Discussion Document

Ministry of Transport
TE MANATŪ WAKA

Enabling New Zealanders to flourish

Enhanced Drug Impaired Driver Testing

May 2019

This Discussion Document seeks feedback on options for enhancements to the process for testing drug impaired drivers in New Zealand. It does not represent Government policy nor does it predetermine the options the Government may consider when making final decisions.

INTRODUCTION

1. Since 2013 the number of road deaths in New Zealand has been rising. In 2013, there were 253 deaths. In 2017, there were 378 deaths – a 49 percent increase over five years.

2. To reverse the upward trend in road deaths, the Government has put safety at the forefront of all decision-making on land transport. In June 2018, we released the Government Policy Statement on Land Transport 2018 (GPS), which sets out the government's priorities for the land transport system over the next 10 years. In the GPS, we elevated safety to one of two key funding priorities.

3. The Government has also commenced the development of a new road safety strategy for New Zealand. This will involve looking at all reasonable options to make our roads safer.

4. Addressing drug impaired driving is an important objective if we are to make our roads safer. Studies show that many illicit substances and prescription drugs have negative effects on driving ability, particularly when taken in combination with alcohol or other drugs.

Objectives of enhanced drug driver testing

5. Developing a new framework for drug impaired driving in New Zealand will require balancing a number of, sometimes conflicting, objectives. These include:

   - deterring people from driving while impaired by drugs;
   - removing drug impaired drivers from the road;
   - sanctioning drug impaired drivers in a way that is proportionate with risk;
   - being consistent with the National Drug Policy 2015-2020; and
   - not unjustifiably limiting rights affirmed by the New Zealand Bill of Rights Act 1990.

Key questions the Discussion Document is looking to answer

6. The Discussion Document is seeking feedback on the following questions (below). If you have comments or suggestions about approaches to drug impaired driving that are not covered by the questions or the material in the Discussion Document, please continue to provide your feedback.

- How can we better detect drug drivers and deter drug driving?
- In what circumstances should drivers be tested for drugs?
- How do we decide which drugs to test for?
- What evidence is required to establish a drug driving offence?
- How should we deal with people caught drug driving?

What consultation process will be followed?

7. The Ministry requests written submissions and they must arrive by 5.00 pm Friday 28 June 2019 to be considered.

8. Submissions can be forwarded to the Ministry at:

   drugdrivingconsultation@transport.govt.nz

   Or

   Drug Driving Consultation
   Ministry of Transport
   PO Box 3175
   WELLINGTON 6140

Publishing and releasing submissions

9. All or part of any written submission (including names of submitters), may be published on the Ministry of Transport's website: **www.transport.govt.nz**.

10. The Ministry will consider that you have consented to posting your submission and your name on our website unless you make it clear in your submission that you do not want this information posted.

11. Contents of submissions may be released to the public under the Official Information Act 1982 following requests to the Ministry of Transport (including via email). Please advise if you have any objection to the release of any information contained in a submission and, in particular, which part(s) you consider should be withheld, together with the reason(s) for withholding the information. We will take into account all such objections when responding to requests for copies of, and information on, submissions to this document under the Official Information Act.

BACKGROUND TO THE DISCUSSION DOCUMENT

Drivers in New Zealand are using drugs and driving

12. In New Zealand, Environmental Science and Research Ltd (ESR) carries out toxicological analysis of blood samples submitted by the Police, a pathologist or the coroner. Analysis of the blood samples of drivers killed in crashes between January 2013 and May 2018, where drugs analysis was requested by a pathologist[1], found that the drivers had used the following drugs[2]:

- 29 percent had used alcohol[3]
- 27 percent had used cannabis
- 10 percent had used methamphetamine
- 15 percent had used other drugs[4].

13. Over the same period, ESR's analysis of the blood samples of drivers who have been stopped by Police and determined to be impaired by drugs, shows that 59 percent used cannabis and 41 percent used methamphetamine. Of the drivers caught drink driving in New Zealand, over a quarter also tested positive for recent cannabis use.

14. Data from the NZ Transport Agency's Crash Analysis System shows that the number of fatalities from crashes where a driver has been found to have used drugs before driving has increased. This reported increase may be partly due to a change in Police policy in mid-2015 to increase the number of samples subject to drugs analysis, but it shows that fatalities involving drivers who have used drugs are more than half those involving drivers who have consumed alcohol, and more than the number of fatalities involving drivers who have exceeding drink driving limits.

Road deaths involving drugs or alcohol			
Year	Deaths involving drugs	Deaths involving alcohol	
		Above limits/refused test.	*Below legal limits*
2018	71	66	43
2017	88	74	80
2016	60	67	73
2015	27	66	58
2014	14	48	40
2013	14	53	28

[1] In this period, 845 samples from 1000 deceased drivers were submitted for analysis. Ninety percent were subject to a full drugs screen.

[2] Drivers may have used more than one of the identified drugs.

[3] Reported where drivers have blood alcohol levels greater than 10 milligrams per 100 millilitres of blood. The legal blood alcohol limit for drivers over 20 years of age is 50 mgs per 100 millilitres of blood.

[4] Most common among 'other drugs' are medicinal drugs such as codeine and tramadol and sedatives such as zopiclone, clonazepam and diazepam.

Presence of a drug in a driver's system does not mean the driver is impaired

15. While research shows that drugs have the potential to negatively affect driving ability, we cannot say for certain that the presence of a particular drug or substance in a driver's blood means they are impaired. People respond to individual drugs, combinations of drugs and different dosages of drugs in different ways. In contrast to alcohol, there is not a clear linear relationship between dosages of drugs, when they are taken, and impairment.

Many illicit and prescription drugs have the potential to impair driving

16. There is a large body of international research on the impacts of drugs on driving ability. Overall, international studies show that many illicit substances and prescription drugs have potentially negative effects on driving ability. They can slow reaction time, increase risk taking and cause fatigue, particularly when taken in combination with alcohol or other drugs.

17. However, the research has limitations. Researchers do not all agree about the magnitude of drug driving or about the degree to which particular drugs or combinations of drugs impair driving and increase crash risk. There is also variability in the methodology of experiments, use of controls, and reporting of findings. For example, a study carried out in the morning, in a small town might find a different degree of drug impaired driving to a study carried out in a nightclub district in a large city[5].

18. To address these variability issues, large scale, multi-country, multi-year projects such as the DRUID (Driving while under the Influence of Drugs, Alcohol and Medicines) project in Europe and the European research project SafetyCube have been established to estimate the size of the drug driving problem and examine the range of interventions.

19. A recent (2017) review by the SafetyCube[6] research project of over 80 papers on drugs and driving performance found that a number of the most used illicit and prescription drugs have a negative impact on road safety. They increase crash risk, injury severity and fatal crash rate, and they reduce the general ability to drive. When combined with alcohol or other drugs, the negative effects can be even larger.

