



Department  
for Transport

# 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

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

December 2013

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# Executive summary

1. The Review of Drink and Drug Driving Law by Sir Peter North, published in June 2010, concluded that there was “a significant drug driving problem” with an estimated 200 drug driving-related deaths a year in Great Britain. However, in 2011, around 41% of the prosecutions in magistrates’ courts for driving whilst impaired through drugs were withdrawn or dismissed. The comparable figure for exceeding the drink drive limit is just 3%.
2. Drug driving remains a primary concern for the public with 34% of people agreeing that drug driving is in the top three road safety issues most important to address<sup>1</sup>.
3. This is why the Government included in a Bill in May 2012 a new offence of driving with a specified controlled drug in the body above the specified limit for that drug<sup>2</sup>. The Bill, which is now the Crime and Courts Act 2013 (<http://www.legislation.gov.uk/ukpga/2013/22/contents/enacted>), received Royal Assent on 25 April 2013. Section 56 of the Crime and Courts Act 2013 inserted a new section 5A into the Road Traffic Act 1988. Section 5A(8) includes a regulation-making power, exercisable by the Secretary of State in relation to England and Wales and by Scottish Ministers in relation to Scotland, to specify the controlled drugs to be covered by the new offence and the corresponding limit for each.
4. A previous consultation that ran from 9 July 2013 to 17 September proposed 17 controlled drugs including amphetamine to be specified in regulations. It also proposed limits to be specified in the regulations for 16 of those controlled drugs but asked what a suitable limit might be for amphetamine. We have now considered those responses and further evidence and propose a limit of 50µg/L for amphetamine.

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<sup>1</sup> TNS British Market Research Bureau 2011

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

5. The previous consultation was extended to Scotland at the request of the Scottish Government but this consultation only relates to the proposed limit for amphetamine for England and Wales. The Scottish Government has informed us that they intend to consult on a proposed limit for amphetamine early in 2014. Any final policy proposal on the specific issue of drug driving in Scotland will be for the Scottish Government and will be taken within the wider context of Scotland's national drugs strategy.
6. The cost and benefit analysis set out in the impact assessment of the earlier consultation still applies and relates to England and Wales and is available at [www.gov.uk/government/consultations/drug-driving-proposed-regulations](http://www.gov.uk/government/consultations/drug-driving-proposed-regulations).
7. In spring 2012 the Department for Transport asked a panel of medical and scientific experts to provide advice on what controlled drugs impair driving and what limits (as a concentration in blood) should be specified for each. The Expert Panel produced their final report '*Driving Under the Influence of Drugs*', which we published on 7 March 2013<sup>3</sup>. The panel proposed a limit of 600µg/L for amphetamine.
8. We received a number of responses to the publication of the Expert Panel's report, all of which welcomed the report. However, some questioned whether the recommended limit for amphetamine was too high, expressing the view that drivers may not exceed the limit proposed by the panel but still pose a very significant risk to the public. The Government also has a concern as to the extent that the drug is used illegally as to whether a risk based approach to the drug was appropriate.
9. In considering what approach to propose for amphetamine and what limit to set, we have weighed up the evidence about the use of the drug when driving; wider drugs policy; whether the drug is used medicinally; whether patients taking the drug are likely to be in a condition where they might drive; the findings and recommendations from the Expert Panel; the responses to the publication of the Expert Panel's report; plus the responses to the previous consultation where we specifically asked for views.

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

10. After considering all of the above we propose to set a limit at 50µg/L for amphetamine. This is close to a zero tolerance approach but slightly higher in order to take account of the level at which a pharmacological effect is likely to take place, which is most likely to impair driving. A full consideration of how the limit was determined is at pages 11-18.
11. The proposed limit for amphetamine does not catch someone who has consumed a very small amount of the drug in question inadvertently. A reliable analytical result can still therefore be obtained, yet be above the level at which issues such as passive consumption or inhalation can be ruled out.
12. This consultation therefore seeks views on the Government's proposed limit of 50µg/L for amphetamine.

