

<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: 27 June 2014		
	Stage: Final		
	Source of intervention: Domestic		
	Type of measure: Secondary legislation		
Contact for enquiries: Martin.Ellis@dft.gsi.gov.uk			

Summary: Intervention and Options	RPC Opinion: Green
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Cost of Preferred Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year	In scope of One-In, Two-Out? Measure qualifies as
£-79m	£0	£0.55m	Yes 'In'

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 impaired drivers (less than 2,500 in 2012, compared to 49,000 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. The Government presented 3 different options in its consultation carried out from 9 July to 17 September 2013. The Government had a preferred option, which was supported in the consultation and is therefore presenting it to Parliament.

The regulations for the new offence therefore cover 16 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'. 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. The limit for a further controlled drug (amphetamine) was proposed following a further consultation carried out from 19 December 2013 to 30 January 2014 but was inconclusive so the Government will re-consult at a later date. The impact assessment does though assume amphetamine will be included at the earliest opportunity.

Will the policy be reviewed? It will be reviewed. 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 new drug driving offence.

Signed by the responsible Minister: _____ **Robert Goodwill MP** Date: 30/06/2014

Summary: Analysis & Evidence

Zero tolerance approach to 8 controlled drugs and a road safety risk approach to a further 8 controlled drugs with a limit for amphetamine to be determined.

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 2015	PV Base Year 2015	Time Period Years 2015-34	Net Benefit (Present Value (PV)) (£m) £-79m		
			Low: £-147m	High: £76m	Best:£-79m

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£4.5m	1	£18m	£263m
High	£4.5m		£24.5m	£357m
Best Estimate	£4.5m		£21.5m	£313m

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

The best estimates of the total monetised costs over the 20 year appraisal period for the Crown Prosecution Service (CPS), criminal justice system, police and offenders are around £22m, £133.5m, £136m and £16m 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. There is an additional cost of £5.7m to business.

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	£8m	£116m
High	N/A		£30m	£433m
Best Estimate	N/A		£16m	£234m

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

The best estimate of the total road casualty savings over the 20 year appraisal period following the introduction of the new offence is around £218m (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 £16m over the 20 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%
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Due to the limitations of the available evidence, the costs and benefits 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 the regulations would result in a Net Benefit or a Net Cost.

BUSINESS ASSESSMENT

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: £0.57m	Benefits: £0	Net: -£0.55m	Yes	'In'

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,¹ 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 32 road deaths, or about 2% of fatal road incidents in Great Britain in 2012². For England and Wales, it is estimated to be 29. This is about a quarter of the share of fatal accidents which had 'impaired by alcohol' assigned as a contributory factor (143). In 2011 it was 54 road deaths which represented around a third of the 149 'impaired by alcohol' fatal accidents. The North Report considered both the 'impaired by drugs' and 'impaired by alcohol' 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 estimate for drink drive related road deaths in 2011 is 210³ for England and Wales (2012 figure will not be available until September 2014). If the under-reporting of the 'impaired by drugs' contributory factor in police data on road traffic incidents (STATS19⁴) 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 70, i.e. approximately a third of 210. However, the Department considers that it is likely that the 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)⁵ conducted between 2007 and 2009 suggests that the prevalence of illegal drugs⁶ 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 105 road deaths related to illegal drugs and impaired driving in 2011

¹ 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/>

² Contributory Factor Type: Report Accidents by Severity GB 2012 (Reported Road Casualties GB 2012), 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.

³ Reported Road Casualties GB 2012 - <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2012>.

⁴ Reported Road Casualties GB 2012 - <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2012>

⁵ 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.

⁶ '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.

5. Work by Tunbridge et al⁷ suggested that illicit drugs could be present in about 18% of road fatalities in 2000. If sustained, in 2012, this would equate to around 305 deaths in Great Britain (i.e. about 18% of 1,754) and would equate to about 285 in England and Wales, 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:
 - 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 data⁸ 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.
 - Hospital Emergency Department data can be variable
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.

⁷ Tunbridge RJ, Keigan M and James F (2001), 'The incidence of drugs and alcohol in road accident fatalities'. TRL Report 495. Crowthorne: TRL.

⁸ Contributory Factors in Road Casualties Great Britain 2012 <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2012>

Low estimate of drug impaired driving casualties (based upon data 2009-2012)

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 from 2009 until 2012 (2013 data 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 2009-2012)

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 2009 and 2012. 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 2008⁹ 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 2009.