20. The negative effects of high doses of cannabis on driving performance are well documented and cannabis use is associated with increased risk of being killed or injured[7]. A number of studies consider the impact of stimulants such as cocaine or methamphetamine. Some studies conclude that stimulants can produce a faster reaction time but overall, most studies note that stimulants may lead to increased risk-taking and

[5] *Driving under the Influence of Drugs, Alcohol and Medicines in Europe – findings from the Druid project*, European Monitoring Centre for Drugs and Drug Addiction.
[6] Leblud, J (2017), *Driving Under the Influence: Legal and Illegal Drugs*, European Road Safety Decision Support System, developed by the H2020 project SafetyCube.
[7] *The effects of cannabis intoxication on motor vehicle collision revisited and revised*, Rogeburg et al (2016)

do not compensate for the effects of fatigue[8]. Methamphetamine has been found to be the most risky drug to use before driving and is the drug found with increasing prevalence compared to other drugs in fatal crash victims[9].

21. There are also numerous prescription drugs that can affect driving performance. Over 1500 different drugs are prescribed in New Zealand and over 200 of these come with the warning "do not drive or operate machinery if affected, may cause drowsiness" and/or "restrict or avoid alcohol"[10]. Research undertaken for the NZ Transport Agency's Substance Impaired Driving Project found that 25 percent of all prescriptions issued in New Zealand are for medication that can impair driving[11] and nearly 65 percent of drivers are unaware that it is illegal to drive while impaired by medication[12].

The New Zealand Bill of Rights Act 1990

22. The New Zealand Bill of Rights Act 1990 affirms rights and freedoms such as the right to be secure against unreasonable search or seizure (section 21), not to be arbitrarily arrested or detained (section 22), and to be presumed innocent until proved guilty (section 25(c)).The proposals in this paper have implications for each of these rights.

23. Specifically, detaining drivers at the roadside to determine whether they have consumed drugs will constitute a detention for the purposes of section 22. A detention will be considered arbitrary if it is capricious, unreasoned or without good cause.

24. Taking a sample of bodily fluid, would constitute a search for the purposes of section 21. Whether that search is reasonable requires consideration of the public interest in conducting the search as well as the procedural safeguards that ensure it is conducted in a reasonable manner.

25. Section 25(c) may be engaged depending on the construction of any offences for a breach of drug driving legislation, for example, depending on whom the burden of proof is placed in a criminal prosecution. 'Presence-based' drug testing schemes, where strict liability offences are committed once a drug is identified, place an onus on drivers to prove their innocence, rather than Police to disprove any potentially available defence.

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[8] *The prevalence and impairment effects of drugged driving in New Zealand*, University of Waikato, Starkey, N and Charlton, S, 2017 and *Impairment due to blood amphetamine and/or methamphetamine concentrations in suspected drugged drivers*, Gustavsen, Morland, Bramness, Accident Analysis and Prevention Journal 2006.

[9] *Risk of road accident associated with the use of drugs: a systematic review and meta-analysis of evidence from epidemiological studies*, Elvik (2013).

[10] Anaesthetics, analgesics, antidepressants, anti-epilepsy, antipsychotics, anti-anxiety agents, sedatives and hypnotics.

[11] NZ Transport Agency (2015). For NZTA Substance Impaired Driving Project. *Memo: Analysis of summary data from the pharmaceutical collection year to July 2014.*

[12] NZ Transport Agency (2015). For NZTA Substance Impaired Driving Project. *Memo: Baseline Driver Survey*.

26. Generally speaking, the rights and freedoms affirmed by the Bill of Rights Act may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

27. Recently, the Attorney-General found that a Member's Bill seeking to introduce random roadside oral fluid testing of drivers in New Zealand was inconsistent with sections 21, 22 and 25(c) of the Bill of Rights Act[13], and the inconsistencies could not be justified under the Act. The Attorney-General found that the proposal in the Member's Bill, which would allow Police to detain and test drivers (some of whom may not have actually taken drugs), was a disproportionate response to the harm of drug-impaired driving.

28. Parliament can decide to legislate in a manner inconsistent with the Bill of Rights Act, if it considers a matter to be an issue of public concern. For example, when compulsory breath testing for alcohol was introduced, the Government decided that the resulting limitations on driver's rights and freedoms were justified in order to address the harm of drink driving.

29. Before introducing new legislation to tackle drug impaired driving, the Government will need to be satisfied that the measures it proposes address any concerns identified by the Attorney-General. The Attorney-General's report on the Member's Bill provides some guidance about how to achieve this, for example, by using oral fluid testing as a screening tool, but blood testing as evidence of an offence of drug-impaired driving.

The National Drug Policy

30. At the core, drug use, is a health issue with impacts on a number of other sectors. Drug issues are closely intertwined with social factors such as income, employment, housing, and education. In the transport context, drug use is a road safety issue.

31. New Zealand's National Drug Policy 2015 – 2020 is the guiding document for policies and practices responding to alcohol and other drug issues. Its overarching goal is to minimise alcohol or other drug-related harm, and promote and protect heath and wellbeing. The Policy's objectives are:

- Delaying the uptake of alcohol and drugs (AOD)
- Reducing illness and injury from AOD
- Reducing hazardous drinking of alcohol
- Shifting attitudes towards AOD.

32. The Policy emphasises a proportionate response to minimise drug-related harm and promotes alternatives to the criminal justice system for dealing with low-level offenders. New measures to address drug driving will need to be consistent with the National Drug

[13] www.justice.govt.nz/justice-sector-policy/constitutional-issues-and-human-rights/bill-of-rights-compliance-reports/section-7-reports

Policy, and support its objectives. It will be important to consider the broader impacts for drivers who are detected driving impaired by drugs. For example, the penalty responses that may be appropriate for preventing and deterring drug-impaired driving should be considered in the context of the Government's overall objective of addressing the health needs of individuals who harm themselves by using drugs.

Trends by ethnic group

33. A 2007/08 survey of drug use in New Zealand by the Ministry of Health[14] found that, People of Pacific or Asian ethnicity had significantly lower rates of drug use than the total population.

34. Compared with people in the total population, people of European ethnicity reported using a wider range of drugs, including cannabis, ecstasy, amphetamines, prescription stimulants, synthetic and natural hallucinogens, ketamine, GHB, and nitrous oxide and party pills. Europeans were also significantly more likely to have injected drugs for recreational purposes in the past year, compared with the total population.

35. Māori men and women had significantly higher rates of having used cannabis in the past year, compared with men and women in the total population. There were no other drugs that Māori men and women were significantly more likely to have used in the past year than men and women in the total population.

36. Overall, Pacific men and women were less likely to have used drugs in the past year than men and women in the total population. The exception was kava, with Pacific men being almost six times more likely to have used kava in the past year, compared with men in the total population. The Ministry of Health survey found that kava was used recreationally more than ecstasy in New Zealand.

Impacts for Māori

37. New measures to address drug impaired driving could have a disproportionate impact for Māori. Cannabis is the drug that drivers in New Zealand use the most. The Ministry of Health's *Cannabis Use 2012/13 New Zealand Health Survey*[15] found that Māori were 2.2 times more likely to report using cannabis in the last 12 months than non-Māori. The survey found that Māori were 1.2 times more likely to have driven under the influence of cannabis in the last 12 months than non-Māori.

[14] Drug Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey. Ministry of Health (2010).

