one taken in policy option 1 where we took account of the number of negative tests and the number of drivers likely to be on illegal drugs. This was done to account for finding the presence of an illegal drug as limits are set taking a zero tolerance approach. The policy option 2 approach would not catch those drug drivers using illegal drugs on limits below the Expert Panel recommendation where the risks of having a road accident increase and the WA actual proceedings where a deemed impairment approach was taken helps support the estimate. However, it must be recognised that there are uncertainties with both approaches.

Casualties

92. The casualty reduction savings are based upon the calculations set out in paragraphs 55-58. Based on this we estimate that there will be approximately 51, 197 and 586 less fatal, serious and slight casualties respectively over the appraisal period as a result of the introduction of the new offence based on our best estimate of 5,700 proceedings at an annual 5% fall in casualties. **Table 12** sets out the range for the increase in enforcement and the annual % fall in casualties whilst **Table 13** sets out the estimated casualty reductions for each amount of estimated proceedings.

⁸² <http://ors.wa.gov.au/Campaigns/Drink-Driving.aspx>

Table 12: Estimated increase in enforcement and annual % fall in casualties

	Proceedings	Increase in Enforcement	Annual % Fall In Casualties
High	8,200	x4	6.0%
Central	5,700	x3	5.0%
Low	2,500	x2	3.5%

Table 13: Estimated Casualty Reductions, total over appraisal period for all 3 scenarios

	Fatal			Serious			Slight		
	Low 2,500	Central 5,700	High 8,200	Low 2,500	Central 5,700	High 8,200	Low 2,500	Central 5,700	High 8,200
Casualties baseline	52	117	192	229	515	778	683	1,536	5,244
Casualty Reduction	19	51	99	60	197	355	182	586	2,394

Appraisal – Road safety risk based approach (Expert Panel recommendation)

93. Due to the limitations of the available evidence, the costs and benefits of Policy Option 2 are subject to considerable uncertainty. To estimate the monetised costs and benefits, a number of assumptions have had to be made. Ranges have been generated to illustrate the scale of this uncertainty. The estimates are very sensitive to the choice of assumptions, and should be interpreted as indicative estimates of the order of magnitude of these costs and benefits. Furthermore, there are a number of non-monetised costs and benefits as for Policy Option 1. Therefore, there is considerable uncertainty over whether Policy Option 2 would result in a Net Benefit or a Net Cost, and over how the costs and benefits would differ between Policy Option 1 and Policy Option 2.

94. **Table 14** shows the ranges of estimates that have been generated. The Best estimates are discussed in more detail below.

95. Based on the central assumptions on the number of proceedings (5,700 per annum) and casualty savings (5% reduction per annum), the best estimate of the Net Benefit of the new offence under this Option is approximately £27m (Present Value) over the appraisal

period 2014-2023. The Best estimates of the total benefits and costs over the 10 year appraisal period are estimated at approximately £136m and £109m (Present Value) respectively.

96. Casualty savings account for the vast majority of the total benefits of this option, with a Best estimate of the total benefits over the 10 year appraisal period of approximately £128.5m (Present Value). The casualty savings arise due to the reduced prevalence of drug-driving as a result of the introduction of the new offence and amendments.
97. The Best estimate of the total police costs over the 10 year appraisal period is approximately £47.4m (Present Value) and includes all the costs associated with enforcing the offence of driving with a specified controlled drug in the body above the specified limit for that drug. The Best estimates of the total CPS costs and the criminal justice costs over the 10 year appraisal period are approximately £7.6m and £46.6m respectively whilst the Best estimates of the total offender costs over the 10 year appraisal period is around £7.6m (Present Value).
98. The costs in **Table 14** are likely to be an underestimate of the true costs for the same reasons as set out in Policy Option 1. Again the low, central and high casualty estimates apply to the three scenarios, i.e. low to 2,500 proceedings, central to 5,700 proceedings and high to 8,200 proceedings.

