Driving: drugs

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Author: Louise Butcher
Section Business and Transport

This note provides information on the offences for drug driving and their enforcement.

Driving while under the influence of drugs is an offence under the *Road Traffic Act 1988* with penalties similar to those for driving while under the influence of alcohol. Section 56 and Schedule 22 of the *Crime and Courts Act 2013* introduced a new offence of driving while over a prescribed drug limit, which can be enforced at the roadside with mobile testing equipment. This came into force in England and Wales on 2 March 2015. Scotland has as yet not introduced this offence.

There have been concerns expressed as to how those taking prescription and over the counter medication will be affected by the 'drug drive limit'. There is a 'medical defence' built into the legislation, it remains to be seen how this will work in practice.

These changes are largely the consequence of the recommendations of the North Review, published in June 2010, which looked in depth at how to improve the approach to detecting and prosecuting drug driving. An Expert Panel led by Dr Kim Wolff later made recommendations on the appropriate levels of drugs that should be proscribed for the drug drive limit.

Information on other driving offences and related matters can be found on the Roads Topical Page of the Parliament website.

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1 Offences

1.1 Impairment and ‘causing death’

Driving whilst impaired by drugs is a serious criminal offence with penalties similar to those for drink driving. Under section 3A of the *Road Traffic Act 1988*, as amended by the *Road Traffic Act 1991*, the offence of ‘causing death by careless driving while under the influence of drink or drugs’ requires the prosecution to show that the driving:

- caused the death of another person;
- fell below the standard expected of a reasonable, prudent and competent driver in the circumstances; and
- the driver was unfit through drink or drugs or the level of alcohol is over the prescribed limit, or a failure to provide a specimen.

The charge can only be heard in the Crown Court.

The maximum penalty is an unlimited fine and/or 14 years imprisonment; an obligatory disqualification for at least two years (three years if there is a relevant previous conviction); and the obligatory endorsement of the driver's licence with 3-11 penalty points. The maximum penalty was originally five years imprisonment and/or an unlimited fine but this was doubled to ten years imprisonment from August 1993 by the *Criminal Justice Act 1993* and increased again to 14 years in February 2004 under the *Criminal Justice Act 2003.*

Under section 4 of the 1988 Act it is also an offence to drive or be in charge of a vehicle while unfit to drive through drink or drugs. The maximum penalty for driving or attempting to drive while unfit is six months in prison, a £5,000 fine and disqualification; for being in charge while unfit it is three months in prison, a £2,500 fine and a disqualification or ten points on the licence.

In January 2007 the Sentencing Advisory Panel announced a consultation on advice about the 'causing death by driving' offences.[1] In January 2008 the Panel published its new advice to the Sentencing Advisory Council[2] on causing death by driving offences. In total the Panel made 18 recommendations; these included:

- Where there is sufficient evidence of driving impairment, the consumption of alcohol or drugs prior to driving will make an offence more serious; and
- The fact that an offender may have consumed alcohol or drugs unwittingly before driving may be regarded as a mitigating factor but consideration should be given to the circumstances in which the offender decided to drive or continue to drive when driving ability was impaired. [3]

1.2 A 'drug drive limit'

Background

In November 2008 the Department for Transport published a consultation document on road safety compliance and asked for views on the creation of a possible new offence for driving with drugs in one's system. The consultation paper explained:

> We could explore the viability of creating a new offence to target those who drive after taking illegal drugs – those that are controlled by the Misuse of Drugs Act 1971 – which can impair a user's ability to drive. The public rightly perceive users of these drugs who drive as a danger to road safety. As this paper has shown, it is difficult for the police to deal with these offenders. The nature of the effects of the drugs they take mean it is inappropriate to regulate the use of impairing illegal drugs using a prescribed limit based on the same principles as the limit for alcohol, even if it was acceptable to do so.
>
> Such an offence could be framed in such a way that a driver could be convicted of a new offence if an appropriate test showed such an illegal drug in their body. The effects of particular drugs on different individuals are complex, and, as set out below, there would be a lot of further work to do to develop this possibility, but our ultimate aim would be to treat in this way any illegal drug that is capable of impairing driving.
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> [...]
>
> The penalties for drivers exceeding the prescribed limit for alcohol are the same as for those convicted of the alternative offence of driving while unfit through drink or drugs. We therefore envisage that penalties for the possible new offence should be the same as for the existing offence of driving while unfit through drugs, which is a mandatory minimum disqualification of 12 months; offenders may also be fined up to £5,000 and sent to prison for up to 6 months.[4]

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1 SAP press notice, "Consultation paper on causing death by driving offences", 25 January 2007

2 now the Sentencing Council

3 SAP, *Advice to the Sentencing Guidelines Council: Driving Offences – Causing Death by Driving,* 9 January 2008, pp59-60 (Annex E)

4 DfT, *Road safety compliance consultation*, 20 November 2008, paras 5.43-5.49

The consultation closed in February 2009 and in December 2009 the Labour Government announced that it would seek further advice on the matter from Sir Peter North.[5] While Sir Peter provided initial advice to Lord Adonis before the 2010 General Election, his final report was not published until 16 June, after the Conservative-Liberal Democrat Coalition Government took power. The main recommendations of the North Review related to drug driving were that police procedures enforcing current drug driving laws should improved and that there should be early approval for saliva testing. The press notice accompanying the Review stated:

> The Review also assesses Great Britain's less well-understood drug driving problem, challenging the lack of reliable statistics, out-dated research and police emphasis on drink driving detection. In the short term, Sir Peter recommends that police procedures enforcing current drug driving laws are improved, making it more straightforward for police to identify and prosecute drug drivers by allowing nurses, as well as doctors, to authorise blood tests of suspects. Medium-term, he recommends early approval of saliva testing of drug driving suspects in police stations, which will largely overcome the environmental problems in roadside use that had previously slowed technological development of so-called 'drugalysers'.
>
> On the question of a new law setting banned drug levels, Sir Peter was keen to say:
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> "The focus should be on public safety. Any new offence should therefore focus on establishing levels of drugs in the blood at which significant impairment – and therefore, risk to public safety – can be reasonably assumed, as is the case now for drink-driving".
>
> Responding to concerns from patients and healthcare professionals that people taking medicines would be banned from driving, Sir Peter stresses that this is not his intention. Instead, he highlights that although medicines can be as impairing to driving as illegal drugs, there is an important opportunity for the relevant parties to work together to improve public awareness and the driving patient's safety.[6]