[15] www.health.govt.nz/publication/cannabis-use-2012-13-new-zealand-health-survey

38. The impacts for Māori could be greater in some regions than others as socioeconomic deprivation increases the likelihood of offending and Māori are more likely to live in highly deprived areas.[16]

39. Māori are significantly over-represented at all stages of the criminal justice system[17] and tend to experience disproportionately more of the risk factors and vulnerabilities leading to offending and entry into the system. In 2016, Māori received 42% of all drug convictions and 42% of low-level convictions, despite making up only 15% of the population.

40. The development of policy options for addressing drug impaired driving will need to take all these factors into account. This could include investigating non-criminal penalty options, such as infringement offences, for low-level drug impaired driving offences; or making enhanced use of New Zealand's existing Therapeutic Courts and Alcohol and Other Drug Treatment Courts, to target responses around treatment, monitoring and mentoring.

[16] Ministry of Justice, Department of Corrections & New Zealand Police. *Maintaining a safe NZ and working towards a more humane and effective criminal justice system.* Wellington, NZ Authors; 2017.
[17] Ministry of Justice, Department of Corrections & New Zealand Police. *What we know: Māori justice outcomes*. Wellington, NZ Authors; 2017.

NEW ZEALAND'S CURRENT DRUG DRIVER TESTING SCHEME

41. There are two elements to drug-driving enforcement in New Zealand: roadside drug testing of drivers who are suspected of being impaired by drugs or other substances; and blood testing of drivers hospitalised following a crash.

Compulsory Impairment Test

42. The roadside element is focused on demonstrating that a driver is not fit to drive (impaired) through a physical impairment test called the Compulsory Impairment Test (CIT). It is conducted by specially trained Police officers and includes eye, walk and turn, and one-leg-stand assessments. Police officers will determine the most appropriate place to require a driver to undergo a CIT, taking into account matters such as the safety of the surrounding environment and the presence of observers. This assessment often results in the driver being required to accompany an enforcement officer to a Police station to undergo the CIT.

43. If a driver's performance on the CIT is unsatisfactory, a Police officer can require the driver to undergo a blood test to establish the presence of a qualifying drug[18]. In 2017/18, 92 percent of blood samples submitted for drugs analysis following a CIT resulted in drug driving criminal convictions. This illustrates that the CIT is accurate at identifying that a driver is impaired by drugs.

44. The CIT process takes 25-60 minutes to conduct, depending on where the test is performed. It takes an additional 30 minutes, on average, to complete a blood test if a CIT is failed. Proof of a drug-driving offence relies on both elements – unsatisfactory performance on the CIT and the presence of at least one qualifying drug in the driver's blood specimen.

45. Unlike breath alcohol testing, drivers cannot be randomly tested for drugs. A Police officer must have 'good cause to suspect' that a driver has used a drug, or drugs, before the driver can be required to undergo a CIT. Good cause to suspect could be determined from a driver's manner of driving, their demeanour when they are stopped and spoken to by Police, or from external cues such as the smell of cannabis.

46. "Good cause to suspect" is not defined in legislation, however, it has been considered and clarified in case law. For example, in 2006 the High Court[19] held that the meaning of the words was plain on their face. The Court said that the interpretation of good cause to suspect had been authoritatively defined in Police v Anderson [1972] NZLR 233 as "a reasonable ground of suspicion upon which a reasonable [person] may act". The Court emphasised that proof of belief was unnecessary; suspicion alone was sufficient provided it met the epithet of good.

[18] Drugs categorised under Schedules 1, 2 and parts of Schedule 3 of the Misuse of Drugs Act 1975.
[19] Police v Enoki HC AK CRI-2006-404-103 6 June 2006, Harrisson J.

Hospitalised drivers

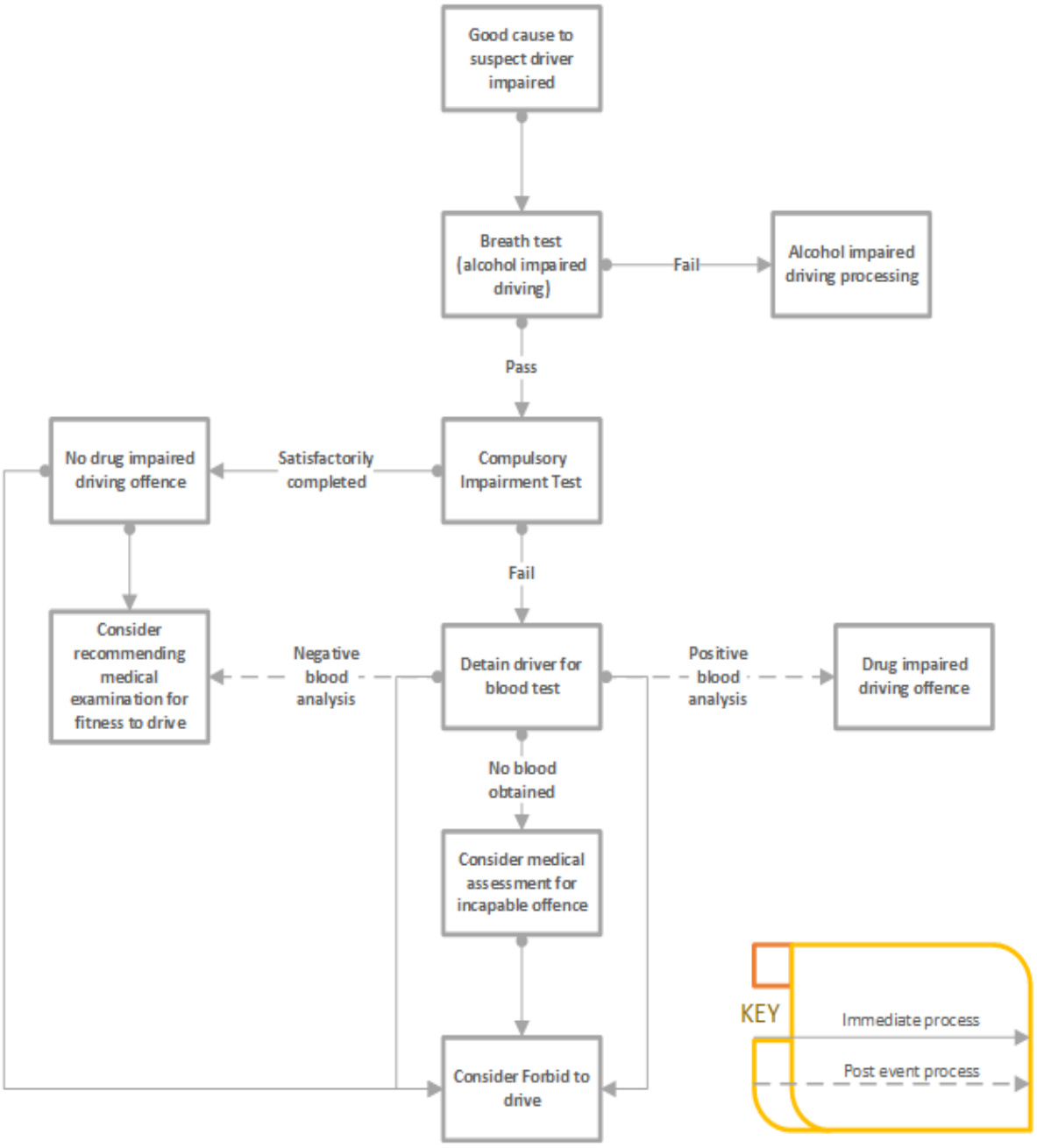
47. Drivers who have been hospitalised because of a crash can be blood tested in hospital to determine whether they have alcohol or drugs in their system. Drivers can only be prosecuted if their blood test shows the presence of a Class A drug (for example, methamphetamine)[20]. This means, for example, that hospitalised drivers who have very high levels of impairing prescription drugs or cannabis in their blood cannot be prosecuted.