Central estimate of Drug impaired driving casualties (based upon data 2009-2012)

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 usually one third of drink driving, which is purely an illustrative assumption, whilst acknowledging that the latest 2012 figure dropped to around one quarter. Serious and slight injuries are assumed to share the same ratios to fatalities as with the

⁹Department for Transport (2011) *Strategic Framework for Road Safety* and Broughton, J. (2009) *Post-2010 Casualty Forecasting*, TRL.

lower estimate. Whilst we cannot claim that choosing 33% of the drink driving casualties (2009-2012) 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 20 year appraisal period we have adopted the following approach:

- TRL forecasts¹⁰ up until 2030 were used to estimate the annual reduction in road traffic casualties for the do nothing scenario. The average annual rate of reduction between 2025 and 2030 was applied for the years 2030-2034.
- The same rate of change was then applied to estimates for 2012 described above up until 2034 to produce the baseline forecast.
- A further percentage reduction from this baseline was then calculated to arrive at potential average casualty savings.

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) ¹¹									
	Deaths			Serious			Slight			Total
Drink Drive (2009 -2012 averages)	256			1,184			8,145			9,585
Estimates	Low	Mid	High	Low	Mid	High	Low	Mid	High	
Drug Impaired (2009 - 12 average)	41	85	141	189	391	651	479	994	4,479	

Level of Enforcement

17. 2012 Ministry of Justice returns indicate that there were far fewer proceedings¹² brought related to drug impaired driving than for drink driving. There were about 49,000 proceedings brought to Magistrates’ Courts in England and Wales¹³ 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 2,500 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 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 2012 (compared to about 3% for the prescribed limit drink drive offence)¹⁴. The North review

¹⁰ http://www.trl.co.uk/online_store/reports_publications/trl_reports/cat_road_user_safety/report_post-2010_casualty_forecasting.htm

¹¹ Reported Road Casualties Great Britain by region (i.e. England and Wales)

¹² We have used the term ‘proceedings’ to mean those prosecutions brought to court.

¹³ Ministry of Justice, Court proceedings database

¹⁴ <https://www.gov.uk/government/publications/criminal-justice-statistics-quarterly-update-to-december-2012>

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.

Proposals 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:
 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 drug¹⁵ 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. A Guide to type approval was issued by the Home Office in September 2013 in relation to drug screening equipment for use at the roadside (step 4). Type approval work is planned so the equipment, which will be able to detect for THC and cocaine, can be available to enable the objectives for the new offence to be achieved. It is expected this equipment will be available as close as practicable to the commencement of the new offence. Guides for type approval for further drugs will follow over the coming years, but THC and cocaine represent around 85% of drug driving cases¹⁶.

¹⁵ 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.

¹⁶ Page 61 (58% cannabis) and Page 74 (29% cocaine) of the Expert Panel report 'Driving under the influence of drugs'

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 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 Parliament¹⁷. 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 included 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 drugs¹⁸.

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 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

¹⁷ By virtue of the amendment to section 195 of the Road Traffic Act 1988 made by subsection (3).

¹⁸ 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>.

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 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 uses¹⁹ 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 are not including in the regulations as the consultation result was inconclusive so the Government will re-consult on a proposed limit at a later date to include in further regulations. For the purposes of this impact assessment we are assuming the inclusion of amphetamine as it will be included at the earliest opportunity.

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 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
Benzoylcegonine	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. 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 with amphetamine to be determined.

¹⁹ Controlled drugs associated with medical uses are those where the amount of prescriptions issued each year runs into the many thousands.

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 and a limit for amphetamine to be determined.

Drug	Threshold limit in blood
Amphetamine	TBC
Benzoylcegonine	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
Methylenedioxymethamphetamine (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

37. 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.
38. In the Impact Assessment of the primary legislation published in May 2012²⁰, 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 too high and not appropriate for the approach the Government has taken as that approach was based upon higher limits, where a road safety risk approach was assumed.
39. For the purposes of the Impact Assessment produced for the consultation we took 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. We expected 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. The methodology explained below produced a figure of 8,800. Although this figure is higher than the estimate in the impact assessment for the primary legislation it would have been much lower if risk based limits were taken for all the drugs.

²⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98433/ia-drug-driving-offence.pdf.