Table 14: Total Costs and Benefits of Option 2 over the 10 year appraisal period (Present Value): Road safety risk based approach (Expert Panel recommendation)

	Total 2014-2023 (2,500 proceedings)	Total 2014-2023 (5,700 proceedings)	Total 2014-2023 (8,200 proceedings)
BENEFITS			
Casualty Savings	£45,000,000	£128,500,000	£262,600,000
Exchequer	Fines	£3,100,000	£7,100,000
	Victim Surcharge	£200,000	£500,000
Total Present Value Benefits	£48,300,000	£136,100,000	£273,500,000
COSTS			
Police Costs	£20,800,000	£47,400,000	£68,200,000
CPS Costs	£3,300,000	£7,600,000	£11,000,000
Criminal Justice System	£20,400,000	£46,600,000	£67,000,000
Offender Costs	£3,300,000	£7,600,000	£10,900,000
Total Present Value Costs	£47,900,000	£109,200,000	£157,100,000
Net Present Value Benefits	£400,000	£26,900,000	£116,400,000

99. Whilst the Best estimate is that Option 2 has a higher estimated net benefit than the Government's preferred approach (Option 1), this option would provide mixed messages around permissible levels of illegal drug use. It also has little potential to benefit from the wider economic benefits that will arise from taking a zero tolerance approach to illegal drug use as explained in Option 1. The Government takes the view that this approach is, therefore, not viable.

Policy Option 3 – A zero tolerance approach for 16 controlled drugs

100. This approach takes a zero tolerance approach to all the 15 controlled drugs recommended by the Expert Panel plus LSD, which the panel did not recommend a limit for, including those controlled drugs associated with medical uses. It does not include 6-MAM as it takes a zero tolerance approach to morphine and therefore it is not necessary to set a separate limit for 6-MAM. The Government has a zero tolerance approach to illegal drug use. For those drivers who have taken properly prescribed or supplied drugs in accordance with the advice of a healthcare professional a statutory medical defence is available. Therefore a zero tolerance approach is also proposed for those controlled drugs with medical uses as they can use the medical defence if they were to be stopped by the police.

101. Firstly, as this option takes a zero tolerance approach towards those controlled drugs that also have medical uses, we need to include an assessment of the additional costs to the police in potentially arresting but not charging those who can successfully apply the statutory medical defence. It is likely that a significant amount of the 34.5 million full licence holders in England & Wales would at some point during the course of the year have taken some medicine that will put them over the limit for opiate based drugs and all the Benzodiazepines. Data on the NHS website⁸³ shows, for example, that 15.1 million prescriptions for Co-Codamol (Codeine) were issued in 2011, which would be metabolised into morphine and thus not distinguishable from opiate drugs such as heroin.

102. If a driver provides a positive result because they are on a properly supplied medication but does not have the evidence at the time of the test such as a prescription, then the police officer may arrest them and take them back to the police station to carry out an

⁸³ <http://www.ic.nhs.uk/searchcatalogue?productid=7930&q=general+pharmaceutical+services&topics=1%2fPrimary+care+services%2fCommunity+pharmacy+services&sort=Most+recent&size=10&page=1#top>

evidential blood test. The blood test will confirm which controlled drug is evident and whether the limit is over the specified limit. We estimated earlier in Policy Option 1 that 8,437 would provide a negative breath test result for alcohol but are also on medical drugs and therefore would provide a positive result if tested under a zero tolerance approach to setting limits.

103. We don't know though how many of these would have a credible medical defence, e.g. were not abusing their medication, or if a driver proves negative from the breathalyser that the police would automatically require them to take a more expensive drug screening test. The police would use their assessment of the situation to consider whether they are likely to prove positive, though they may be more confident with a zero tolerance approach. There is, though, no incentive to obtain 'false positives', i.e. arrest someone who will have a credible medical defence if their driving is not impaired, as that will just create needless work for the police. Drivers may also state that they are on medication and if their driving was not impaired, depending on why they were stopped, there is little incentive to carry out a drug screening test, particularly after just providing a negative result for alcohol. Clearly the police have no interest in catching people who are likely to be on medication and are not posing a road safety risk. The Code for Crown Prosecutors also states "should swiftly stop cases ... where the public interest clearly does not require a prosecution."