## Duration of consultation

The consultation period will last 6 weeks, beginning on 19 December 2013 and running until 30 January 2014.

In deciding on the length of time for which to consult, we have considered the Consultation principles guidance at Annex A. We have concluded that, as we recently consulted upon the proposed controlled drugs and their limits where the approach to amphetamine was discussed and thus stakeholders are aware of the relevant issues, 6 weeks should be a sufficient period in which to consider the single proposed limit and respond, even taking account of the Christmas holiday period.

## The devolved administrations

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

As set out in the Executive Summary, this consultation has not been extended to cover Scotland. The Scottish Government intends to conduct its own consultation on a proposed limit for amphetamine early in 2014. The regulation-making power to specify limits for the offence is exercisable by Scottish Ministers in relation to Scotland by virtue of section 5A(8)(b) of the Road Traffic Act 1988 (as inserted by the Crime and Courts Act 2013). Any final policy proposal on the specific issue of drug driving in Scotland will be for the Scottish Government in line with the Crime and Courts Act 2013, and will be taken within the wider context of Scotland's national drugs strategy.

The Road Traffic Act 1988 (with minor exceptions which are not relevant for present purposes) does not extend to Northern Ireland.

## How to respond

The consultation period will run until 30 January 2014. Please ensure that your response reaches us before the closing date. If you would like further copies of this consultation document, it can be found at <https://www.gov.uk/government/consultations/drug-driving-amphetamine-limit> or you can contact Martin Ellis at the Department for Transport (contact details below) if you need alternative formats (Braille, audio CD, etc).

Please use the link <https://www.surveymonkey.com/s/PXRLQCG> to access the response form in order to send consultation responses. If you have any further queries about the consultation, please address them to:

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A list of those consulted can be found at Annex B.

We do not intend to acknowledge individual responses unless by request.

## Freedom of Information Act 2000

Information provided in response to this consultation, including personal information, may be subject to publication or disclosure in accordance with the Freedom of Information Act 2000 (FOIA) or the Environmental Information Regulations 2004. If you want information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence.

In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the Data Protection Act 1998 and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.



## What will happen next?

We will carefully consider the responses to this consultation and finalise our considerations of the earlier consultation on the other proposed 16 drugs and their limits with a view to whether any changes are required to the draft regulations before they are laid before Parliament. We will then publish the summary of responses to both consultations, including next steps in 2014 soon after the close of this consultation at

[www.gov.uk/government/organisations/department-for-transport](http://www.gov.uk/government/organisations/department-for-transport).

Paper copies will be available on request.

# 1. Introduction to the proposal

## Expert Panel recommendation

- 1.1 The Expert Panel recommended a limit of 600µg/L for amphetamine based upon the blood concentrations observed in apprehended drivers suspected of or proven to have been driving under its influence. The range of means from different studies varied from 456µg/l to 651µg/L. However, the panel also acknowledged that amphetamine “is a long standing member of the drug scene and is widely available in the UK” with much of it manufactured illegally.

## Issues set out in the earlier consultation

- 1.2 The original consultation explained that the approach to take in proposing a limit for amphetamine is less clear than for the other drugs. As the panel acknowledged, drugs containing amphetamine are commonly used illicitly but also includes medicines used to treat conditions such as Attention Deficit Hyperactivity Disorder (ADHD) and also sometimes used to treat hypersomnia (excessive sleepiness) and narcolepsy. A response to that earlier consultation brought our attention to the medication selegiline, which is used in the treatment of those suffering from Parkinson’s disease. The metabolic pathway may cause persons taking selegiline to test positive for amphetamine and or methamphetamine on drug screening tests. There is therefore a question as to whether to take a zero tolerance approach in line with drugs such as cannabis and cocaine or whether to specify a limit at which a road safety risk becomes unacceptable to ensure that patients are not unduly penalised.
- 1.3 Whilst ADHD is generally not found in the driving population because it is a condition associated with children and adolescents, diagnoses of adult ADHD is becoming more common. ADHD, narcolepsy and Parkinson’s disease are conditions that are required to be reported to DVLA if the person wishes to drive. A medical opinion must then be provided on whether the person is safe to drive.