40. For this approach we first estimated 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. The National Roads Policing lead confirmed in their response to the consultation that this would be the approach the police would take. According to the latest available data for England and Wales (2011) around 605,000 drivers underwent a breathalyser test and were not above the prescribed blood alcohol limit²¹.
41. 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 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)²² measured the prevalence of alcohol and other drugs in the driving population in thirteen European countries (the UK did not participate)²³. 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.
42. 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.
43. 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 physician²⁴. 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 UK

²¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/188288/ppp-breath-tests-1112-tabs.xls

²² http://www.druid-project.eu/cln_031/nn_111632/Druid/EN/about-DRUID/about-DRUID-node.html?__nnn=true

²³ DRUID Deliverable 2.2.3 data collected 2007-2009 (Houwing et al 2011).

²⁴ Page 28 of *Driving under the influence of drugs*.

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

44. Therefore, assuming that 1.9% of drivers might be on controlled drugs associated with illegal use, it is estimated that 11,495 drivers that underwent a breathalyser test and were not above the legal blood alcohol limit in 2011 might be on controlled drugs associated with illegal use (i.e. 1.9% of 605,000). 1.3% of drivers on controlled drugs with medical uses would equate to around 7,865. If we then attempt to apply a UK perspective to the European data by applying the CAST ratio of 62% for illegal drugs then the figure would increase slightly to 12,003 ($7,865 + 11,495 = 19,360$ and 62% of $19,360 = 12,003$). As these estimates are uncertain we have taken a mid-point of 11,750 (i.e. $12,003 - 11,495 = 508/2 = 254 + 11,495 = 11,749$, rounded to 11,750).

45. 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%.

- 60% of 11,750 = 7,050
- 70% = 8,225
- 80% = 9,400.

46. We therefore propose a range of 7,000-8,200-9,400 and therefore a central scenario of **8,200** 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 methodology was used last time and produced a figure of 8,800 but as the later data is now available it now produces a slightly lower figure. The previous range was discussed informally with the police prior to being included in the consultation but they responded that they thought 8,800 too high, particularly for the first few years. The Ministry of Justice (MoJ) agreed that it is likely that it will take around 10 years before the new offence is fully bedded in and for widespread use of mobile drug screening equipment. We have therefore agreed with the MoJ that the central scenario figure of 8,200 is achievable but most likely to be the central figure over a longer time period, i.e. it will be much lower in the early years but higher in the latter years and thus 8,200 will be the average over the 20 years appraisal period. We have therefore agreed that the appraisal period for this impact assessment will be over 20 years.

47. To extend the analysis to cover the 20 year appraisal period we have made one further assumption:

- the number of offenders charged under the existing impairment offence will be unchanged.²⁵

48. 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.

49. 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).

50. 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.²⁶ Table 3 shows the estimated annual distribution of proceedings brought among the different offence scenarios based on the central case of an estimated 8,200 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	7653
Being in charge of a motor vehicle with a specified controlled drug in the blood or urine above the specified limit	301
Driving and failing to provide specimen for analysis or laboratory test	154
Being in charge of a motor vehicle and failing to provide specimen for analysis or laboratory test	92

²⁵ 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.

²⁶ The distribution of drink-drivers among the offence types is from MoJ 2010 Data

Casualties

51. 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.
52. Elvik et al²⁷ 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.
53. 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 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.
54. Shults et al (2001)²⁸ 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.²⁹ 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%.
55. 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.
56. DRUID³⁰ adapt a 'dose response' model used by Elvik (2001)³¹ 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).
57. Having established a baseline as set out in paragraphs 6-16 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:

²⁷ The Handbook of Road Safety Measures: Rune Elvik, Alena Hoye, Truls Vaa and Michael Sorensen

²⁸ 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

²⁹ '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)

³⁰ DRUID, 'Cost-benefit analysis of drug driving enforcement by the police' 2011 page 13, http://www.druid-project.eu/cln_031/nn_107548/Druid/EN/deliverables-list/downloads/Deliverable_3_3_1_templateId=raw.property=publicationFile.pdf/Deliverable_3_3_1.pdf

³¹ 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.

- 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.
- 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' (currently 2,500 people per year). Therefore, under the central scenario, it is estimated that the actual level of enforcement will rise from 2,500 to 10,700 (2,500 + 8,200), 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:

58. **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	9,400	x4.75	6.2%
Central	8,200	x4.25	6.0%
Low	7,000	x3.75	5.5%

59. Based on this our Best estimate is that there will be approximately 105, 394 and 940 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 8,200 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 7,000	Central 8,200	High 9,400	Low 7,000	Central 8,200	High 9,400	Low 7,000	Central 8,200	High 9,400
Total casualties (2013)	41	85	141	189	391	651	479	994	4,479
Total Casualty Reduction over 20 year appraisal period compared to annual baseline.	40	84	146	147	331	573	471	843	3,932

60. 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.