In written evidence to the Transport Select Committee, submitted in September 2010, the Department for Transport set out the government's views on how it intended to proceed in the area of drug driving. This mostly concerned introducing preliminary testing devices to assess suspected drug driving and discussed the difficulties involved in ascertaining the prevalence of driving impaired by drugs.[7] In March 2011 the Secretary of State for Transport, Philip Hammond, set out how the government would proceed in these areas (see below).[8]

Legislation

In the 2012 Queen's Speech, the government announced its intention to introduce a new drug driving offence. Section 56 and Schedule 22 of the *Crime and Courts Act 2013* provides for a new specific offence of driving or being in charge of a motor vehicle with a concentration of a controlled drug above a specified limit and makes further provision for the taking of preliminary tests to determine the level of drugs in a person's blood or urine.

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5 HC Deb 3 December 2009, cc136-138WS

6 North Review press notice, ""Time to give the public what they want": North proposes crack down on drink and drug driving", 16 June 2010; the report and supporting research can be found on the North Review website

7 Transport Committee, *Drink and drug driving law* (first report of session 2010-11), HC 460, 1 December 2010, written evidence from the Department for Transport; the Coalition Agreement makes a specific commitment that the government will "switch to more effective ways of making our roads safer, including authorising 'drugalyser' technology"

8 HC Deb 21 March 2011, cc44-46WS

As set out above, it is already an offence under section 4 of the 1988 Act to drive whilst impaired by drugs (or alcohol), and the section 4 offence will remain in place alongside the new offence. Unlike the section 4 offence, the new offence will not require proof of impairment. The maximum penalty available for the new offence is 51 weeks' imprisonment and a fine of £5,000 in England and Wales; six months imprisonment and a similar fine in Scotland.

In July 2013 the Government published a consultation on Regulations that would provide for the specified limits that would apply to this offence. A zero tolerance approach was proposed for eight drugs most associated with illegal use and a 'road safety risk approach' was proposed for eight drugs most associated with medical uses. For a further controlled drug, amphetamine, a limit was not proposed in the consultation but the Government sought views on what a suitable limit might be.[9] In December 2013 the government published a further consultation on a proposed limit of 50µg/L for amphetamine.[10] These proposals were based on the report of the Expert Panel led by Dr Kim Wolff, published in March 2013.[11]

In March 2014 the government published responses to both consultations, setting out how it intended to proceed, i.e. with its preferred option to set a 'lowest accidental exposure limit' for eight controlled drugs most associated with illegal drug use and road safety risk based limits recommended by an Expert Panel for a further eight controlled drugs. These are as follows:

Drug	**Threshold limit in blood**
Benzoylecgonine	50µg/L
Clonazepam	50µg/L
Cocaine	10µg/L
Delta – 9 – Tetrahydrocannabinol (Cannabis & Cannabinol)	2µg/L
Diazepam	550µg/L
Flunitrazepam	300µg/L
Ketamine	20µg/L
Lorazepam	100µg/L
Lysergic Acid Diethylamide (LSD)	1µg/L
Methadone	500µg/L
Methylamphetamine	10µg/L
Methylenedioxymethaphetamine (MDMA – Ecstasy)	10µg/L
6-Monoacetylmorphine (6-MAM – Heroin & Morphine)	5µg/L
Morphine	80µg/L
Oxazepam	300µg/L
Temazepam	1,000µg/L

It further stated its intention to include amphetamines in regulations once it was satisfied as to the appropriate limit.[12] The limits for the 16 listed drugs were legislated for by the *Drug Driving (Specified Limits) (England and Wales) Regulations 2014* (SI 2014/2868) and came

9 DfT, *Drug driving: proposed regulations*, 9 July 2013

10 DfT, *Specifying a limit for amphetamine in Regulations for the new offence of driving with a specified controlled drug in the body above the specified limit – A Consultation Document*, December 2013

11 DfT, *Driving under the influence of drugs: report from the expert panel on drug driving*, 7 March 2013

12 DfT, *Drug Driving - Summary of Responses to the 2 Consultations*, March 2014, p9

into force on 2 March 2015.[13] There were reports that at least one police force will not enforce the new law: Chief Inspector Mark Dexley of Greater Manchester Police said:

> We have taken the decision, in GMP, not to make use of the legislation while we satisfy ourselves that the legal and procedural issues involved in prosecuting these cases can properly withstand legal scrutiny. This will be a temporary delay whilst we ensure our equipment has the right certification and our officers have the right training and understand the required procedures. We are mindful that if we get this wrong then a significant amount of court time and public money could be wasted.[14]

The proposed 50µg/L limit for amphetamines has been increased to 250µg/L. This will be provided for by the *Drug Driving (Specified Limits) (England and Wales) (Amendment) Regulations 2015*, currently in draft, and due to be debated in the House of Commons on 16 March. In its explanatory memorandum to the draft regulations the government explains its decision to increase the limit and not to submit it for further public consultation:

> The Government recognised that there was some concern from specialists in the treatment of Attention Deficit Hyperactivity Disorder (ADHD) on specifying a limit of 50µg/L and made a commitment to reconsider the limit in the light of those concerns and to re-consult at a later date. The Government informally consulted with the medical community, particularly those specialising in the treatment of ADHD based at Kings College London, regarding what amphetamine blood concentration levels would typically result from legitimate medicinal usage and based on that advice has concluded that a limit of 250µg/L as a limit that would not discourage ADHD sufferers from seeking treatment. The Government also consulted with the Secretary of State's Honorary Advisory Panel on Alcohol, Drugs and Substance Misuse regarding the amphetamine blood concentration levels that would typically result from substance misuse. The Advisory Panel, quoted analysis of 2,995 blood samples taken between 2008 and 2012 from across the UK in suspected drug drive cases showing median and average concentrations of amphetamine were 270µg/L and 456µg/L respectively.
>
> The Government has, therefore, concluded from its consultation with the above ADHD specialists and the Advisory Panel that the level of 250µg/L is one that would successfully balance the legitimate use of amphetamine for medical purposes against its abuse by those who kill and injure on the road as a result of taking amphetamine. In September 2014 the Government indicated that it intended to re-consult on a limit for amphetamine. However, given the extensive discussions that it has held with medical stakeholders it now takes the view that it has had a sufficient opportunity to consider the views of all of the relevant parties and that conducting a third formal consultations on a limit for amphetamine is no longer appropriate or necessary.[15]

More general concern about the impact of the new law on those taking **prescription medication** is provided in section 2.3, below.