Penalties for drug impaired driving

48. Serious criminal penalties result from a conviction for drug driving. For a first and second offence, a drugged driver could receive a prison term of up to 3 months, or a fine of up to $4,500; and a mandatory disqualification of 6 months or more. Police also have the power to forbid a person to drive for a period – usually for 12 hours, if a driver's performance on a CIT is unsatisfactory. This is to allow the driver sufficient time to recover from the impairment.

49. The legal requirements for drug testing, including offences and penalties, are set out in the Land Transport Act 1998. Below is a simplified diagram of New Zealand's drug-driving enforcement process.

[20] Section 58(1)(b) of the Land Transport Act 1998 established the offence. Class A drugs are drugs that carry a very high risk of harm. They are listed in Schedule 1 of the Misuse of Drugs Act 1975.


Good cause to suspect driver impaired
Breath test (alcohol impaired driving)
Fail
Alcohol impaired driving processing
Pass
No drug impaired driving offence
Satisfactorily completed
Compulsory Impairment Test
Fail
Consider recommending medical examination for fitness to drive
Negative blood analysis
Detain driver for blood test
Positive blood analysis
Drug impaired driving offence
No blood obtained
Consider medical assessment for incapable offence
Consider Forbid to drive
KEY
Immediate process
Post event process

WE NEED TO DO MORE TO PREVENT DRUG DRIVING IN NEW ZEALAND

Limitations of New Zealand's current approach to drug driver testing

50. Our current 'good cause to suspect' CIT process has challenges and limitations. A Police officer must explicitly identify a reason to suspect a driver is potentially impaired from using drugs from external cues, such as erratic or poor driving, or the driver's behaviour once stopped.

51. The 'good cause to suspect' threshold ensures that drivers who are not impaired are not subjected to a CIT, however, applying the threshold means that it is likely that there are drug impaired drivers who are not being tested because there are no observable signs of impairment at the time of driving. Some drivers may be impaired from using drugs but drug use may only become apparent when the driver faces a situation that requires a quick or unexpected decision.

52. Police are also frequently unable to require drivers to undergo a CIT because they are injured or in a state of shock or emotional distress following a crash.

Low number of drug tests

53. The number of CITs undertaken each year is low. Police do not record the number of CITs conducted, however, Police records show that 473 blood specimens were submitted for analysis in 2017/18. The number of specimens submitted indicates that the total number of tests conducted by Police is likely to be in the hundreds, not thousands, per annum. This limits the opportunity to achieve a general deterrence effect, meaning that the perceived and actual risk of detection of drug driving is minimal.

54. Police procedure is not to conduct a CIT if a driver is being processed for a drink driving offence. This means that drivers who may be impaired from both alcohol and drugs will not be subject to a CIT if an offence of drink driving is established. This contributes to the low number of CIT Tests conducted.

55. In comparison to the number of drug tests undertaken, around 2 million compulsory alcohol breath tests are carried out each year.

The theory of General Deterrence

56. Deterrence theory suggests that the key to reducing the number of people drug driving is lifting the level of detection and enforcement to create a greater deterrent effect[21]. This

[21] Davey, J. & Freeman J. (2011). *Improving road safety through deterrence-based initiatives: a review of research*. Sultan Qaboos University Medical Journal.

is achieved when the mere threat of being caught and sanctioned deters the majority of drivers from committing an offence.

57. General deterrence is achieved only if the testing of drivers is conducted at sufficiently intense levels, and in a visible manner such as at checkpoints, to increase the public's perception of the risk they will be caught if they drive after having used drugs. The consequences that follow for a drug driver are also important. Publicity in the form of advertising also supports enforcement efforts and, over time, assists to shape public attitudes that drug-driving is unacceptable.

58. In New Zealand, compulsory testing for alcohol in large numbers is connected to a reduction in fatalities from drink-driving. Since the mid-1990s, there has been an overall increase in the amount of breath-testing[22] and a corresponding decrease in alcohol-related road crashes. In 1990, there were 268 fatal crashes, out of a total of 638 (42%) involving alcohol, compared to 74, out of 342 (20%) in 2017[23].

59. New Zealand's current drug driving enforcement approach is not delivering enough tests to create a strong deterrence effect. A University of Waikato survey of drivers in 2017[24] found that 60 percent of drivers thought people were likely to be caught by Police for drink driving but only 26 percent thought people were likely to be caught for drug driving.

60. Significantly increasing the number of CITs to achieve better road safety outcomes would be impractical, due to the 'good cause to suspect' threshold for testing and the time a CIT takes to complete.

Impacts to consider

61. Greater enforcement of drug driving could have significant impacts, including costs, for the Justice system, and the people entering it, especially if offending is penalised with a criminal sanction that can lead to imprisonment. An enforcement approach involving fines, as opposed to criminal sanctions, could still affect drivers' ability to travel and work (possible approaches to penalties are discussed later in this document).

62. Prison does not prepare young offenders to make different choices[25]. There is longstanding evidence of the need to intervene early, to prevent involvement in drug consumption and supply in the first place[26]. During the development of policy options, it will be important to consider what other tools or approaches are available and how they

[22] New Zealand introduced random stopping in 1984 and compulsory breath testing in 1993.
[23] Reported where a driver's blood sample tested over the applicable legal limit or driver refused a blood test.
[24] *The prevalence and impairment effects of drugged driving in New Zealand*, University of Waikato, Starkey, N and Charlton, S, 2017.
[25] Using evidence to build a better justice system: The challenge of rising prison costs. Office of the Prime Minister's Chief Science Advisor. 29 March 2018.
[26] Stockings E, Hall WD, Lynskey M, et al. Prevention, early intervention, harm reduction, and treatment of substance use in young people. *The Lancet Psychiatry* 2016; 3(3): 280-96.

can be accessed and utilised in the drug driving context. An example could be referring drug drivers to drug education or drug rehabilitation programmes, mental health services or counselling, with or without proceeding to the processing of an offence.

63. Another example could be enhanced use of New Zealand's Therapeutic Courts and Alcohol & Other Drug Treatment Courts. In New Zealand, there are three therapeutic courts: two in Auckland and one in Wellington. Therapeutic courts are for people who have committed less serious offending and who have admitted their guilt. They aim to reduce reoffending, alcohol, drug use, and addiction. They aim to improve a person's overall health and well-being, so they can move on with their lives.