Unit Costs

61. **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. A number of respondents to the consultation also suggested that a further impact assessment should consider the potential implications of drug users moving to other drugs to avoid detection. The Government believes that it would be difficult to monetise changes in drug taking behaviours and its impact on road safety as there isn't any evidence to base any estimates upon.
- 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 eligibility³².
- Police costs: We have estimated the police costs by multiplying time spent arresting, preparation and attendance in court by the hourly rate³³ of a police officer and the number of proceedings. In line with Webtag 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 (£18.35) was multiplied by a mark-up of 21.2%³⁴. 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. A laboratory responded to the consultation that the costs of analysing blood samples is likely to increase as they seek to develop better testing methods and seeking the relevant accreditations. Those costs would be passed onto the police but the Government believes that it is for the laboratories to determine whether it is in their commercial interest to provide a service and to price their services competitively. Police forces already chose to contract to the laboratory that provides the service that best suits their needs and the Government expects this to continue. We cannot therefore second guess what those costs might be in the future so have based our estimates on current prices.
- 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%)³⁵ 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.
- Payment Rate of Financial Penalties: The payment rate used for appraisal purposes is that recorded in the most recent published version of Court Statistics Quarterly main

³² This was advised by Ministry of Justice due to the limitations of the evidence available.

³³ Hourly rate is derived from information supplied by the Home Office in May 2013.

³⁴ 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)

³⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203847/3-court-proceedings-dec12.xls

tables B2³⁶. For Q3 2011 this was 55% after 18 months. It should be noted that this is the percentage by value paid after 18 months and that additional payment may be received beyond the 18months period. It should also be noted that the published payment rate covers all financial impositions.

- Victim Surcharge: We have assumed that 70% of those fined also paid a victim surcharge³⁷.

Table 7: Unit cost - Criminal justice system costs³⁸

Type of Cost	Unit Cost	Unit Cost	Percent of those charged that result in cost	Cost per case
Legal Aid³⁹	Cost of a legal aid trial in the Magistrates Court	£551.86	We assume 4% of drug drive cases are eligible for legal aid.	£551.86
HMCTS⁴⁰	Cost per sitting day.	£1,473.28	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.	£132
CPS⁴¹	Cost per defendant in a Magistrates' Court	£152.92	We have assumed 100% of cases are tried in Magistrates' Courts	£152.92
Probation / Community Sentences⁴²	Cost per offender per year	£3,196.12	We have assumed that 21% of drug drive cases result in a community service	£3,196.12
Prison⁴³	Cost per Offender per Year	£28,688.53	We have assumed 3% of offenders go to prison for about 6 months, half of their custodial sentence.	£14,344.26
Average fine⁴⁴	Average fine in Magistrates' Court	£259	We assume around 70% of defendants are fined, and 75% of these pay the fine.	£241
Victim Surcharge⁴⁵	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 £284.54 to £15,180.66 ⁴⁶

³⁶ Information provided by Ministry of Justice and referencing <https://www.gov.uk/government/organisations/ministry-of-justice/series/courts-and-sentencing-statistics>

³⁷ Information provided by Ministry of Justice

³⁸ With the exception of prison costs, the victim surcharge and community sentence costs (all 2013) have been updated from 2010-11 prices to 2015 prices using GDP per capita growth and the GDP deflator.

³⁹ Source: Crime Lower report by the Legal Services Commission

⁴⁰ Ministry of Justice

⁴¹ Ministry of Justice Cost Benefit Framework

⁴² Ministry of Justice Cost Benefit Framework

⁴³ NOMS management accounts addendum (2011)

⁴⁴ Ministry of Justice

⁴⁵ Victim and Witness Consultation Response (available online at: <https://consult.justice.gov.uk/digital-communications/victims-witnesses/results/ia-victim-witness-combined.pdf>)

⁴⁶ 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.

Table 8: Unit Costs - Police costs⁴⁷

	Description	2015 Prices and Values
Forensic Medical Examiner	Forensic Medical Examiner (FME) call out charge for taking blood sample at Police Station.	£110.83
Blood Test Kit	Cost per suspect	£7.06
Lab Test Analysis	Cost of examining specimen	£223.07
Custodial Costs⁴⁸	Custodial cost per suspect per hour	£207.44
Police Costs	Cost of on duty policeman/woman (below sergeant) per hour	£24.31

62. **Table 9** contains an estimate of how police costs are then distributed across their activity⁴⁹.