- 1.4 Adult ADHD is a developing branch of medicine and we set out in the earlier consultation that there was a lack of available research evidence to determine either the road safety risk of prescribed drugs containing amphetamine on drivers with ADHD or the appropriate blood threshold limits for adults taking properly prescribed drugs containing amphetamine in accordance with the advice of a healthcare professional. The Department of Health has provided data on the amount of prescriptions issued for dexamphetamine which is the amphetamine based medicine prescribed for the above conditions. 3,555 prescriptions were issued between May 2012 and May 2013 and has remained roughly constant over the last 4 years. However, the majority of these are likely to be for treatment of ADHD patients below the driving age.
- 1.5 The Department received a number of responses after publishing the Expert Panel's report '*Driving under the influence of drugs*', some of which expressed a view that the limit of 600µg/L was too high, typically expressing a view that the limit was very significantly higher than those used in other countries. France, Netherlands and Poland have set the limit at 50µg/L while Norway, Belgium, Germany and Finland have set it even lower.
- 1.6 We set out in the previous consultation that there were potentially 4 different limits which could be set in relation to amphetamine: the limit recommended by the Expert Panel (600µg/L), a lower limit of 100µg/L that would still not catch most people on standard dosages for the treatment of ADHD; a limit of 50µg/L in line with some other European countries; finally, a 'lowest accidental exposure limit', which the Expert Advisory Committee that is advising the Department recommended at 10µg/L. We therefore asked for views on the most suitable approach to take for amphetamine.

## Consideration of the responses on a limit for amphetamine

- 1.7 In the earlier consultation on all 17 controlled drugs proposed we had 18 responses suggesting a limit for amphetamine. These were as follows:
- Zero tolerance approach ('lowest accidental exposure limit', i.e. 10µg/L) = 6

- 50µg/L = 5
- 100µg/L = 2
- 300µg/L = 1
- 600µg/L (Expert Panel recommendation) = 4

1.8 For the 6 who suggested a zero tolerance approach the overriding view was that it is an illegal drug that is widely abused and given that it is a relatively small number being prescribed amphetamine who are likely to be driving then the medical defence was open to them. Others suggested that as ADHD is a notifiable condition then they should be on the DVLA database and ADHD patients can therefore be informed of the new offence and advised to be prepared to provide evidence of their prescriptions in the same way as Multiple Sclerosis patients are in relation to Sativex. Those that suggested a zero tolerance approach included one police force, a road safety charity, a sustainable travel charity, a driving instructor, a toxicologist and the Chief Fire Officers Association.

1.9 At the other end of the scale, those who proposed 600µg/L did so on the basis that they agreed with the recommendation of the Expert Panel. One of the 4 responses also argued to accept the recommendations of the Expert Panel in full so consequently agreed with 600µg/L. Those that suggested a limit of 600µg/L included 2 charities concerned with safety, a medical professional body and the DVLA. We also received one response from a toxicologist proposing 300µg/L, but the same respondent's overall response suggested a zero tolerance approach (Policy Option 3), so the suggested limit for amphetamine conflicted with its response to the earlier question.

1.10 We had 2 responses proposing a limit of 100µg/L. One forensic laboratory suggested that whilst some recreational users may be less than 100µg/L this limit would catch chronic users. ACPO England recommended 100µg/L because 50µg/L might catch those on prescriptions whilst 600µg/L might miss a considerable amount of illegal use. ACPO England also suggested that a level of 100µg/L is unlikely to include most prescribed use, and would seem to best meet the needs of operational policing and the road safety gains from the prevention of drug driving.

1.11 For the 5 respondents who suggested 50µg/L the common theme was to be in line with several other countries. An equal theme was

a 50µg/L limit was likely to only catch a small number of patients and that the same approach as to those taking Sativex should be taken. This is discussed in the next chapter. Of the 5 respondents who agreed with this approach one was from a Road Safety Partnership who wanted to see a limit towards the lower end, one was from a medical professional body, a further one from a private organisation and one was from the Welsh Government who suggested 50µg/L after taking professional advice. The final respondent was from a toxicology laboratory but suggested a cumulative approach to all amphetamine type drugs as in France. This would result in a tougher approach as other amphetamine drugs such as the presence of MDMA would be added to the presence of amphetamine.