64. Alcohol and Other Drug Treatment Courts are based at Waitakere District Court and Auckland District Court. They are designed to supervise offenders whose offending is driven by alcohol and other drug dependency. As an alternative to prison, the court applies evidence-based best practices in a potentially transformative programme of case management, treatment, drug testing, monitoring and mentoring. Sentencing is deferred while participants go through the programme, which includes regular court appearances to check on progress, and may take one to two years to complete.

HOW CAN WE BETTER DETECT DRUG DRIVERS AND DETER DRUG DRIVING?

Roadside screening for drugs

65. Screening drivers for drugs at the roadside could make it possible to test a significantly greater number of drivers, identify more drug-impaired drivers and improve the visibility of drug driving enforcement, creating a greater deterrent effect. However, unlike screening for alcohol, screening for drugs cannot currently be undertaken by breath testing. Evidence of drug use can be determined from urine, blood or oral fluid.

66. New technologies are emerging. In the future blood spot analysis, fingerprints, pupillometry[27] or breath testing may be viable options for screening for drug use but those technologies are not sufficiently developed for use now.

67. Blood and urine testing are invasive procedures to impose on drivers who may not have consumed any drugs. They are also generally considered to be impractical options for roadside screening. Testing urine involves significant privacy issues for drivers. Testing blood requires a blood sample to be drawn by a doctor or nurse. Both urine and blood need to be analysed in a laboratory.

68. As noted above, taking a sample of bodily fluids from a driver amounts to a physical search of a person and a seizure of bodily fluids. The right to be secure against unreasonable search and seizure is a right affirmed under section 21 of the Bill or Rights Act 1990.

69. Detaining drivers to conduct drug testing without a reasonable suspicion that the driver is impaired from using drugs, for example through random testing, is likely to be inconsistent with section 22 of the Bill of Rights Act. This is because the lack of any specific, reasonable grounds for detaining someone creates an appreciable risk the detention will be arbitrary, particularly given the potential length of the detention and possibility of arrest for non-compliance.

70. Before introducing new legislation to tackle drug impaired driving, the Government will need to be satisfied that any measures it proposes that limit these rights are a justifiable and proportionate response to the harm of drug driving.

Oral fluid screening

71. For practical reasons, oral fluid testing is the standard internationally for screening for drug driving and would likely be the method of testing used initially in New Zealand. This is because screening for drugs at the roadside needs to be completed swiftly, both to minimise driver detention and to enable sufficient testing to achieve a deterrent effect.

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[27] Pupillometry is the measurement of pupil size and reactivity. It is a key part of the clinical neurological exam for patients with a wide variety of neurological injuries. It can be used to detect drug use and predict impairment.

72. Oral fluid testing is the least invasive method available to screen drivers at the roadside and is used in other countries, such as the United Kingdom among a number of European states and Australia. A number of states in Australia operate oral fluid testing programmes. For example, Victoria has operated a roadside oral fluid testing programme for over 15 years. The number of tests conducted in Australia is approaching 500,000 per annum.

73. Oral fluid screening devices work by detecting the presence of a drug (or active ingredient of a drug) by taking a swab of a driver's saliva and inserting the swab into a testing device. The device then shows either a positive result for drugs or a negative result. Drug screening devices currently take around three to five minutes to produce a result[28], which is considerably less than it takes to undertake a CIT, however, significantly longer than an alcohol breath test, which takes a few seconds. Devices can detect more than one drug at a time, however, the time taken to conduct the test can be longer if multiple drugs are screened.

Presence-based test

74. Unlike alcohol breath tests, oral fluid screening devices can only detect the presence of drugs. They cannot test for impairment. Accordingly, most countries operate a zero-tolerance policy in presence-based schemes, especially for illegal drugs. This means that some drivers who have used drugs, but may not be impaired, will fail drug screening tests and face penalties. In the jurisdictions that operate these schemes, this is considered a justifiable response to addressing the harm of drug driving and deterring drug driving behaviour.

Reliability and effectiveness of oral fluid screening devices

75. The technology of oral fluid drug detection devices is improving, however, there is a residual risk of screening devices producing false positives. A recent study of the performance of a pool of drug screening devices[29] available in Canada in 2017 found that, considering all drugs/drug categories tested for together, the screening devices collectively performed as follows[30]:

- in 87 percent of cases where a person had used one of the substances included in the screen, it was detected by the screening device;
- when a drug was detected by the screening device, in 96.5 percent of cases the positive result was confirmed by laboratory analysis;

[28] Timing may vary depending on the number of and type of drugs being tested for.
[29] Douglas J. Bierness & D'Arcy R. Smith (2017) *An assessment of oral fluid drug screening devices*, Canadian Society of Forensic Science Journal.
[30] Results presented are averages and vary by drug type.

- in seven percent of cases, where subjects had not used any of the substances, the tests produced a false positive.

76. Mitigation measures to address the problem of false positives could include:

- only using devices to screen for the drugs that the devices have the highest level of accuracy in detecting;
- conducting a second oral fluid screening test if an initial test is failed (this is the standard approach in some jurisdictions with oral fluid testing processes);
- requiring an evidential blood test as proof that an offence being committed.

Oral fluid testing devices can detect a limited range of substances

77. Basic oral fluid drug screening devices can detect the main illicit and recreational drugs of concern in New Zealand, such as THC (the active ingredient in cannabis), methamphetamine (P) and MDMA (ecstasy). They can also detect some of the drugs in the opioid class (e.g. heroin and codeine) and the benzodiazepine class (e.g. anti-anxiety medication), and amphetamines (stimulants).

78. However, currently, drug screening devices cannot detect synthetic cannabinoids and other 'designer drugs', the use of which is a growing concern in New Zealand. They also detect only a small number of prescription drugs. This is a compelling reason to retain the current CIT process, which is able to identify drivers who are impaired from drugs that oral fluid screening devices cannot detect.

79. Legislation developed to address drug impaired driving will need to enable new testing devices to be approved for use as technology improves and they come on to the market. This could include setting performance criteria around the sensitivity and accuracy of devices.

Cost of oral fluid screening devices

80. An oral fluid test is much more expensive than an alcohol breath test. Alcohol breath testing devices can be used many times as long as they are regularly calibrated. In comparison, a saliva testing device can be used only once. An oral fluid test is likely to cost between $20 and $45, compared to a few cents for an alcohol breath test. Unless the cost falls significantly, or the Government is prepared to spend more on this activity, oral fluid tests could not be delivered in the large volumes that alcohol breath tests are.

Legal limits

81. Some countries have established legal drug limits for certain drugs, in an attempt to correlate drug use with impairment. In these countries drivers may have taken drugs but do not commit an offence if they are below the legal limits. However, because the

relationship between the type, amount and combination of drugs in a driver's system and their ability to drive is not straightforward, setting legal drug limits for driving is considered by some researchers and policy-makers to be arbitrary. There is also a risk that drivers who are impaired, but below the legal limits, are able to continue driving on the road. The 'trade-off' for legal limits is that levels of presence of a drug cannot be determined by an oral fluid test and must be confirmed by a blood test, meaning greater inconvenience for drivers.

82. Establishing legal limits is one way of protecting the right of people to be presumed innocent until proven guilty. In New Zealand, this right is affirmed in section 25(c) of the Bill of Rights Act 1990.