Table 9: Police costs in relation to arrests and prosecutions

Procedure	Police Time (hrs)	Police Costs (£2015)
Arrest Time	0.5	12.16
Police Station Investigation	1.5	36.47
Booking in with Custody Officer	0.5	12.16
Case File	1.5	36.47
Extra Hour Investigating Medical Defence	1	24.31
Time at Court	3.75	91.17
Witnessing Police Officer		
Arrest	0.5	12.16
Police Station Investigation	0.5	12.16
Write-up Notes	0.45	10.94
Other Costs		
Forensic Medical Examiner		110.83
Blood test kit		7.06
Lab Test Analysis		213.07
Total Police Time (before court)	6.45	156.81
Total Police Time (including court)	10.2	247.98

63. **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 capita⁵⁰. We have not included costs that are not specific to casualties as damage only accidents are not comprehensively reported to police⁵¹. If such costs were included potential cost savings could be substantially higher.

⁴⁷ Information provided by the Home Office and updated to 2013 prices using GDP deflator.

⁴⁸ This is an estimate of the costs involved in the charging of a suspect and include factors, such as duty Custody Sergeant.

⁴⁹ As advised by the DfT police liaison officer

⁵⁰ DfT Webtag 3.4.1 [The Accidents Sub-Objective](#)

⁵¹ DfT Webtag 3.4.1 [The Accidents Sub-Objective](#)

Table 10: Value of Preventing a Casualty⁵²

Casualty Severity	2015 Prices and Values
Fatality	£1,921,124
Serious	£215,884
Slight	£16,636

64. The unit costs in Tables 7 and 8 have been up-rated over the 20 year appraisal period using the forecast GDP per capita growth rate.⁵³ 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.

65. 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

66. Due to the limitations of the available evidence, the costs and benefits 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 the proposals would result in a Net Benefit or a Net Cost.

67. 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 costs to offenders, they are not included as part of this cost benefit analysis⁵⁴. 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.

68. One In Two Out (OITO): In the impact assessment at the consultation stage we did not believe the Government's preferred proposed approach would have a direct impact on business as the new legislation is aimed at the individual citizen to comply with road safety law. There may be indirect costs (as discussed above); however, these do not fall within the remit of OITO. However, we asked the question on whether any business had a view on whether the Government's proposals will have any impact on them, directly or indirectly. One pharmaceutical company stated that they would have to amend their patient information leaflets (PILs) to ensure they adequately advise on the new drug driving offence.

69. We considered this claim and after consulting with the Medicines and Healthcare products Regulatory Agency (MHRA) and the Cabinet Office we accept there will be some cost to business. The company (Napp Pharmaceuticals) claimed the legislation change will cost them £10k. However, since the consultation closed the MHRA issued advice to Market

⁵² DfT Webtag 3.4.1 The Accidents Sub-Objective, Table 1

⁵³ DfT Webtag 3.5.6: Values of Time and Operating Costs, Table 3a

⁵⁴ This treatment has been chosen in discussions with Ministry of Justice

Authorisation Holders (MAHs) in December 2013 to amend their PILs but also the Summary of Product Characteristics and to produce 'flash' warnings on the packaging. In addition, the MHRA advised them to "include those medicines that will be metabolized into one of these active substances". Napp thus contacted the Department to say that their costs would significantly increase on their initial estimate. They provided a more detailed estimate of £372,328. However, £60,237 (16.2%) of that is stock write-off costs, but MHRA have informed us that there is no requirement to write off existing stock as these communication channels are just part of a wider communications plan. We therefore have reduced their estimate by £60,237 to £312,091. Napp also informed us that their market share based on data information they purchase from *IMS Health* is 7% of the UK market. The cost to the 93% of other MAHs would then equate to £4,146,352 giving a total of £4,458,443 – rounded to £4.46m. MHRA have informed us that it is difficult for them to give a precise number of companies affected as many MAHs have multiple trading names. Some companies will market separate products or the same product under separate trading names and some will vary to the extent they follow MHRA's advice so we cannot be completely sure of the costs.