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13 the regulations were debated and approved by both Houses of Parliament; see: HL Deb 24 July 2014, cc503-9GC and HC DL8 Deb 10 September 2014

14 "Manchester police will not charge suspects under new drug-drive law", *The Guardian*, 2 March 2015

15 EM to the draft *Drug Driving (Specified Limits) (England and Wales) (Amendment) Regulations 2015*, section 8 (page 3)

2 Evidential issues

2.1 Roadside testing

The police have the power, introduced by Schedule 7 of the *Railways and Transport Safety Act 2003*, to conduct roadside drug tests. Guidance was issued in December 2004 on the conduct of the preliminary impairment tests.[16] The police may ask drivers they suspect are under the influence of drugs to perform a series of physical tests, usually at the roadside, such as walking along a straight line, touching the tip of their noses with their finger, and standing on one leg. The police also examine drivers' pupils to see if they are dilated while checking for slurred speech and poor co-ordination. If the police officer is not satisfied the suspect is taken to a police station and a blood test undertaken.[17] The problem with these tests is that they are subjective and not scientific compared with breathalysers, but the police still feel that they are successful in identifying those who have been taking drugs. Moreover, the law does not make a distinction between illegal or misused drugs and over-the-counter prescription drugs taken as directed by a GP or other medical practitioner.

For these reasons, there were often problems associated with prosecuting those who drove under the influence of drugs. In practice, the police have preferred to use the *Misuse of Drugs Act 1971*, as amended, if they stop a person whom they suspect of taking drugs. Section 5(1) of the Act makes it unlawful to possess a controlled drug unless authorised by regulations under section 7. It may more often be the case that drivers thought to be unfit to drive and found with drugs in the vehicle would be prosecuted for possession of drugs and not for driving while unfit. However, problems may arise with the prosecution of a driver found in possession on the basis of a positive blood or urine sample due to the fact that once drugs have been consumed their character is altered and the person consuming the drug(s) is no longer considered to be in possession.[18] The same problem was highlighted in the review of evidence prepared for the North Review (see above):

> The complex nature of drug pharmacodynamics and pharmacokinetics[19] makes it difficult to establish values that would represent impairment in the general population.
>
> The main challenges in determining suitable cut-offs include: individual variations, drug tolerance, interactions with other drugs, and the variable effects of the same blood concentrations of drugs depending on whether the concentration is rising or falling.
>
> One review of the evidence for levels of cannabis related to impairment has suggested a cut-off for THC in whole blood of between 3.5–5 ng/ml, although a population-based study in France suggests that impairment is evident at lower levels (above 1 ng/ml).
>
> Attempts to develop comparable levels for amphetamines, however, have found greater variation in the association between blood concentrations and tests of impairment and thus recommend that per se cut-offs are inappropriate for this drug group.
>
> Tolerance issues and interactions with other drugs suggest that identifying suitable cut-off values for other drugs may also be inappropriate.

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16 DfT press notice, "Tougher Measure to Target Drug Drivers", 22 December 2004

17 for a discussion of impairment tests, see: Tunbridge, R., Keigan, M. and James, F., *Recognising drug use and drug related impairment at the roadside* (TRL Report 464), 2000

18 Criminal Law Library, *Bucknall and Ghodse on Misuse of Drugs* (2nd ed); the Divisional Court held this in regard of traces of amphetamine detected in a urine sample in *Hambleton v. Callinan* [1968] 2 Q.B. 427

> Within Europe, a variety of drug driving policies has been adopted by the different countries, ranging from zero tolerance per se limits (e.g. Sweden) to proof of impairment (e.g. current UK laws), each with subtle variations.
>
> A zero tolerance approach overcomes the difficulties associated with: a) proving impairment; and b) deciding on scientifically valid cut-offs from conflicting sources of data. However, zero limit per se laws also have the potential to penalise drivers who are not impaired and pose no risk to safety.
>
> Studies of the effectiveness of Sweden's zero tolerance laws have found them to have been unsuccessful in deterring DUID re-offenders.
>
> Further research into the correlations between blood concentrations of certain drugs and impairment may help to move toward developing suitable cut-offs (like those developed over time for alcohol). However, 'before' and 'after' studies of newly introduced laws to evaluate the performance of these various approaches in practice may be more useful.[20]

In March 2011 the Government published its response to the North Review, which included a commitment to:

> ... examine the case for a new specific drug driving offence – alongside the existing one – which would remove the need for the police to prove impairment on a case-by-case basis where a specified drug has been detected.[21]

Over the past few years Christopher Chope MP has put down successive Private Members' Bills designed to make provision for roadside testing for illegal drugs. Most recently, his Bill on the above in the 2010-12 session was debated on 10 June 2011.[22]

As set out below, the first mobile drug testing device was approved for use in January 2015.