104. In Policy Option 1 we estimated that there would be 1.3% of the 649,000 of drivers who provide a negative alcohol breath test and on controlled drugs with medical uses. This would equate to 8,437. If we then adjust to the CAST England and Wales data of a 38% proportion as opposed to a 40% European proportion then the figure reduces slightly to 7,892 ($8,437 + 12,331 = 20,768$; 38% of $20,768 = 7,892$). Just as the estimates are uncertain in Policy Option 1 we propose to use a mid range of 8,165 ($8,437 - 7,892 = 545/2 = 272.5 + 7,892 = 8,165$). There is probably no way of using any evidence to determine how many of the 8,165 on medication are likely to be drug tested, but from informal discussions with the police and agreed with Ministry of Justice, we propose between 10-30% may go on to be tested and therefore 20% as a reasonable central scenario. 20% of 8,165 would provide a figure of 1,633 and we will assume for the purposes of monetising this cost to the police to be the best estimate of the amount tested and arrested but subsequently have a credible

medical defence. In **Table 15** we have set out a range of 817(10%) – 1,633(20%) – 2,450(30%) for all the costs.

Q. Do you have a view on the methodology used to estimate those arrested on a credible medical defence? If so please give your reason(s)

105. We then need to apply the police costs as set out in Tables 8 and 9 and reproduced in **Table 15** to reflect the actual police time. We assume the arrest itself will take 30 minutes⁸⁴. Booking the suspect into the police station with the custody officer takes a further 30 minutes. The investigation into the suspect's medical defence 1.5 hours. Writing up the case file takes a further 1.5 hours. A witnessing police officer is also assumed to be present at the arrest and the investigation and will also have to write up their own notes. The cost in Table 15 is based upon a central scenario of 1,633 arrests.

Table 15: Police costs in relation to time spent per case

Procedure	Police Time (hrs)	Police Costs (£)
Arrest Time	0.5	11
Police Station Investigation	1.5	33
Booking in with Custody Officer	0.5	11
Case File	1.5	33
Extra Hour Investigating Medical Defence	1	22
Time at Court	3.75	83
Witnessing Police Officer		
Arrest	0.5	11
Police Station Investigation	0.5	11
Write-up Notes	0.45	10
Other Costs		
Forensic Medical Examiner		104
Blood test kit		7
Lab Test Analysis		200
Custodial Costs		408
Total Police Time (before court)	6.45	142
Total Police Time (including court)	10.2	224
Total Costs (before court)		861
Total Costs (including court)		943

⁸⁴ Discussions with DfT police liaison officer

Total Annual costs (1,633 positive tests)		1,406,013
Total Annual Costs (including court proceedings)		1,539,919

106. The total police time excluding court attendance is 6.45 hours at £141.90 per arrest. If the suspect goes to court the total time is 10.2 hours at £224.40. If we then add the other costs it brings the total to £861 and multiplied by 1,633 (the total number of estimated arrests of drivers with a credible medical defence) the total cost for the police is £1,406,013 per year which is in effect wasted police costs under this central scenario.

107. There are also some additional costs to the courts and CPS where they are charged but a conviction is not secured because the medical defence is successfully used in court. In order to estimate how many that might be, we looked at the number of proceedings in England and Wales for the latest year available (2011) of those driving after consuming alcohol we find that 3% do not result in a successful conviction⁸⁵. If we therefore apply 3% of 1,633 as a purely illustrative estimate that would give us a figure of 49 who may go to a Magistrates court where a successful conviction is not secured. The low scenario would be 25 and the high scenario 74. However, there is no robust evidence on the proportion of arrested drivers with a credible medical defence that may go to court, so this estimate is subject to considerable uncertainty.

Criminal Justice System: $49 \times £121$ (see Table 7) = £5,929

CPS: $49 \times £143$ (see Table 7) = £7,007

108. The police would also incur costs in attending court which equates to 3.75 hours of an officers time \times £22 which = £82.50 \times 49 proceedings = £4,043. Total police costs would be £1,539,919 in one year based on 2013 costs.