70. Napp were the only MAH to make the claim so in order to test their estimates and see if it is accurate across the entire UK industry we asked another MAH, Shire, who responded to the consultation on a limit for amphetamine and informed us that the costs per pack would equate to 0.25p. They also included stock write off costs but we have discounted these for the reasons above. As the Department of Health 2012 data estimates that 18.9 million prescriptions would be affected we have multiplied that by 0.25p giving a total of £4,725,000. As these 2 costs were supplied separately and independently and are very similar we are reasonably confident that a mid-figure of £4.59m is an accurate estimate of the costs to business for amending the product information to prescription medicines. However, Napp also reminded us that some over the counter medicines, which could also metabolise into the drugs listed in the draft regulations may also need to be included. Napp estimate the total cost to industry to be £6.9m including over the counter medicines. However, if we consider the inclusion of stock write off costs representing 16.2% then that would equate to £1.12m to be subtracted from £6.9m giving a total of £5.78m. £1.12m represents 25.1% of Napp's original £4.46m estimate and over the counter medicines affected by the legislation thus represent around an additional 25% to be added to our mid-figure of £4.59m (£1.15m + £4.59m = £5.74m). There may be more over the counter medicines but MHRA has informed us that MAHs will vary the extent to which they will make the changes and with the higher limits for the potentially impacted medicines, which can also be sold over the counter we agree with Napp's assessment that an additional 25% is a reasonable assessment. We are therefore using £5.74m as our estimated cost to business for the purposes of the impact assessment.

71. We believe these costs will be one-off as once the artwork changes are made there will be no subsequent printing costs and the MHRA has advised MAHs that they can remove the 'Flash' wording on the package after 12 months. There is no regulatory costing charge for updates to the PILs and hence will have minimal impact on the cost of printing. Changes to product information is regularly undertaken as MAHs have an obligation to take into account new safety issues as they arise and update their information appropriately to inform healthcare professionals and patients in line with the EC Directive 2001/83 as amended. Therefore, this is not an unusual requirement for pharmaceutical companies to undertake and these types of changes are regularly undertaken during the lifespan of a medicine. We have shared this estimate with the MHRA and they believe it is a generous estimate and very difficult to provide exact costs as the MAHs will be updating their product information anyway to accommodate new legislation on pharmacovigilance. The drug driving changes can thus be rolled up with others which are on-going and MAHs are already taking advantage of this opportunity.

72. We do not believe it is necessary to carry out a Small and Micro Business Assessment (SMBA) because we gave an opportunity to all businesses to respond to a specific question

in the consultation on whether the new offence would impact on them and only the pharmaceutical companies responded with a legitimate claim. The pharmaceutical companies who manufacture medicines are large corporations, many of them being multi nationals. As stated above in paragraph 68, the new legislation is aimed at the individual citizen to comply with road safety law. Clearly any person driving for work will need to comply and that will have a positive impact on all businesses including small and micro businesses (SMBs) by reducing their exposure to staff having road traffic accidents. Many SMBs, such as driving instructors, responded to the legislation positively as it will contribute in making the roads safer. The only potential SMBs to raise the fact that the new offence will impact on them were the laboratories who provide the service of testing the blood samples for the police forces as they will need to make arrangements to be ready to test for the 17 drugs proposed. However, they acknowledge that any increased cost to them will be passed onto the police forces.

73. The costs will be spread over 2 financial years (2013/14 and 2014/15) as the MAHs had until 28 February 2014 to submit their variations to the MHRA and the PILs and new packaging to be ready by September 2014. The regulations are therefore now within the scope of one in two out as the cost in any one year, i.e. 2014/15 is over £1million.
74. Costs to the Health Service: A number of NHS respondents to the consultation expressed that there may be additional costs upon healthcare providers to ensure patients understand the new offence. The Government has set out its communication plan in its response to the consultation and is working with the Department of Health, the Medicines and Healthcare products and Regulatory Agency, the medical profession and the DVLA to ensure that guidance is provided to minimise the impact. We therefore believe the costs on the health service will be minimal.
75. Costs to charities: Some road safety charities also responded to the consultation that they will be updating their road safety information to reflect the new offence. We have not included this in the impact assessment as this information is often updated to reflect what is topical and indeed one organisation stated that they will help to promote the 'do not take drugs and drive' message.
76. **Table 11** shows the ranges of estimates that have been generated. The Best estimates are discussed in more detail below.
77. Based on the above central assumptions on the number of proceedings (8,200 per annum) and the casualty savings (6% reduction per annum), the Best estimate of the Net Cost of the new offence is approximately £-79m (Present Value) over the appraisal period 2015-2034. The Best estimates of the total benefits and costs over the 20 year appraisal period are approximately £234m and £313m (Present Value) respectively.
78. Casualty savings are estimated to account for the vast majority of the total benefits, with a Best estimate of the total benefits over the 20 year appraisal period approximately £218m (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.
79. 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 20 year appraisal period is approximately £136m (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 costs over the 20 year appraisal period are approximately £22m and £133m (Present Value) respectively.