2.2 Drug screening devices

For over a decade now, the Home Office was been developing a type approval specification for a drug screening device ('drugalyser') that would help police at the roadside to detect the presence of drugs. A Metropolitan Police trial took place between January 2001 and 2002. This had some success but was hampered by the fact that testing had to be voluntary.[23] In its February 2007 review of road safety the Labour Government stated that the first devices developed to specification could be available by the end of 2007 and that the Home Office was also developing a prototype device that could both screen and analyse samples. This was likely to be ready in two to three years.[24] In February 2008 the Minister told the House of Commons that:

> The HO Scientific Development Branch (HOSDB), in consultation with the Department for Transport, continues to discuss possible improvements to the field impairment test

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19 put simply, pharmacodynamics explores what a drug does to the body, whereas pharmacokinetics explores what the body does to a drug

20 DfT, *A Review of Evidence Related to Drug Driving in the UK: A Report Submitted to the North Review Team*, June 2010, pp13-14

21 DfT press notice, "Government crackdown on drink and drug driving", 21 March 2011; the full response is available at: DfT, *The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving*, Cm 8050, March 2011

22 *Drugs (Roadside Testing) Bill 2010-12*; and HC Deb 6 June 2011, cc400-49

23 reported by Angela Watkinson MP in a debate on roadside testing, see: HC Deb 14 January 2004, c266WH

24 DfT, *Tomorrow's Roads – safer for everyone: The second three-year review*, February 2007, paras 168-169

> currently used by the police [...] HOSDB continues to investigate a possible impairment measuring device through established contacts working in this area. Opportunities for partnership with a suitable university or other outside agency continue to be sought.[25]

The Times subsequently reported that the Home Office was "preparing to approve" handheld drug screening devices and that "Philips … announced yesterday that it will start deliveries to police next year [i.e. 2009] of a machine that detects five different drug groups, including cocaine, heroin and cannabis, in just 90 seconds from a single saliva sample".[26] However, no type approval has yet been given. The North review reported on the problems as follows:

> [T]o date a type-approval specification for such a device has not been produced. Consequently, while a range of commercial drug screening devices is available, none is suitable for enforcement purposes in the UK.
>
> Home Office Scientific Development Branch has been working on the development of a roadside screening device based on surface-enhanced Raman spectroscopy (SERS) over the last 10 years, both in house and externally. A SERS based device would be a considerable advance over existing commercially available devices in that it would be capable of identifying any drug.
>
> Following an expert peer review in 2008, the in-house development by HOSDB of the SERS substrates required for such a device was halted and the emphasis placed on developing external technologies, including those based on SERS. Following two calls for research initiated at the start of 2009, two external research contracts were placed, with the aim of developing prototype devices within the next three years.
>
> With regard to drug screening devices for use at the roadside, the preferred matrix for analysis is oral fluid, which is easy and convenient to collect, and any drugs detected in this medium are indicative of recent use.
>
> Early trials of roadside drug screening devices based on oral fluid (ROSITA, ROSITA 2) concluded that none of the devices tested at that time was suitable for use in enforcement at the roadside. However, recent evaluations of drug screening devices have highlighted continued improvements in sensitivity and the general performance of oral fluid drug testing devices, but also that the reliable detection of cannabinoid use and benzodiazepines still remains problematic.
>
> DRUID (DRiving Under the Influence of Drugs, Alcohol and Medicines), a project funded by the European Commission, includes an analytical evaluation of several on-site oral fluid screeners. The final report is still in production but early results suggest that:
>
> Police evaluations of the devices tested were broadly positive;
>
> Eight out of the 13 evaluated devices were rated as ''promising'' and were subsequently included in a scientific evaluation focusing on sensitivity and specificity;
>
> Research papers in press have reported on the evaluations of four of these devices. While one device was considered unsuitable, three devices demonstrated excellent sensitivity for amphetamine/MDMA and moderate sensitivity for the detection of cocaine and cannabis. A newer version of one of the devices using 'new generation' oral fluid screening tests demonstrated improved sensitivity (93%) for THC.

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[25] HC Deb 19 February 2008, cc581-582W

[26] "Hidden danger of drugs taken weeks ago", *The Times*, 21 November 2008

> A recent evaluation of the zero tolerance approach adopted in parts of Australia is particularly informative. A report on the first 12 months of the new law in Western Australia reveals that during this period 9,716 roadside tests were conducted. Of these, 517 tested positive for one or more proscribed drug (5.3%).
>
> The results suggest that a 'zero tolerance' policy utilising roadside screening devices has distinct advantages over the UK's impairment-based approach. Specifically, the process is simple, straightforward, quick to administer and unambiguous.
>
> Drug Impaired Driving (DID) legislation (which is akin to our own impairment-based approach) was introduced in conjunction with the ROFT (Roadside Oral Fluid Testing) procedures. However, DID appears to have been largely ignored as an anti-drug-drive measure, in favour of the ROFT approach: during the study period only five drivers were charged with DID.
>
> Police officers appeared to be more comfortable with administering the ROFT rather than trying to demonstrate impairment in order to secure a conviction for DID.
>
> The Australian experience suggests that, were the UK to move to a zero tolerance system, one effect would be that police officers would be less likely to pursue a case for Driving Under the Influence of Drugs (section 4 of the Road Traffic Act 1988).[27]

In its March 2011 response to the North Review the government stated its intention to take decisions on type-approval by the end of June.[28] However, this was again delayed. In the House on 6 June 2011 the Home Office Minister, James Brokenshire, said:

> Six devices are going through field trials and detailed laboratory tests are also necessary. Timing of approval depends on device performance, manufacturer's reaction, and how quickly it is able to sign the agreement required with the Home Office before the Secretary of State signs the approval order. Purchase and deployment of the devices would then be matters for local police decision. We are pressing hard to see that by the end of this year. That then feeds through to the next step, which is the roadside testing, and our advisers are finalising the additional environmental requirement that devices would have to meet for use at the roadside.[29]

There were reports in June 2012 that manufacturers had been asked to submit devices to the government for approval, with the aim of having testing machines in police stations in 2013 and available for use at the roadside sometime in 2014.[30] Reports in January 2013 indicated that the first drugalyser had been given approval by the Home Office.[31]

In January 2015 the government formally announced the type approval of the first mobile drug testing device: the Securetec DrugWipe 3S device known as 'Drugwipe' is the first portable device that can detect the presence of cannabis and cocaine:

> Drugwipe is a disposable detection device that works by analysing a small quantity of saliva. The results are indicated by the appearance of lines on the device (similar to a pregnancy test) within eight minutes of starting the test. Following a positive reading,

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27 op cit, *A Review of Evidence Related to Drug Driving in the UK: A Report Submitted to the North Review Team,* pp12-13

28 op cit., "Government crackdown on drink and drug driving"

29 HC Deb 6 June 2011, c445

30 e.g. "Drug testing machines in police stations by 2013", *The Daily Telegraph*, 1 June 2012

31 "'Drugalyser' test is ready for police use", *The Times*, 5 January 2013

> the police will take the individual to the police station for a blood sample, which will be used in any subsequent prosecution.
>
> […] This groundbreaking new device will allow the police to more quickly identify those drivers potentially under the influence of cocaine or cannabis and enable the taking of an evidential blood test without the need for a doctor's authorisation.
>
> […] The mobile device is now available to forces for purchase and builds on the existing capability to screen for drug drivers in police stations using the Draeger Drug Test 5000, which was type approved for detection of cannabis in December 2012.[32]

2.3 Medicinal drugs

General

The individual driver is responsible for ensuring he does not commit an offence by driving when under the influence of drugs. Doctors have a responsibility to advise their patients of the dangers of side-effects of any medication. The DVLA issues advice to GPs about possible effects of a variety of drugs and GPs are advised to assume that the majority of adult patients are either actual or potential drivers. The Medical Commission on Accident Prevention publishes a booklet, available to all medical practitioners, setting out current views upon the commoner conditions that affect fitness for safe driving. *Medical Aspects of Fitness to Drive* contains chapters on both prescribed and illicit medicines and driving. Various suggestions are given as to advice that should be offered to patients, such as not driving until any side effects are known, not driving if feel unwell, not combining alcohol with drugs, and a warning that stimulant and euphoria producing drugs may lead to unnecessary risks being taken. A review on the effects of over-the-counter medicines and the associated potential for unwanted sleepiness was published in January 2004.[33]

The DVLA issues *At a glance: guide to the current medical standards of fitness to drive*, which contains sections on driving when taking medication for psychiatric and cardiovascular disorders.[34] Specific illnesses such as epilepsy and diabetes are also covered.

The North Review also addressed the question of medicinal drugs. On their potential impact on drivers, the review said:

> While cannabis remains the most commonly used drug associated with driving impairment, there are various medicines which have been detected in suspected driver impairment (although not necessarily associated with increased crash risk). The medicines most frequently implicated are benzodiazepines (e.g. 'Valium', temazepam), sedative hypnotics (e.g. zopiclone, zolpidem), first generation antidepressants (e.g. amitriptyline), antihistamines (e.g. chlorpheniramine), muscle relaxants (e.g. carisoprodol) and narcotic analgesics (e.g. codeine, morphine, tramadol and methadone).
>
> It should be noted that abuse or misuse of therapeutic drugs or 'medicines' can produce significant impairment and adverse effects. The Medicines and Healthcare Products Regulatory Agency (MHRA) highlighted in its evidence to the Review that

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[32] Home Office press notice, "Policing Minister urges police forces to take up new mobile drug testing device", 15 January 2015

[33] DfT, *Over-the-counter medicines and the potential for unwanted sleepiness* (Road Safety Research Report No. 24), 22 January 2004

[34] DVLA, *At a glance guide to the medical standards of fitness to drive*, November 2014

> there is an increasing trend of buying prescription only medicines over the Internet. It is likely that a proportion of medicines bought in this way may be misused.
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> [...]
>
> However, despite evidence of impaired driving, the evidence regarding the role of medicines in road crashes remains unclear, mainly due to the lack of adequately large and robust research studies. A recent OECD review of the international literature on the effect of psychoactive substances used as medicines (including anticonvulsants, antidepressants, antipsychotics and sedatives) has concluded that there is currently insufficient evidence to determine the extent to which these psychoactive substances are associated with an increased crash risk.[35]

In its March 2011 response to the North Review the Government stated its intention to:

> ... allow custody nurses to advise the police whether or not a suspected driver has a condition that may be due to a drug. This will remove the need to call out police doctors and so speed up the testing process – ensuring that drug drivers do not escape punishment because a doctor is not available and also freeing up police time.[36]

Interaction with the 'drug drive limit' from March 2015

In its July 2013 consultation on what became the 2014 Regulations the government set out the 'medical defence' that applies under section 5A(3) of the new drug driving offence:

> The new offence in section 5A of the 1988 Act contains a medical defence. This applies where the specified controlled drug, which the person has taken was prescribed or supplied for medical or dental purposes; where the accused person took the drug in accordance with any directions given by the healthcare professional who prescribed or supplied it, or with any accompanying instructions given by the manufacturer (to the extent that these were consistent with the advice of the healthcare professional); and provided that the accused person's possession of the drug was not unlawful under section 5(1) of the Misuse of Drugs Act 1971.
>
> The defence places an evidential burden on a person accused of committing the offence. This means that the accused person must simply put forward enough evidence to "raise an issue" regarding the defence that is worth consideration by the court. It is then for the prosecution to prove beyond reasonable doubt that the defence cannot be relied upon.[37]

Advice on the Gov.uk website states:

> It's illegal in England and Wales to drive with legal drugs in your blood if it impairs your driving.
>
> It's an offence to drive if you have over the specified limits of certain drugs in your blood and you haven't been prescribed them.
>
> Talk to your doctor about whether you should drive if you've been prescribed any of the following drugs:
>
> - clonazepam

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35 North Review, *Report of the Review of Drink and Drug Driving Law*, June 2010, paras 6.44-6.47

36 op cit., "Government crackdown on drink and drug driving"

37 op cit., *Drug driving: proposed regulations*, p13

- diazepam
- flunitrazepam
- lorazepam
- methadone
- morphine or opiate and opioid-based drugs
- oxazepam
- temazepam

You can drive after taking these drugs if:

- you've been prescribed them and followed advice on how to take them by a healthcare professional
- they aren't causing you to be unfit to drive even if you're above the specified limits[38]

In effect, this means that if you are stopped and screened and found to be over the limit, you will have to go to court and present your medical defence. The prosecutor will have to prove beyond reasonable doubt that the defence cannot be relied upon.