83. Legal limits provide clarity around when a person will be held criminally liable. The United Kingdom has adopted a zero tolerance approach to eight drugs most associated with illegal use, but has set limits for the presence of those drugs that rule out claims of accidental exposure.

84. Setting a legal driving limit for drugs that are illegal could be seen as sending a contradictory message about whether such drugs should be used at all. This is especially the case for illicit drugs. However, it may be appropriate for prescription drugs, which are taken for medicinal purposes.

QUESTION 1: Do you think that roadside drug screening is a good option for deterring drug driving and detecting drug drivers? Are there other options not mentioned in this Discussion Document?

QUESTION 2: Do you support oral fluid screening for roadside drug testing of drivers? Are there other options not mentioned in this Discussion Document that could be considered?

QUESTION 3: Is it reasonable to delay drivers by 3 to 5 minutes to administer a roadside drug screening test, in order to detect drug drivers and remove them from the road?

QUESTION 4: Is a presence-based, zero-tolerance approach to drug driving, where presence of a drug is sufficient for an offence, appropriate for New Zealand?

QUESTION 5: Should there be legal limits for some drugs?

IN WHAT CIRCUMSTANCES SHOULD DRIVERS BE TESTED FOR DRUGS?

Roadside drug screening options

85. There is a range of approaches for enhanced drug driver screening using oral fluid testing. Screening could be targeted, for example to scenarios in which drivers may be perceived to be 'at-fault' following an incident, such as a crash, or after committing a driving offence. At the other end of the scale, random drug screening could be undertaken at any time, as is the case for alcohol.

86. Three approaches have been identified for consideration in this Discussion Document but they are not the only possible approaches. They are:

- testing under the current 'good cause to suspect' criterion
- targeted testing following an incident or a driving offence
- random roadside drug screening, along the lines of the current breath alcohol testing model.

87. The main difference between the approaches is the criteria that would enable a Police officer to undertake the testing process. The perceived likelihood of being tested, and the deterrent effect, would also vary between each approach.

88. Each approach has impacts on the rights and freedoms of drivers. For example, introducing random testing would impact rights affirmed and protected by the New Zealand Bill of Rights Act 1990, such as the right to be secure against unreasonable search and seizure (section 21), the right not to be arbitrarily detained (section 25) and the right to be presumed innocent until proven guilty (section 25(c)). Measures that produce limitations on these freedoms need to be a reasonable and proportionate response to the harms the measures seek to address.

89. The approaches discussed below are suggested as enhancements to the current CIT process. This is because, despite its limitations, the CIT process is effective at identifying drug drivers who are significantly impaired and removing them from the roads.

90. Oral fluid screening devices can detect the presence of a limited number of drugs. It will be important that Police have the option to use the CIT process where a driver is suspected of being impaired by drugs that cannot be confirmed by an oral fluid test.

Approach 1: Testing under the current 'good cause to suspect' criterion

91. Under this approach, Police would still need to determine if they had good cause to suspect a driver had used a drug or drugs before conducting a drug screening test. This screening test would take considerably less time to conduct than the existing CIT, creating

some efficiency for both Police and drivers. However, Police would still be limited in the number of drivers they could process by the requirement to establish 'good cause to suspect' before undertaking the test.

92. Maintaining the good cause to suspect criterion would reduce the chance of drivers being unnecessarily tested. However, the main disadvantage of the approach is that it is unlikely to have an increased deterrent effect because it will limit the number of possible tests that can be completed. A study by Monash University in Australia concluded that, to achieve optimal levels of general deterrence, 10 percent of licensed drivers should be tested for drugs each year.

93. Police estimate they might perform up to 1,000 drug screening tests per annum using the 'good cause to suspect' approach, which is unlikely to be sufficient to provide a general deterrence effect. Therefore, this approach may not achieve any significant additional road safety benefits.

94. This approach would have the least overall impact on New Zealand drivers' rights and freedoms under the Bill of Rights Act, as drivers who are not exhibiting symptoms of drug use will be very unlikely to be stopped and tested for the presence of drugs. It would also be the least expensive approach, due to the low number of tests completed.

95. Canada adopted this approach when it introduced roadside oral fluid testing as a complementary option to CIT testing, in 2018. Canada has a random testing regime for drink driving but not for drug driving – a driver can only be tested for drugs if an enforcement officer has "reasonable grounds to suspect a driver has drugs in their body".

96. Canada does not have a random drug testing regime, in recognition of the difference in time it takes to screen a driver for alcohol compared to drugs. The length of time drivers would be detained for drug testing, when they had potentially not consumed any drugs, was considered to be an unjustifiable breach of the Canadian Charter of Rights and Freedoms.

Approach 2: Targeted testing following an incident or a driving offence

97. Under this approach, a driver could be tested following either a suspected driving offence or involvement in a motor vehicle crash. This approach differs from Approach 1, because drivers may be tested for drugs in circumstances where Police have not established good cause to suspect the driver has used a drug or drugs.

98. Eligible driving offences could consist of offences relating to driving that are enforced by a Police officer or limited to more serious driving offences. Parking offences and owner liability offences such as speed camera and toll offences could be excluded.

99. This approach would provide a wider pool of potentially drugged drivers, including drivers who may be injured or in a state of shock or emotional distress who cannot fairly be

requested to complete a CIT following a crash. The Police find that they are seldom able to use impairment testing for crash-involved drivers. Testing following a crash is a common approach following workplace accidents where people are involved in safety sensitive roles.

100. Drivers suspected of committing driving offences and those involved in motor vehicle crashes would provide a much wider pool of potentially drug impaired drivers compared to those who are tested through current drug driving enforcement. There are approximately 300,000 driving offences each year, where Police would be able to undertake drug tests. There are over 50,000 drivers involved in crashes each year that Police attend.

101. These higher levels of testing would increase both the perceived and actual risk of being caught while driving after using drugs.

102. This approach would have a more significant impact on New Zealand drivers' rights and freedoms under the Bill of Rights Act than Approach 1, as drivers who may not exhibiting symptoms of drug use will be tested for the presence of drugs[31].

103. Drug testing drivers without a reasonable suspicion that they are impaired, is inconsistent with section 22 of the Bill of Rights, which affirms the right not to be arbitrarily arrested or detained. The fact that a driver has been involved in a crash, or has committed a driving offence, is not sufficient evidence that they have consumed drugs.

104. However, only drivers who have committed a driving offence or been involved in a motor vehicle crash will be tested, meaning that they will have already been detained at the roadside while police complete vehicle and/or licence checks, issue an infringement notice or complete an incident report. This may address concerns that the detention of the driver is arbitrary or unreasonable.

105. This approach would be more expensive than Approach 1 as more drug tests will be completed.

Approach 3: Random roadside drug screening

106. Under this approach, the legal power the Police would have to test drivers would be very similar to the power they have to test drivers for drink-driving. A driver could be stopped and tested without any reason. In practice, the Police would likely undertake screening in a targeted way. There would be a specific emphasis on targeting high risk driving behaviours, such as fleeing drivers, illegal street racing, or speeding at night and in high risk places.