109. There is an additional cost to society of each individual's time (i.e. the 1,633 who are likely to have a credible defence) from the time a positive preliminary test is made at the roadside, which is made up of:

- Transported to the police station

⁸⁵ <http://www.justice.gov.uk/downloads/statistics/criminal-justice-stats/2011/motoring-tables-1211.xls>

- Wait for availability of Custody officer
- Custody Officer booking in process
- Drug Drive investigation up to the point of calling a doctor
- Doctor process in taking an evidential blood test
- Release / bail process

110. Transport Analysis Guidance (TAG)⁸⁶ estimates are used to determine the proportion of distance travelled for work and non-work, as well as the value of work and non-work time⁸⁷. There is an additional cost to passengers travelling with drivers with a credible defence who are stopped by police (passengers are assumed not to accompany those drivers who attend court). TAG provides estimates of the average number of passengers per driver for work and non-work trips. Ratios of work to non-work are applied to the number of drivers assumed in each scenario. The hourly costs for the drivers and additional passengers are then calculated and multiplied by the number of hours spent in custody and court. Under a central scenario we estimate this to be £142,104 per annum.

Table 16: Costs for a successful medical defence for a zero tolerance approach to drugs with medical uses (2013 price and values)

Description	817 arrested 25 proceedings	1,633 arrested 49 proceedings	2,450 arrested 74 proceedings
Police costs	£728,358	£1,539,919	£2,185,157
HMCTS Costs at Magistrates Court	£2,275	£4,559	£6,916
CPS Costs in a Magistrates Court	£3,700	£7,252	£11,248
Costs to individual	£71,038	£142,104	£213,142
Total	£805,371	£1,693,834	£2,416,463

Casualties

111. The casualty estimates is assumed to remain the same in the ranges as set out in Policy Option 1. This is because it is taking

⁸⁶ http://www.dft.gov.uk/webtag/documents/expert/pdf/u3_5_6-vot-op-cost-120723.pdf

⁸⁷ Although Webtag treats commuting time separately, it is assumed here that commuters will continue on to work once they are released by police, and that individuals are forced to forego work time rather than commuting time. Time treated by Webtag as commuting time is therefore valued as work time.

approximately the same level of proceedings. However, we have re-produced the tables here for ease of reference. **Table 17** sets out the range for the increase in enforcement and the annual % fall in casualties whilst **Table 18** sets out the estimated casualty reductions for each number of estimated proceedings.

Table 17: Estimated increase in enforcement and annual % fall in casualties

	Proceedings	Increase in Enforcement	Annual % Fall In Casualties
High	10,174	x4.75	6.2%
Central	8,849	x4.25	6.0%
Low	7,625	x3.75	5.5%

Table 18: Estimated Casualty Reductions, total over appraisal period for all 3 scenarios

	Fatal			Serious			Slight		
	Low 7,625	Central 8,849	High 10,174	Low 7,625	Central 8,849	High 10,174	Low 7,625	Central 8,849	High 10,174
Casualties baseline	52	117	192	229	515	778	683	1,536	5,244
Casualty Reduction	24	61	104	96	237	367	286	640	2,476

Appraisal – Zero tolerance approach

112. Due to the limitations of the available evidence, the costs and benefits of Policy Option 3 are subject to considerable uncertainty. To estimate the monetised costs and benefits, a number of assumptions have had to be made. Ranges have been generated to illustrate the scale of this uncertainty. The estimates are very sensitive to the choice of assumptions, and should be interpreted as indicative estimates of the order of magnitude of these costs and benefits. Furthermore, there are a number of non-monetised costs and benefits as for Policy Option 1. Therefore, there is considerable uncertainty over whether Policy Option 3 would result in a Net Benefit or a Net Cost, and over how the costs and benefits would differ between Policy Option 1 and Policy Option 3.

113. **Table 19** shows the ranges of estimates that have been generated. The Best estimates are discussed in more detail below.