80. 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.
81. 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).
82. 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.
83. Table 11 sets out all the costs and benefits of the new offence. It assumes a road safety risk based approach to amphetamine as it will not be a zero tolerance approach. 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. 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 7,000 proceedings, central to 8,200 proceedings and high to 9,400 proceedings.

Table 11: Total Costs and Benefits over the 20 year appraisal period (Present Value):

		Total 2015-2034: (Low scenario - 7,000)	Total 2015-2034: Central scenario - 8,200)	Total 2015-2034: (High scenario - 9,400)
BENEFITS				
Casualty Savings		£102,354,381	£217,778,648	£414,544,384
Exchequer	Fines	12,647,214	£14,815,308	£16,983,402
	Victim Surcharge	996,354	£1,167,157	£1,337,961
Total Present Value Benefits		£115,997,949	£233,761,113	£432,865,747
Average Benefits (Undiscounted)		£7,995,468	£15,990,422	£29,633,884
COSTS				
Police Costs		£115,971,407	£135,852,220	£155,620,325
CPS Costs		£18,745,619	£21,959,153	£25,172,688
Criminal Justice System		£108,861,175	£133,367,415	£152,022,530
Offender Costs		£13,643,568	£15,982,466	£18,321,363
Business Costs		£5,740,000	£5,740,000	£5,740,000
Total Present Value Costs		£262,961,769	£312,901,253	£356,876,906
Average Costs (Undiscounted)		£18,164,951	£21,636,092	£24,692,693
Net Present Value Benefits		-£146,963,819	-£79,140,140	£75,988,841
Average Net Present Value Benefits (Undiscounted)		-£10,169,484	-£5,645,671	£4,941,191

84. The Best estimate is that there is a Net Cost but 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.
85. 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 strategy⁵⁵, which seeks to bear down on those criminals seeking to profit from others' misery; and 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.
86. The social and economic costs of drug supply in England and Wales is estimated to be £10.7 billion a year⁵⁶. Drug use in the UK remains too high. According to the Crime Survey for England and Wales, 8.2% adults in 2012/13 used an illegal drug which is around 3 million people⁵⁷.
87. 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.⁵⁸ 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 drugs⁵⁹. 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.
88. Cannabis and alcohol are the most common substances used amongst young people⁶⁰. In 2012/13 around 20,000 under 18 years accessed specialist support for substance misuse⁶¹, 68% with cannabis as their primary substance. 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

⁵⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98030/impact-assessment.pdf

⁵⁶ Mills, H., Skodbo, S. and Blyth, P. (2013). *Understanding the organised crime: estimating the scale and the social and economic costs*. Home Office Research Report 73
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/246390/horr73.pdf

⁵⁷ Home Office. (2013). *Drug Misuse Declared: Findings from the 2012/13 Crime Survey for England and Wales*
<https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

⁵⁸ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98030/impact-assessment.pdf

⁵⁹ <http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2011/rrcgb2011-05.pdf>

⁶⁰ Home Office. (2013). *Drug Misuse Declared: Findings from the 2012/13 Crime Survey for England and Wales*:
<https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

⁶¹ Department of Health/National Treatment Agency. Statistics from the National Drug Treatment Monitoring System (NDTMS). Statistics relating to young people England, 1 April 2012– 31 March 2013 <http://www.nta.nhs.uk/uploads/annualypstatistics2012-13-final%5b0%5d.pdf>

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.

89. The Crime Survey for England & Wales 2012/13⁶² also shows that it is not just the 'hard pressed' in society of which 4.3% of this group take illegal drugs but is prevalent across all social groups from 'moderate means' to 'wealthy achievers' with 4.7% of the 'urban prosperous' group taking illegal drugs. Driving a car is likely to be a regular occurrence for this group so 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.
90. 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.
91. 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 if risk based limits were set. 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. The post implementation review will consist of the evaluation of the new offence that has already been commissioned. The researcher, Risk Solutions, was appointed in October 2013 and has been scoping the extent of the research and collecting baseline data. The evaluation will seek to assess the implementation and enforcement of the new offence including collecting evidence on attitudes towards it. The evaluation contract ends in February 2016 and the Department will publish the research report and provide a consideration of any next steps that might be needed regarding the new offence in 2016.