[31] Requiring a person to provide bodily fluid sample for drug testing is considered to fall within the definition of "search and seizure".

107. Deterrence theory[32] suggests that random screening is the most effective for achieving an increased general deterrence effect. This is because random testing models provide the greatest increase in the public perception of the possibility of being caught drug driving anytime, anywhere.

108. Random drug screening would be significantly more expensive for the Police than random testing for alcohol, due to:

- higher costs of roadside drug screening devices
- higher costs of the laboratory testing of specimens for drugs that would be required for evidential purposes
- higher costs to Police resources, specifically for Police time and training.

109. There could be corresponding increases in costs for the Justice and Corrections sectors, but these would be low if an infringement offence was adopted (discussed later in this document).

110. Of the three approaches described in this Discussion Document, random drug screening would have the greatest impact on drivers' rights and freedoms under the Bill of Rights Act, including the right to be secure against unreasonable search and seizure and the right not to be arbitrarily detained. This is because a larger number of drivers will be detained for drug testing and subjected to an invasive procedure, the majority of whom have not used any drugs.

111. Before introducing new legislation to tackle drug impaired driving, the Government will need to be satisfied that any measures it proposes that limit rights affirmed in the Bill of Rights Act are a justifiable and proportionate response to the harm of drug driving.

112. Similar issues are sometimes raised about drink-driving. However, oral fluid testing will delay potentially unimpaired drivers longer than drivers screened for alcohol (3-5 minutes per test). Taking a swab from a driver's mouth is more invasive than breath testing.

113. Approach 3 is also the most expensive option due to the number of drug tests that would need to be completed.

[32] Davey, J. & Freeman J. (2011). *Improving road safety through deterrence-based initiatives: a review of research*. Sultan Qaboos University Medical Journal

QUESTION 6: If roadside drug screening was introduced, which of the three approaches discussed above do you prefer?

- Testing under the current 'good cause to suspect' criterion
- Targeted testing following an incident or a driving offence
- Random roadside drug screening, along the lines of the current breath alcohol testing model.

Are there other approaches that should be considered?

QUESTION 7: If random drug screening was introduced, do you think it is a reasonable and proportionate response to the harm of drug driving? Are there circumstances in which it would be more or less reasonable?

HOW DO WE DECIDE WHICH DRUGS TO TEST FOR?

114. Under the Land Transport Act 1998 it is an offence to drive while impaired and with evidence in the blood of a 'qualifying drug'. 'Qualifying drugs' include Class A and B drugs specified in the schedules to the Misuse of Drugs Act 1975[33] but also numerous medicinal drugs prescribed for depression and anxiety and various other medical conditions. All of these drugs can be detected by blood testing, which can determine the presence of several hundred illicit and medicinal drugs.

115. For practical reasons the drugs that could be screened for in New Zealand under enhanced drug screening would be limited by the method of testing adopted and, if physical samples are to be taken, the capability of the devices used by the Police. As discussed earlier in this document, basic oral fluid drug screening devices can detect THC, methamphetamine and MDMA, some drugs in the opioid class such as heroin and codeine, benzodiazepines and amphetamines.

116. However, even the most sophisticated devices cannot detect the array of drugs that blood testing can identify. Currently, devices cannot reliably detect synthetic cannabinoids and other 'designer drugs'.

117. In Australia, screening is undertaken for THC, MDMA and methamphetamine. From mid-2018, cocaine has been added in New South Wales. Studies show that New Zealanders are currently using these three drugs and driving and there is significant research on their potentially impairing effects.

Length of time drugs can be detected

118. A concern sometimes raised about oral fluid testing is that drugs could be detected in a driver's system well after a driver had consumed them and when they are no longer having an impairing effect. Drugs affect every person differently and will remain detectable for varying times. This will depend on the strength of the drug, the amount taken, how it was taken, and if it was used with other drugs.

119. Cannabis would likely be detected most by roadside oral fluid testing because it is used most widely as a recreational drug. The active ingredients of cannabis can be detected by an oral fluid test for about 4-6 hours after use. The detection time varies, depending on the amount and potency of the cannabis used and the person using it. Inactive THC residue in the body of a driver from use in previous days or weeks will not be detected.

120. An oral fluid test could detect methamphetamine and MDMA (ecstasy) for around 12 hours after use. As with cannabis, the exact time will be dependent on a number of factors, such as the size and potency of the dose. Cannabis and methamphetamine remain

[33] An exception is drivers who have been hospitalised because of a crash can only be prosecuted if their blood test shows the presence of a Class A drug (for example, methamphetamine).

present in the blood for a shorter time than other bodily fluids (e.g. saliva) so their presence in a blood sample is indicative of recent use.

121. Oral fluid devices and blood tests only detect active compounds of drugs. They do not detect inactive compounds, which can be detected in body tissues and fluids for days or sometimes weeks after they have been taken.

Prescriptions drugs

122. Numerous prescription drugs can affect driving performance. Over 1500 different drugs are prescribed in New Zealand and over 200 of these come with the warning "do not drive or operate machinery if affected, may cause drowsiness", or "restrict or avoid alcohol". Basic drug screening devices can detect the presence of only some of these drugs.

123. Research undertaken for the NZ Transport Agency's Substance Impaired Driving Project found that 25 percent of all prescriptions are for medication that can impair driving[34] and nearly 65 percent of drivers are unaware that it is illegal to drive while impaired by medication[35].

124. In 2017, the University of Waikato undertook a study on the prevalence and impairment effects of drug driving in New Zealand[36]. The study included an internet survey of drivers that found that the percentages of drivers who used potentially impairing prescription drugs within three hours prior to driving were: strong painkillers (16.6%), antidepressant medication (14.3%), anti-nausea medication (5.8%), and anti-anxiety medication (5.5%).

125. Currently, oral fluid screening devices can only detect a small range of prescription drugs. For this reason, most jurisdictions only conduct roadside screening of drivers for illicit drugs, and rely on CIT type testing to identify drivers who are impaired from prescription drugs.

Medical defence

126. The impacts of a zero-tolerance presence-based approach on drivers who are taking prescription medication could be mitigated by including a medical defence for circumstances in which a driver has taken medication in accordance with a prescription from a medical professional. This defence is currently available in New Zealand for drivers who are taking prescribed qualifying drugs, such as medicinal cannabis.

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[34] NZ Transport Agency (2015). For NZTA Substance Impaired Driving Project. *Memo: Analysis of summary data from the pharmaceutical collection year to July 2014.*

[35] NZ Transport Agency (2015). For NZTA Substance Impaired Driving Project. *Memo: Baseline Driver Survey*.

[36] *The prevalence and impairment effects of drugged driving in New Zealand*, University of Waikato, Starkey, N and Charlton, S, 2017

127. Section 19(1) of the Bill of Rights Act, in combination with section 21(1)(h) of the Human Rights Act 1993, affirms the right of people to be free from discrimination on the basis of disability. A medical defence is one way to ensure drug driver testing measures are responsive to the needs of individuals with medical conditions.