114. As this approach takes a zero tolerance approach to illegal drugs and controlled drugs most associated with medicinal use we have to therefore add the costs in **Table 16** to the estimates of Policy Option 1 (i.e. central scenario of 8,800 proceedings). Based on the above central assumptions on the number of proceedings (8,849 per annum) plus additional costs to the police of 1,633 arrests of those with a credible medical defence and casualty savings (6.25% reduction per annum), the Best Estimate of the Net Benefit of the new offence under this Option is approximately £-18.6m (Present Value) over the appraisal period 2014-2023. The Best estimates of the total benefits and costs over the 10 year appraisal period are estimated at approximately (Present Value) £165m and £184m respectively. This is set out in Table 19.

115. Casualty savings account for the vast majority of the total benefits of this option, with a Best estimate of the total benefits over the 10 year appraisal period of approximately £153m (Present Value). The casualty savings arise due to the reduced prevalence of drug-driving as a result of the introduction of the new offence and amendments.

116. The Best estimate of the total police costs over the 10 year appraisal period is approximately £87m (Present Value) and includes all the costs associated with enforcing the offence of driving with a specified controlled drug in the body above the specified limit for that drug. The Best estimates of the total CPS costs and the criminal justice costs over the 10 year appraisal period are approximately £12m and £72m (Present Value) respectively. The Best estimate of the total offenders cost over the 10 year appraisal period is around £12m (Present Value) and Best estimate of the total additional costs to drivers with a credible medical defence over the 10 year appraisal period is around £1.4m (Present Value).

Table 19: Net Present Benefits of Option 3: Zero Tolerance Approach (Total 2014-2023)

		Total 2014-23 (7,625 proceedings + Med Defence 817 arrests)	Total 2014-23 (8,849 proceedings + Med Defence 1,633 arrests)	Total 2014-23 (10,174 proceedings + Med Defence 2,450 arrests)
BENEFITS				
Casualty Savings		£61,500,000	£153,100,000	£274,100,000
Exchequer	Fines	£9,500,000	£11,000,000	£12,700,000
	Victim Surcharge	£600,000	£700,000	£800,000
Total Present Value Benefits		£71,700,000	£164,800,000	£287,600,000
COSTS				

Police Costs		£70,600,000	£87,300,000	£104,800,000
CPS Costs		£10,200,000	£11,800,000	£13,600,000
Criminal Justice System		£62,100,000	£72,000,000	£82,700,000
Individual costs to those applying successful medical defence		£700,000	£1,400,000	£2,000,000
Offender Costs		£10,100,000	£11,800,000	£13,500,000
Total Present Value Costs		£153,700,000	£184,300,000	£216,600,000
Net Present Value Benefits		£-82,000,000	£-19,500,000	£71,000,000

117. The potential inconvenience and distress which could be caused to those on properly prescribed or supplied medication makes Policy Option 3 difficult to take forward. In addition, the estimated £13m (Best estimate, Present Value) wasted public resources over the 10 year period plus the £1.4m (Best estimate, Present Value) of costs to individual citizens in proving a successful medical defence, some of whom will be working is equally not an attractive option. For this reason we do not believe this approach is viable.

Risks and Assumptions

118. This Impact Assessment for the specific offence of drug driving assumes the availability of approved screening equipment. The assessment assumes significant changes to enforcement practices. In addition there are some uncertainties related to the policing and criminal justice system costs discussed under a previous heading of 'unit costs'.

119. The level of assurance of the analysis underpinning this Impact Assessment is considered to be medium. The analysis is rigorous, thorough and has been reviewed by skilled staff in the Department. However, time constraints mean we have not conducted further studies to gather data, such as on the incidence of drug driving in England and Wales. Due to the limitations of the available evidence, the costs and benefits of this measure are subject to considerable uncertainty. In particular, there is considerable uncertainty as to the current and forecasted number of drug driving casualties and the forecasted number of proceedings over the appraisal period. The estimates are very sensitive to the choice of assumptions, and should be interpreted as indicative estimates of the order of magnitude of these costs and benefits. Furthermore, there are a number of non-monetised costs and benefits. Therefore, there is considerable uncertainty over whether this measure would result in a Net Benefit or a Net Cost. Specific issues are as follows:

- There is limited evidence of the incidence of drug driving in England and Wales, and of the number of casualties caused by drivers impaired by legal and illegal drugs. With more time we could have conducted more extensive studies to gather evidence to feed into our analysis. We have instead used evidence from other sources. It is reasonable to apply this to England and Wales, however, the incidence of drug driving and the impact of enforcement is known to vary between countries;
- The Ministry of Justice has supported us in gathering data and costings to estimate the number of new offences under the proposed legislation. However, there remains uncertainty over the incidence of drug driving among the driving population as well as the degree to which the legislation will deter drivers from driving whilst impaired by drugs;
- Although the assumptions underpinning our analysis are reasonable given available evidence and wider literature, they do heavily influence our results, and it has been necessary to make several illustrative assumptions when estimating the monetised costs and benefits. Similarly, although we consider the approach adopted to estimate both the level of enforcement and the reduction in the number of casualties to be reasonable in the light of the available evidence, it is possibly open to challenge. The uncertainty is illustrated in the wide ranges for both casualty forecasts and the level of enforcement, and is therefore to be emphasised.

120. The Impact Assessment includes a central scenario, with a lower and higher range across all 3 Policy Options.

121. The costs in this assessment do not include publicity or campaigning costs.

Equality Impact Assessment

1. This Equality Impact Assessment (EIA) relates to the drugs and corresponding limits proposed for inclusion in regulations for the purposes of the new drug driving offence. It also relates to the consequential amendments to other related offences in the 1988 Act.

Equality duties

2. Under the Equality Act 2010, when exercising its functions, the Department for Transport has an ongoing legal duty to pay 'due regard' to:
 - the need to eliminate unlawful discrimination, harassment and victimisation;
 - advance equality of opportunity between different groups; and
 - foster good relations between different groups.
3. The payment of 'due regard' needs to be considered against the nine protected characteristics – namely race, sex, disability, sexual orientation, religion and belief, age, marriage and civil partnership, gender identity, pregnancy and maternity. The Department for Transport has a legal duty to investigate how policy proposals are likely to impact on the protected characteristics and take proportionate steps to mitigate the most negative ones and promote the positive ones. The Department for Transport records how 'due regard' has been exercised by completing an Equality Impact Assessment (EIA).

Aims and outcomes for the policy

4. It is already an offence to drive whilst unfit through drugs. However, securing a conviction for that offence requires a complex set of evidence to prove that: the offender was driving or in charge of a vehicle; the offender was impaired so as to be unfit to drive; and the impairment was caused by drugs. Cases rely on being able to bring together the evidence of the impaired driving and the drug test result so as to convince the court of a causal link. Because this is difficult, levels of enforcement against drug driving are low and for the proceedings brought using the impairment offence there is a low rate of guilty findings.
5. As a result of introducing a new offence of driving or attempting to drive or being in charge of a motor vehicle with a specified controlled drug in the body, above the specified limit for that drug, we expect

that more offenders will be convicted of drug driving. As a result of the greater threat of conviction and a more objective assessment of when an offence of drug driving is committed we expect that over time less people will be driving while they are under the influence of drugs and that road safety will improve.

Methodology and evidence sources:

6. Data on court disposals are from the Court Proceedings Database. This holds information on defendants proceeded against, found guilty and sentenced for criminal offences in England and Wales. It includes information on the age of the defendant, their gender, ethnicity, the police force area and court where proceedings took place as well as the offence and statute for the offence. Information on gender reassignment, disability, pregnancy and maternity, sexual orientation, religion or belief or marriage and civil partnership for criminal offences may be held by the courts on individual case files. However, it has not been possible to collate these data for this Equality Impact Assessment because of practical difficulties.

Stakeholder consultation and engagement

7. The new offence has been created following the recommendation of the independent North Review into the law on drink and drug driving, which reported to the Secretary of State for Transport in June 2010. The Review drew on large amounts of research and consulted widely with interested experts and stakeholders.