- 1.12 We therefore conclude that of those who responded the suggested limit was towards the lower end, i.e. between zero tolerance and 100µg/L and that a limit of 50µg/L or less is most acceptable to the respondents in the consultation.

## 2. The proposed amphetamine limit

- 2.1 After considering the above along with the Government's wider drug strategy, and consideration of further academic evidence the Government has concluded that a limit of 50µg/L is appropriate.
- 2.2 In coming to our conclusion we also re-examined the European research project, 'Driving Under the Influence of Drink, Drugs and Medicines' (DRUID) and other evidence based studies.
- 2.3 The DRUID project identified that amphetamine was the third most prevalent illicit drug amongst drivers killed or seriously injured behind cannabis and cocaine. It was also more prevalent in northern Europe. In addition, data predominantly from England and Wales presented to the Expert Panel by the Centre for Applied Science and Technology from a forensic laboratory showed that amphetamine type compounds were in the top five of the most prevalent drugs amongst drug drivers. It is clearly important that a limit is set which errs towards a zero tolerance approach given the extent of its illicit use.
- 2.4 However, none of the DRUID studies investigating the effects of stimulants such as amphetamine and dexamphetamine found that the consumption alone resulted in increased impairment or risk-taking. In general, low doses of stimulant drugs produce neutral or even stimulating effects on a range of psychomotor functions. Indeed ADHD sufferers taking low doses of amphetamine can improve their driving skills<sup>4</sup>.
- 2.5 Some studies found that stimulants may have detrimental effects on specific cognitive functions and increase risk-taking behaviours. Considering the likely drug use setting, the stimulant effects of amphetamine were not sufficient to overcome or compensate for driving impairments resulting from alcohol use or a night's sleep deprivation, which often accompany illicit amphetamine use. Moreover, users of stimulant drugs were not aware of post-acute fatigue effects (the 'comedown'). One night of sleep deprivation

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<sup>4</sup> What We Know About ADHD and Driving Risk: A Literature Review, Meta-Analysis and Critique' looked at a range of studies in North America, see <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2277254/>

alone caused impairments comparable to those observed under the influence of 80mg/100ml Blood Alcohol Concentration.

- 2.6 DRUID quotes a case study<sup>5</sup> of killed and seriously injured drivers in 9 European countries and found that the risk for amphetamine was higher than in the studies conducted in the DRUID project. When amphetamine was found in drivers injured or killed in road traffic accidents, the median concentrations were very high compared with the concentrations of subjects in the DRUID experiments. The study concluded that these may have detrimental effects on self-perception, critical judgement and risk-taking, and while the stimulating effects are wearing off the driver may suffer fatigue, anxiety and irritability. It is also likely that drivers who choose to drive when positive for (large concentrations of) amphetamines are more prone to taking risks than the average road user.
- 2.7 The DRUID Deliverable 1.2.1 'Effects of stimulants on actual and simulated driving'<sup>6</sup> found that experimental studies conducted according to a uniform study design (road tracking tests, car-following scenario and risk-taking scenario) designed to assess the effects of dexamphetamine doses on actual or simulated driving performance gave impairment effects of dexamphetamine at doses of 10mg and 40mg. The study suggested that a 10mg dose would be equivalent to a likely concentration in blood of between 0 to 40µg/L and a 40mg dose equivalent to a likely blood concentration of 20 to 140µg/L. More than half of the participants had difficulties falling asleep the day after taking the high dose (40mg). Some felt drowsy for a couple of days following the test, mainly after having taken the higher dose. Where sleep deprivation led to impaired driving there was no evidence in the data that the resulting impaired driving was compensated for by taking a dose of dexamphetamine.
- 2.8 A further Norwegian study (Gustavsen et al., 2004), of 878 motorists who tested positive for amphetamines/ methamphetamines only, found a positive correlation between blood amphetamine concentrations and impairment between a blood concentration range of 27–53µg/L. Furthermore, although 73% of subjects were judged to be impaired using clinical tests, the mean concentration of amphetamine did not differ from those