In July 2014 the government issued new guidance to medical professionals to assist them in explaining the changes to the drug driving offence and what it means for patients. The guidance also advises patients who take legitimately supplied medicines to keep evidence with them in case they are stopped by police: "this will help speed up any investigation into the medical defence and reduce the inconvenience to the patient".[39]

This issue came up a lot as the 2013 Act was going through Parliament.

For example, at Committee stage in the House of Lords, Baroness Meacher put down a series of amendments which, taken together, would have the effect of relating the proposed offence to the risk associated with particular drugs, rather than their legality, and to ensure that people taking prescription medication were not unfairly caught by the law. She explained:

> The purpose of my amendments is to ensure that young people are not criminalised unless any drugs in their system really are causing impairment while they are driving. ... there are several reasons why a driver may have a drug in their system but be entirely safe behind the driving wheel. One of my main concerns is that a very substantial minority of young people, as we know, take herbal cannabis. That is a relatively harmless thing to do [...] The distinction between controlled and uncontrolled drugs is not evidence-based. Alcohol and tobacco, as we know, are far more dangerous than some drugs that are controlled under the Misuse of Drugs Act. Any evidence-based legislation - which I understand this is designed to be-should not reference the outdated and discredited Misuse of Drugs Act. [...]

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38 Gov.uk, *Drugs and driving: the law*, 2 March 2015

39 DfT, *Guidance for healthcare professionals on drug driving*, 3 July 2014

> My second point is that a number of the so-called legal highs, or new psychoactive substances, are the drugs that may prove far more of a risk to drivers. Of course, these are controlled through temporary bans, but as Ministers and everybody else know, as soon as one of these drugs is controlled, the creators of these substances get back into their labs and create some new ones by changing a few molecules, and for a while those substances will be legal. There is, therefore, no rationale for limiting this legislation to controlled drugs, because drugs that are not controlled cause just as many problems, if not more.
>
> [There should also be] a good reason for police involvement, either that the police are responding to a road accident, or that the roadside evidence suggests that the driver is impaired and that this may be due to alcohol or a drug in their system [...] I am concerned that the legislation could cause the inappropriate arrest and charging of patients prescribed medications for chronic pain and other long-term conditions.[40]

At Report Stage the baroness proposed a slightly different amendment to replace the word 'controlled' with 'psychoactive', in effect to achieve the same effect as her earlier amendment in Committee.[41] Baroness Smith also sought assurances, on behalf of the Opposition, that the new law would not result in action being taken against those on prescribed medication, unless it was clear that their driving was impaired.[42] The Minister, Earl Attlee, replied to the concerns as follows:

> First, I emphasise that any passengers would not be screened for drugs following a vehicle being stopped by the police and the driver being tested for drugs [...]
>
> The Government expect roadside drug test equipment to be available in 2014, when we anticipate bringing the new offence into force. We would expect breath tests to be conducted first, as they are quicker and easier. We cannot speculate on how many tests would be taken, as that is an operational matter for the police.
>
> [...] Focusing on controlled drugs limits the scope of the offence to a specific category of drugs. This category of drugs is considered to be sufficiently harmful to warrant restricting its availability under the Misuse of Drugs Act 1971. Within the category, the Government will set limits only for drugs which are known to affect road safety.
>
> [...] A police officer may only require a person to co-operate with a preliminary drugs test in certain circumstances. Preliminary testing can be required only if the officer suspects that a driver is under the influence of a drug or has a drug in his body; if the driver has committed a moving traffic offence; or if the driver has been involved in a road traffic accident.
>
> [...] As we have heard, a number of noble Lords are concerned about the impact which this legislation could have on patients taking prescription medication and have tabled Amendments 118GA, 118H, 118J, 118K and 118L to address this issue. It is to no one's benefit for drivers who are innocent of any wrongdoing to be arrested. The new offence is intended to target those who drive after taking illicit drugs or prescription drugs which are being misused and therefore give rise to road safety risks. The Government have therefore included a defence so that a person who has taken their medication in accordance with medical advice would not be guilty of an offence.

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40 HL Deb 4 July 2012, cc767-8GC
41 HL Deb 12 December 2012, c1105
42 ibid., c1112

> The noble Baroness, Lady Smith, asked me what happens if the doctor's advice conflicts with the advice on the leaflet supplied with the drugs. Proposed new Section 5A(3)(b) says:
>
> "so far as consistent with ... directions".
>
> A doctor's instructions therefore take precedence over the patient information leaflet, so the doctor trumps the leaflet.
>
> [...] The medical defence places what is known as an "evidential" burden on a person accused of committing the offence. This means that the accused person must simply put forward enough evidence to "raise an issue" regarding the defence that is worth consideration by the court, following which it is for the prosecution to prove beyond reasonable doubt that the defence cannot be relied on [...] Another point to note is that the Code for Crown Prosecutors specifically states that prosecutors "should swiftly stop cases" ... Furthermore, the Government expect that the courts will take a sensible approach to the operation of the new offence. For example, a defendant seeking to rely on the medical defence may be afforded more or less leeway depending on the facts of a particular case, such as the nature of the medical advice provided, including the wording of any leaflet accompanying the medicine.[43]

At Second Reading in the Commons, the Home Secretary, Theresa May, introduced the proposed new offence as one which would contribute to road safety and support the government's "zero-tolerance approach on illicit drugs".[44] However, Mrs May did acknowledge the concerns that had been raised in the Lords about the possible impact of the new offence on those who take controlled drugs on prescription. She said: "we have no intention of preventing people from driving where they are taking medication in accordance with medical advice, so the Bill includes provision for a medical defence".[45]

In Committee the Opposition tabled four amendments. David Hanson, speaking for the Opposition, stated that amendments 5, 6 and 7 were designed to achieve the following:

> The amendments taken together were to delete the proposal in the Bill that once charged with drunk driving, the onus is on the defendant to prove that the exact instructions from the manufacturer were followed. Under amendments 5, 6 and 7, the onus instead is on the prosecution to prove beyond reasonable doubt that the defendant knowingly took the drugs in a way that the manufacturer did not intend. One of the concerns put to us very strongly—this should not be a strange argument to the Minister, because it was raised in another place—is the argument that some of the drugs that potentially fall under clause 37 could be drugs that are taken for a cold, flu or other illnesses, or else standard drugs which could change, once taken, and impact upon any drug test downstream.[46]

The Minister, Jeremy Browne, replied that the Government "fully accept that the concerns [about prescription drugs] are legitimate", and sought to reassure the Committee that: "the medical defence itself provides considerable protection to those taking properly prescribed or supplied medical drugs" because it:

> ... places what is known as an evidential burden on a person accused of committing the offence. In practice, that means that the accused person must simply put forward

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43 ibid., cc1112-7
44 HC Deb 14 January 2013, cc640-41
45 ibid., c642
46 PBC Deb 7 February 2013, c375

> enough evidence to raise an issue regarding the defence that is worth consideration by the court, following which it is for the prosecution to prove beyond reasonable doubt that the defence cannot be relied on. In other words, if somebody were to bring forward a prescription, that would be sufficient, unless it could be proven by the other side that they had behaved improperly.[47]

He also made the point that there was a self-evident protection where those taking legal drugs did not drive in a manner which would bring them to the attention of the police. He said:

> ... in most cases those on prescribed medicine containing specified controlled drugs would only come to notice—this relates to the point made by the hon. Member for Dover—if their driving was impaired or for some other reason requiring police action. It is important that the Committee appreciates that the police can only stop and question an individual driver in very particular circumstances, such as when they have been involved in an accident. People who are taking their medication appropriately and driving safely would no more expect to be stopped under this legislation than they are today.[48]

Mr Hanson withdrew his amendments.

3 Road safety strategies

The Conservative-Liberal Democrat Coalition Government published its strategic framework for road safety in May 2011. On drug driving, it stated:

> On drink and drug driving our priority is to deter driving when unfit through drugs or alcohol, and to ensure that those who persist in this dangerous behaviour are detected and punished effectively. Considerable progress has been made in the abatement of drink-driving, but we now aim to achieve similar results with drivers who are impaired through the use of drugs. The prospect of an effective means of detecting and deterring drug-driving will – for the first time – allow a serious enforcement effort against this dangerous behaviour. That is our first priority, which we believe is shared by the police.
>
> It can be just as dangerous for people to drive impaired by alcohol or drugs, and it is currently unbalanced that it is easier to get away with one than the other. We want to give the police the means to identify drug-drivers and allow them to request evidential samples for testing. There needs to be a clear message that drug-drivers are as likely to be caught and punished as drink-drivers.
>
> Our strategy is to focus resources and any legislative changes on measures which will have the most impact in reducing dangerous behaviours. There are therefore two main priorities to continue the successful abatement of drink-driving and achieve similar success against drug-driving;
>
> - To give the police effective tools to identify and proceed against drug-drivers;
> - To streamline the enforcement process for drink and drug driving to relieve pressure on police and other enforcement resources, and enable these to be targeted better.

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47 ibid., c378
48 ibid., cc380-81

> We have issued a specification to manufacturers for drug testing technology that will be able to be used in police stations. It is for manufacturers to supply, and police forces to obtain, approved devices and put them to use. We are also finalising the additional requirements for type approving such devices for use at the roadside.
>
> We will explore the case for introducing an offence of having a specified drug in the body while driving in addition to the current offence of driving while impaired by drugs. An objective measure of whether a drug driving offence has been committed should deliver a significant improvement in the enforcement of drug driving.
>
> This is a complex issue and so we will continue the research and other work that is necessary before any decisions can be made. We cannot at this stage pre-empt that work by describing any additional offence, or give a firm date for its potential introduction. Any proposals will be subject to further consultation, regulatory clearance and other impact assessments in the usual way.[49]

The Labour Government published its road safety strategy, *Tomorrow's roads - safer for everyone,* in March 2000, which included a section on driving under the influence of drink and drugs. On drug-driving, it promised action in the following areas:

- to improve the way drug-driving is identified so that existing laws can be enforced more effectively;
- to develop equipment for screening drivers for drugs at the roadside;
- to introduce improved training for police officers, in techniques for recognising and testing drivers who may have taken drugs, and in tests of co-ordination to help assess whether a driver's behaviour is impaired by drugs;
- to allow the police to undertake tests of co-ordination and, when suitable equipment is available, to require suspected drivers to give samples for screening;
- to undertake research to identify the prevalence of drugs among drivers; to examine the nature of the effects which different drugs have on driving behaviour; and to devise techniques to address the problem by enforcing the law;
- to produce targeted public information advertising to highlight the risks of driving under the influence of drugs;
- to ensure that where a prescription medicine is likely to affect a patient's ability to drive, this information will appear in the patient information leaflet;
- to agree a European-wide symbol on the labelling of medicines known to affect driving;
- to strengthen penalties and enforcement in the drug field to reflect the changes proposed in relation to alcohol, including higher penalties and longer disqualification for high risk offenders, requirements to re-take the test following disqualification, targeted enforcement and extended rehabilitation options.[50]

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[49] DfT, *Strategic Framework for Road Safety*, 11 May 2011, paras 5.6-5.11

[50] DETR, *Tomorrow's roads: safer for everyone*, March 2000, paras 4.26-4.37

The first three-year review of the road safety strategy was published in April 2004. It highlighted some of the research that the Department and the Scottish Executive had sponsored and stated that by 2010 the government expected to see the development of devices to screen for the presence of drugs in a driver and to test for impairment.[51]

The second three-year review of the road safety strategy was published in February 2007. This stated that publicity and education about illegal drug driving was being channelled towards specific target groups most at risk and, to date, had proved effective in raising awareness of the issue and were "seen by the target audience as an appropriate intervention". It stated that it would increase the budget spent on the drug campaign in 2007 to target more venues.[52] It also pledged to begin a consultation process to establish whether the current process of police enforcement for drug impairment could be made more effective.[53]

In the event, Labour did not publish a further road safety strategy before the 2010 General Election.