Analysis

Impact on victims:

8. The introduction of the new offence is expected to have an impact on reducing the numbers of road casualties. For the purpose of assessing the possible impact on victims we have looked at the data on road casualties where drugs were recorded as a contributory factor⁸⁸. In 2011, impairment by drugs (illicit or medicinal) was reported as a contributory factor in 925 casualties of all severities, including 49 deaths in England and Wales.
9. Looking at the average for the three years from 2008 to 2011 in England and Wales, young people between the ages of 16 and 30 are over-represented among Killed and Seriously Injured (KSI)

⁸⁸ Data in this section is sourced from Reported Road Casualties GB 2011 - <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2011> and adjusted to England and Wales.

casualties in road traffic accidents (excluding pedestrians) who had a contributory factor of impaired by drugs (illicit or medicinal) attributed to them by the police. Of the total of 265 KSI casualties in 2011 for all age groups, around half fell into that age group.

10. Looking at the average for the three years from 2008 to 2011, men are over-represented among Killed and Seriously Injured (KSI) casualties in road traffic accidents (excluding pedestrians) who had a contributory factor of impaired by drugs (illicit or medicinal) attributed to them by the police. Of the total 265 KSI casualties in 2011 around three quarters were male.
11. Assuming that around 331 KSI casualties will be saved over the appraisal period as a result of the new offence being introduced this may also disproportionately benefit the younger age group, as well as men. It may be assumed that the casualty saving may include around 170 young people aged 16 to 30, and around 250 men.

Impact on offenders:

12. In order to assess the impact on offenders, we have looked at the offenders who are currently being charged under the offence of driving or in charge of a motor vehicle while impaired by drink or drugs (the impairment offence). We are assuming that the vast majority of these offences are related to drug rather than drink driving (as the majority of drink driving cases will be charged under the prescribed alcohol limit offence in section 5 of the 1988 Act).

Potential Age Impacts:

In 2011, 2,626 proceedings were brought at Magistrates Courts under the impairment offence⁸⁹, and of these a total of 1,389 resulted in findings of guilt (at Magistrates or Crown Court). Of those found guilty, 46% were aged between 17 and 29 years, and another 30% were 30 to 39 years old, so those found guilty were more likely to be in these age groups than members of the general population.

If the age distribution of guilty findings for drug driving following the introduction of the new offence is in line with the current age distribution, these data suggest that there are potential impacts in relation to age, with people in younger age groups more likely to be found guilty.

⁸⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/162619/motoring-tables-1211.xls.xls

Potential Disability Impacts

Due to limitations in the available evidence we are unable to rule out the potential for any differential impact. Please note that if Policy Option 3 was taken then it would be likely to have significant impacts on patients and drivers with disabilities taking controlled drugs for medical uses taken in accordance with the advice of a healthcare professional. The potential impacts on this option are explained in paragraphs 79 to 87.

Potential Gender Reassignment Impacts

Due to limitations in the available evidence we are unable to rule out the potential for any differential impact.

Potential Marriage and Civil Partnership Impacts

Due to limitations in the available evidence we are unable to rule out the potential for any differential impact.

Potential Pregnancy and Maternity Impacts

Due to limitations in the available evidence we are unable to rule out the potential for any differential impact.

Potential Race Impacts

Due to limitations in the available evidence we are unable to rule out the potential for any differential impact.

Potential Religion or Belief Impacts

Due to limitations in the available evidence we are unable to rule out the potential for any differential impact.

Potential Sex Impacts

Due to data on the split of guilty finding at Magistrates Courts only being available at aggregate level for the group of motoring offences that the impairment offence falls into, we assume that that split is the same for the impairment offence. This suggests that those found guilty of the impairment offence are significantly more likely to be male than female compared to the general population. This suggests that there are potential impacts in relation to gender.

Potential Sexual Orientation Impacts

Due to limitations in the available evidence we are unable to rule out the potential for any differential impact.

Mitigation

13. We consider the potential impacts on equality groups among offenders to be justified on the basis that it is a proportionate means of achieving the legitimate aim of addressing drug driving and its impact on road safety. We also consider that the disproportionate benefits for the same equality groups in terms of casualty savings provides an additional justification.

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