Risks and Assumptions

92. 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'.
93. 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

⁶² <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales>

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.

94. The Impact Assessment includes a central scenario, with a lower and higher range.

95. 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 factor⁶³. In 2012, impairment by drugs (illicit or medicinal) was reported as a contributory factor in 944 casualties in GB (adjusted to 855 in England and Wales) of all severities, including 29 deaths in England and Wales.
9. Looking at the average for the three years from 2009 to 2012 in England and Wales, young people between the ages of 16 and 30 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 of 254 KSI casualties in 2012 for all age groups, around half fell into that age group.
10. Looking at the average for the three years from 2009 to 2012, 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

⁶³ Data in this section is sourced from Reported Road Casualties GB 2012 - <https://www.gov.uk/government/publications/reported-road-casualties-great-britain-annual-report-2012> and adjusted to England and Wales.

to them by the police. Of the total 254 KSI casualties in 2012 around three quarters were male.

11. Assuming that around 499 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 250 young people aged 16 to 30, and around 375 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 2012, 2,464 proceedings were brought at Magistrates Courts under the impairment offence⁶⁴, and of these a total of 1,269 resulted in findings of guilt (at Magistrates or Crown Court). Of those found guilty, 46% were aged between 17 and 29 years, and another 31% 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.

Potential Disability Impacts

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

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

⁶⁴ <https://www.gov.uk/government/publications/criminal-justice-statistics-quarterly-update-to-december-2012>

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.

Regulatory Policy Committee (RPC) comments

1. Whilst the RPC provided an overall green rated assessment of the impact assessment they did provide some comments where they thought the impact assessment could be improved.
2. Firstly, the RPC stated “the Department estimates that the proposal may have a significant negative impact on society. The IA needs to provide a stronger justification for why the proposal remains the Department’s preferred option”. The RPC goes on to say “the IA does not demonstrate with any degree of certainty that potential non-monetised benefits are likely to outweigh the costs.”
3. The Government takes the view that the other options outlined in the public consultation are unviable and the preferred option was supported in the consultation despite the negative cost impact. The impact assessment states that by aligning with the overall drug policy, there is greater potential to reduce drug taking in the first place. The impact assessment provides some examples of where this may arise, but it is extremely difficult to monetise something where we cannot be sure of an absolute causal link. The Government is confident that its preferred option of taking a tough approach to illegal drugs is the best option as it is likely to have the greatest deterrent effect.
4. To support this view, the results of the Crime Survey for England and Wales shows that self-reported drug driving has fallen from 1.3% in 2010/11 to 0.5% in 2012/13. Even amongst those drivers who do take illegal drugs, the survey showed a reduction in the proportion who said they have driven under the influence of drugs. In 2010/11, 20% of drivers who had taken an illegal drug in the last year said they had driven under the influence of it. In 2012/13, this had fallen to 9%. It is possible that emphasis on the development of the new legislation has already helped to discourage drug driving and may also have had an impact in the overall reduction in drug taking. It is not possible though to disentangle these two effects and it would be disingenuous for the Department to take the credit and attempt to monetise it or to provide a more detailed discussion on the likely profile of impacts in achieving the stated objectives when there is considerable uncertainty.
5. The second point the RPC makes is that the Department has assumed that the number of proceedings against drivers will remain constant over the 20 year appraisal period. The RPC stated “this analysis does not appear to take account the improvements that will be made in equipment and detection methods over time.” The Department accepts that paragraph 47 did state proceedings will remain constant but then in paragraph 46 this is contradicted by the statement, “The Ministry of Justice (MoJ) agreed that it is likely that it will take around 10 years before the new offence is fully bedded in and for widespread use of mobile drug screening equipment. We have therefore agreed with the MoJ that the central scenario figure of 8,200 is achievable but most likely to be the central figure over a longer time period, i.e. it will be much lower in the early years but higher in the latter years and thus 8,200 will be the average over the 20 years appraisal period.”
6. The Department agrees with the view in Paragraph 46 and has thus amended paragraph 47 so that the contradiction in the impact assessment is now removed, i.e. there is no assumption that the proceedings will remain constant.
7. Finally, The RPC also suggested that the Department reconsider whether the post implementation review date of October 2016 allows sufficient time to for the policy to take effect. The Department will consider the scope for postponing the post implementation review until later in the decade.