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<sup>5</sup> Pages 24-25 of the 'Findings of the DRUID project' 2012

<sup>6</sup> [http://www.bast.de/nr\\_107548/Druid/EN/deliverables-list/downloads/Deliverable\\_1\\_2\\_1.templateId=raw.property=publicationFile.pdf/Deliverable\\_1\\_2\\_1.pdf](http://www.bast.de/nr_107548/Druid/EN/deliverables-list/downloads/Deliverable_1_2_1.templateId=raw.property=publicationFile.pdf/Deliverable_1_2_1.pdf)

judged not to be impaired (on average, 53µg/L = impaired; 50µg/L = not impaired) (Gustavsen, 2006; cited by Jones, 2007).

- 2.9 In conclusion these studies demonstrate that whilst low doses of amphetamines can improve performance in some simple tasks and increase alertness and focus soon after consumed, it can still lead to increased risk taking. Whilst the later phase of use (the 'comedown'), particularly when taking higher doses can lead to disoriented behaviour, distorted perception, fatigue and poor judgement. We also sought views of experts in the field of ADHD and were advised that many consultants in the UK monitor the research undertaken in the USA, where it has been more extensive, and kindly pointed us to some of these studies. The advice provided suggests that typical doses of amphetamine equate to 20-50µg/L in blood, though some prescriptions can equate up to 200µg/L<sup>7</sup>.
- 2.10 DRUID quotes the analytical cut off at 20µg/L<sup>8</sup> (lowest detectable level) whilst the Expert Advisory Committee advised 10µg/L. Given the context in which illicit amphetamine use is often taken, i.e. suffering post consumption fatigue we believe an approach should be taken that is close to the zero tolerance approach but which reflects the levels at which impairment has seemed to be most apparent in the various studies and which is above most therapeutic ranges. That level appears to be at 50µg/L and is one that is common in several European countries.
- 2.11 Of those who responded to the specific question on what a suitable limit for amphetamine might be 13 were zero tolerance to 100µg/L, whilst 5 were 300-600µg/L. This would indicate that a limit between zero and 100µg/L would be more in line with the views of those who specifically responded on a limit for amphetamine than the higher range.

### **Question 1.**

Do you agree with the Government's proposed limit for amphetamine? If not please provide your reason(s).

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<sup>7</sup> University of Rochester Medical Center in the USA provides reliable therapeutic ranges, see [http://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=167&ContentID=amphetamine\\_blood\\_screen](http://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=167&ContentID=amphetamine_blood_screen).

<sup>8</sup> Page 51 of the 'Findings of the DRUID project' 2012



2.12 By proposing a limit of 50µg/L we are aware that there may be some ADHD sufferers or those who have a recognised sleep disorder such as narcolepsy that may be prescribed dexamphetamine that in some less common cases may be above the proposed 50µg/L limit. Equally this may apply to those in the early stages of Parkinson's disease who may be taking selegiline. However, as these conditions are required to be notified to the DVLA we propose to offer the same solution as we have proposed for Sativex in the earlier consultation. If a patient's doctor provides an opinion to the DVLA that the patient is safe to drive then the DVLA would notify the patient that a short-term driving licence will be issued for up to three years. In the notification letter the DVLA proposes to provide the following advice:

*“If you are currently being treated with or start being treated with (Selegiline/Dexamphetamine) please be aware that if you are tested by police for drugs or accused of drug driving and, specifically, if you are asked by police if you are taking any medication, you should declare your use of prescribed (Selegiline/Dexamphetamine). You may also need to provide the Police with anything you have that would confirm this, such as the medication if you have it with you or a prescription, counterfoil or any medical letter, report or advice.”*

2.13 The above will of course be sent separately to those with the condition, i.e. those suffering from Parkinson's disease will only get a letter referring to selegiline.