4 Further reading: research reports

A summary of recent literature is provided in A Review of Evidence Related to Drug Driving in the UK: A Report Submitted to the North Review Team, produced for the North Review in June 2010.

Publicity was probably first given to the problems of driving under the influence of drugs, particularly licit drugs, by a report published in April 1995.[54] In comparison with research into drink-driving, there was little real understanding of the effects of drugs on driving ability or the levels at which drug taking - particularly of legal prescription or 'over the counter' drugs - become unacceptable. Other reports and work have followed.

A three year research programme initiated by the Department of Transport, the Home Office, the Coroners Society and the Association of Chief Police Officers aimed to establish systematically the instance of drug use among fatal road casualties, not just illicit drugs but also those that are prescribed and those sold over the counter. Interim results were released in February 1998 and were included in the road safety White Paper published in March 2000:

> Studies have shown that compared with ten years ago, five times as many people killed in road accidents had a trace of an illegal drug in their body. Cannabis was by far the most common illegal substance found. However, whilst it is likely that shortly after use the active ingredient of cannabis impairs driving, traces of the drug can remain in the body for up to four weeks, long after it has ceased to have any effect. This can present difficulties for enforcement until we have further research findings.
>
> Class A drugs are most likely to have an adverse effect on driving. According to interim survey results, they were found in 6% of cases (compared with 12% for cannabis). This was a small increase compared with 10 years ago.

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51 DfT, *Tomorrow's Roads – safer for everyone: The first three-year review*, April 2004, paras 127-129 and para 132

52 DfT, *Tomorrow's Roads – safer for everyone: The second three-year review*, February 2007, para 167

53 ibid., para 169

54 Institute of Human Psychopharmacology, *Drugs other than alcohol and driving in the European Union*, April 1995

> In the studies of road accident fatalities referred to above, it was found that there had been no change in the incidence of medicinal drugs over the period. There is scope, nevertheless, to improve enforcement and to make people more aware of the risks of driving while their ability is affected by drugs. [55]

The RAC surveyed a group of young drivers and found young people are twice as likely to have been driven by someone who had taken illegal drugs as by someone over the drink-drive limit.[56]

A Transport Research Laboratory (TRL) report into the effects of cannabis on driving was published in December 2000.[57] This found there were measurable effects on driver performance and that drivers can be impaired. A report on the effects of cannabis and alcohol was published in 2002.[58] This confirmed the earlier observations and judged that the general medical examination and standardised impairment testing applied by police surgeons was generally effective in determining impairment.

There have been several other small-scale qualitative and quantitative studies that have examined patterns of recreational drug use and driving. The Scottish Executive undertook a study, published in 2001, to examine aspects of driving while under the influence of recreational drugs.[59] The study identified general patterns of personal drug use. Three per cent of toll bridge survey respondents aged 40 and over and thirteen per cent of those aged 17 to 39 had taken an illegal drug in the previous twelve months. In the dance survey, 76 per cent of respondents had taken illegal drugs in the previous month. Drug-driving was particularly evident among those attending nightclubs, much more so than among the general population (in this instance, the toll bridge sample). Eighty-five per cent of clubbers had driven on at least one occasion after taking illegal drugs. Thirty-seven per cent reported that they *currently* drove after taking illegal drugs on at least a weekly basis, most of whom (89 per cent) were cannabis users. However while drug-driving appeared to be widespread among the sample of clubbers interviewed, drug-driving was not identified as widespread among the general population.

In 2001 TRL published a study to measure the incidence of drugs in fatal road accident casualties.[60] An earlier study published in 1989 had found that the incidence of medicinal drugs (5.5 per cent) and illegal drugs (three per cent) was relatively low in comparison to alcohol (35 per cent).[61] However the 2001 study, based on results collected between 1996 and 2000, found that the incidence of medicinal and illegal drugs in the blood samples of road traffic fatalities was three times higher than in the previous study (24 per cent) while the incidence of alcohol had fallen slightly (31 per cent).

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55 op cit., *Tomorrow's roads: safer for everyone*, paras 4.23-4.25

56 RAC press notice, "Drug driving as big a problem as drink driving", 26 January 2000

57 TRL, *The influence of cannabis on driving* (TRL report 477), 2000

58 TRL, *The influence of cannabis and alcohol on driving* (TRL report 543), 2002

59 Neale, J., McKeganey, N., Hay, G. and Oliver J. For the Scottish Executive, *Recreational Drug Use and Driving: A Qualitative Study*, 2001

60 TRL, *The incidence of drugs and alcohol in road accident fatalities* (TRL Report 495), 2001

61 Everest, J., Tunbridge, R. and Widdop, B., *The incidence of drugs in road accident fatalities* (Research Report RR202), 1989

The ESRC-sponsored research led by Dr Phillip Terry.[62] He found that 52 per cent of those surveyed had driven while under the influence of cannabis and of these more than 70 per cent believed it had impaired their driving.

In December 2005 the BMJ published an extract of a paper by Bernard Laumon, Blandine Gadegbeku, Jean-Louis Martin, and Marie-Berthe Biecheler on cannabis intoxication and fatal road crashes in France (based on a sample of 10,748 drivers, with known drug and alcohol concentrations, who were involved in fatal crashes in France). The paper found that of the drivers studied, seven per cent tested positive for drugs and 21.4 per cent for alcohol, including 2.9 per cent for both. Men were more often involved in crashes than women, and were also more often positive for both cannabis and alcohol, as were the youngest drivers, and users of mopeds and motorcycles. Positive detection was more commonly associated with night-time crashes.[63]

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62 ERSC, *Indirect harm from regular cannabis use,* January 2004

63 BMJ, *Cannabis intoxication and fatal road crashes in France: population based case-control study*, December 2005