2.14 We also propose to write to the Association of Chief Police Officers (ACPO) to make them aware of the above situation. It will be for ACPO to disseminate the information as they see fit to ensure that police officers are aware that some ADHD, recognised sleep disorder sufferers and Parkinson's disease sufferers who are taking dexamphetamine or selegiline may be driving legitimately. Drivers taking dexamphetamine or selegiline will of course be able to seek to rely on the statutory medical defence. If in the view of the police officer their driving was not impaired, then we propose that these drivers should not be arrested nor any further action be taken against them.

2.15 Changes to medicines information must be made through the marketing authorisation via the Medicines Healthcare products Regulatory Agency (MHRA) and should be in line with the provisions of Title V of Council Directive 2001/83/EC.

2.16 We believe this approach to dexamphetamine and selegiline users is reasonable and will not deter them from taking their medicine in order to continue driving provided it is safe to do so.

**Question 2.**

Is the approach we are proposing to take when specifying the limit for amphetamine reasonable for those who are driving and being prescribed with dexamphetamine (which is used to treat ADHD, certain sleep disorders such as narcolepsy and Parkinson's disease)? If not what is the evidence to support your view?

**Question 3.**

Are there any other medicines that we have not taken account of that would be caught by the limit we propose for amphetamine and the conditions they treat? This may include medicines that metabolise in the body to amphetamine. If so please give your reason(s).

2.17 We are currently considering the responses to the earlier consultation on whether there is an impact on business. We would also be interested to know if the proposed limit of 50µg/L for amphetamine will have any impact on business.

**Question 4.**

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

## 3. The draft regulations

- 3.1 The draft regulations are set out at Annex C and include the proposed limit for amphetamine. We have included the limits for the other drugs proposed in the original consultation and no consideration of the responses to that consultation has been taken into account here. The limits for all drugs may therefore change once we have fully considered the responses to both that consultation and this one. We will then publish a summary of the responses to both consultations and our final conclusions in 2014 soon after the close of this consultation.

## 4. Impact assessment

- 4.1 The impact assessment produced for the initial consultation on the other drugs and their limits is still valid for this consultation and is available at Annex D of the initial consultation at:  
<https://www.gov.uk/government/consultations/drug-driving-proposed-regulations>
- 4.2 We will consider all the responses to both this and the earlier consultation and if necessary amend the impact assessment and publish it when we lay the final regulations before Parliament.

## 5. Consultation questions

The consultation asks respondents to formulate their responses specifically to the following questions:

### **Question 1.**

Do you agree with the Government's proposed limit for amphetamine? If not please provide your reason(s).

### **Question 2.**

Is the approach we are proposing to take when specifying a limit for amphetamine reasonable for those who are driving and being prescribed with dexamphetamine (which is used to treat ADHD and certain sleep disorders such as narcolepsy) and selegiline (which is used to treat Parkinson's disease)? If not what is the evidence to support your view?

### **Question 3.**

Are there any other medicines that we have not taken account of that would be caught by the limit we propose for amphetamine and the conditions they treat? This may include medicines that metabolise in the body to amphetamine. If so please give your reason(s).

### **Question 4.**

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

# Annex A: Consultation principles

The consultation is being conducted in line with the Government's key consultation principles which are listed below. Further information is available at <https://www.gov.uk/government/publications/consultation-principles-guidance>

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

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

## Consultation principles

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

# Annex B: List of those consulted

Action on Addiction  
Add Action  
Advisory Council on the Misuse of Drugs  
Age UK  
Alcohol Concern Cymru  
Association of British Insurers  
Association of Chief Police Officers (ACPO) (Wales & England)  
Association of Directors of Environment, Economy, Planning & Transport (ADEPT)  
Association of Independent Multiple Pharmacies  
Association of the British Pharmaceutical Industry  
Automobile Association  
BRAKE  
British Generic Manufacturers Association  
British Medical Association  
British Pain Society  
Chief Fire Officers  
Chief Police Officers  
Chronic Pain Policy Coalition  
College of Mental Health Pharmacists  
Crown Prosecution Service  
Driving Standard Agency  
Driver Vehicle & Licence Authority (DVLA)  
Drug Equality Alliance  
Drugscope  
D. Tec International  
European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)  
Focal Point  
General Pharmaceutical Council  
General Practitioners Committee  
Highways Agency  
Independent Healthcare Advisory Services  
Independent Pharmacy Federation  
Independent Scientific Committee on Drugs  
Institute of Advanced Motorists  
LGC Forensics  
Liberty

Living Streets  
Mayor's Office for Policing And Crime (MOPAC)(London)  
Medicines & Health Products Regulatory Agency (MHRA)  
Mental Health Foundation  
MIND  
MS Society  
MS Trust  
Napp Pharmaceuticals  
National Attention Deficit Disorder Information and Support Service  
National Pharmacy Association  
National Pharmaceutical Association  
National Rheumatoid Arthritis Society  
Pain UK  
Parkinson's UK  
Parliamentary Advisory Council for Transport Safety (PACTS)  
Parliamentary Office of Science and technology  
Pharmaceutical Services Negotiating Committee  
Pharmacy Substance Misuse Advisory Group  
Pharmacy Voice  
Policy Connect  
RAC Foundation  
Reckitt Benckiser Pharmaceuticals  
Release  
RoadPeace  
RoadSafe  
Road Safety GB (Association of local authority road safety officers)  
ROAR Forensics  
Royal College of Anaesthetists  
Royal College of Nurses  
Royal College of Physicians  
Royal College of Practitioners  
Royal College of Psychiatrists  
Royal College of Psychiatrists in Wales  
Royal Pharmaceutical Society of Great Britain  
Royal Society for the Prevention of Accidents  
Sickle Cell Society  
The Alliance  
The Alliance of British Drivers  
The Company Chemists Association  
The Law Society  
The Patients Association  
Transport for London  
TTP Counselling



Turning Point  
UK Adult ADHD Network  
UK Clinical Pharmacy Association  
UK Psychiatric Pharmacy Group  
Welsh Government  
Young Minds

# Annex C: Draft Regulations

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

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## DRAFT STATUTORY INSTRUMENTS

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**[2014] No. 0000**

### **ROAD TRAFFIC, ENGLAND AND WALES**

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

*Made* - - - - - \*\*\*

*Coming into force* - - - - - \*\*\*

The Secretary of State makes the following Regulations in exercise of the power conferred by section 5A of the Road Traffic Act 1988<sup>(9)</sup> and after consultation with representative organisations in accordance with section 195(2) of that Act.

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

#### **Citation, commencement and extent**

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

**2.** These Regulations extend to England and Wales.

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

**3.** The table below specifies the controlled drugs<sup>(10)</sup> and, in each case, the limit in blood for the purposes of the offence in section 5A of the Road Traffic Act 1988.

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<sup>(9)</sup> 1988 (c.52); section 5A was inserted by section 56(1) of the Crime and Courts Act 2013 (c.22).

<sup>(10)</sup> Section 11(2) of the Road Traffic Act 1988 provides that the term “controlled drug” has the meaning given by section 2 of the Misuse of Drugs Act 1971 (c.38). The definition of “controlled drug” was inserted into the Road Traffic Act 1988 by section 56(2) of the Crime and Courts Act 2013.

**Table**

<i>Controlled drug</i>	<i>Limit [microgrammes per litre of blood]</i>
Amphetamine	50
Benzoylcegonine	50
Clonazepam	50
Cocaine	10
Delta-9-Tetrahydrocannabinol	2
Diazepam	550
Flunitrazepam	300
Ketamine	20
Lorazepam	100
Lysergic Acid Diethylamide	1
Methadone	500
Methamphetamine	10
Methylenedioxymethamphetamine	10
6-Monoacetylmorphine	5
Morphine	80
Oxazepam	300
Temazepam	1000

Signed by authority of the Secretary of State for Transport

Date \_\_\_\_\_ Name  
 Parliamentary Under Secretary of State  
 Department for Transport

### **EXPLANATORY NOTE**

*(This note is not part of the Regulations)*

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

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