128. However, drivers who take medicinal drugs in excess of prescribed amounts (potentially even at prescribed amounts) or combined with other drugs or alcohol can be a danger to themselves and other road users. We are interested in your views about how the use of prescription drugs should be managed, at the point where drug screening devices can reliably detect their presence. Should there be a medical defence? Is it appropriate that there is a defence for driving after taking prescription drugs that may impair driving?

Criteria for determining which drugs should be screened for

129. As discussed above, initially, the number and type of drugs that can be screened at the roadside will be limited by the method of testing and the capability of the testing devices available to Police. As technology advances, the range of drugs that can be screened will increase. Information about what drugs can be screened should be available to drivers. This would be particularly important if there is no medical defence for prescription drugs.

130. Criteria for including drugs for screening could include:

- there is conclusive and robust evidence that they have impairing effects in dosages that are commonly taken
- their usage is prevalent in drivers in New Zealand
- they are able to be reliably detected by screening devices to an established standard of accuracy

Process for adding drugs to be screened

131. The range of drugs available is constantly evolving, particularly synthetic drugs. There needs to be flexibility to adapt to changing patterns of drug use and the devices that can test for a wider range of drugs.

132. The drugs that are subject to screening could be specified in primary legislation, such as the Land Transport Act 1998. This option would mean that changes are subject to parliamentary processes but is inflexible compared to other options. An alternative could be to provide Police with the discretion to determine what drugs are to be tested for and to publish those details periodically, but this would reduce government oversight and accountability and put Police under a high level of scrutiny.

133. A middle ground could be to specify the drugs that are to be screened by Order in Council on the recommendation of the Minister of Transport. This would mean there was Cabinet

oversight of decisions to expand or remove drugs from the screening scheme. Details would be published in the *New Zealand Gazette* and media sources.

QUESTION 8: What criteria should be used to determine if a drug is included, or excluded, from drug screening?

QUESTION 9: What regulatory process should be used to specify the drugs that are identified for screening?

QUESTION 10: Should illicit and prescription drugs be treated differently?

QUESTION 11: Should there be a medical defence for drivers who have taken prescription drugs in accordance with a prescription from a medical professional?

WHAT EVIDENCE IS REQUIRED TO ESTABLISH A DRUG DRIVING OFFENCE?

Evidential reliability

134. While the accuracy of oral fluid testing devices has improved over recent years, they can produce false-positive results. This is where the device incorrectly indicates the presence of a drug. It can occur because of a failure of the screening device or from operator error, though the latter can be reduced by training. This risk weighs heavily against using a single oral fluid test for evidential purposes.

Two oral fluid tests

135. An option for mitigating the risk of false-positives is for a second screening test to be taken at the roadside if a driver fails the initial test. Conducting a second oral fluid test would reduce the overall risk of a false-positive outcome for a driver. However, undertaking two tests would mean more time stopped at the roadside for the small percentage of drivers who are subject to an initial false-positive. If a driver passed the second screening test, they would be free to go.

136. In most states in Australia, a second evidential oral fluid test is conducted if a positive result is achieved on the first test. The sample from the second test is sent for laboratory analysis to provide evidence for a conviction. In South Australia, only one oral fluid test is conducted and used for evidentiary purposes.

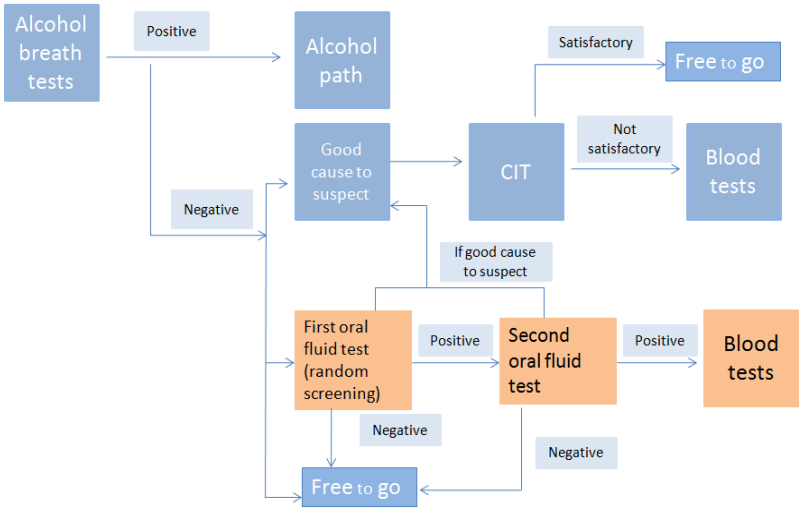
137. In the United Kingdom, a positive oral fluid test is followed by the taking of a blood or urine sample. There is no second oral fluid test. In the United Kingdom, a Police officer must suspect a driver is impaired by drugs before conducting an oral fluid test.

Blood test for evidentiary purposes

138. Blood testing remains the most accurate method for confirming the presence of drugs and is the standard procedure in many countries that conduct oral fluid drug screening. Blood tests are conclusive and provide no false positives. Under the current process, a failed CIT is followed by an evidentiary blood test.

139. Requiring an evidentiary blood test as proof of an offence would mitigate concerns about drivers being penalised for false-positives and would be an important safeguard in the drug testing scheme.

140. A flow chart illustrating how testing could be conducted under a random roadside testing approach is set out below:



Drug screening followed by a CIT

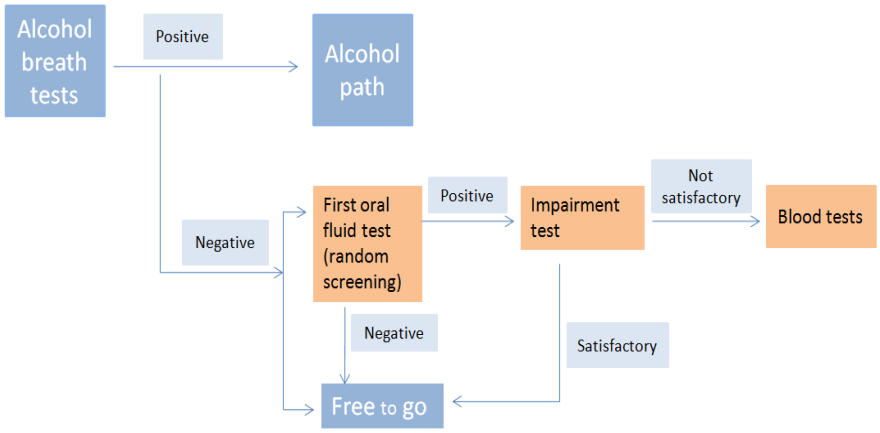
141. A further option could be to require Police to undertake a CIT following a failed drug screening test. Failing the CIT would lead to an evidentiary blood test and, due to the predictive accuracy of the CIT, in most cases a criminal conviction.

142. While this approach would ensure that only impaired drivers are convicted for drug impaired driving, the limitations of the current CIT process would remain. The time consuming and resource intensive nature of CITs, would limit the number of drivers that can be tested and would reduce the general deterrent value of the enforcement activity.

143. For example, if a drug screening test was delivered through a check point – a highly visible general deterrent activity - Police officers' time could quickly become appropriated to conducting CITs, which would reduce the number of drivers who could subsequently undergo a drug screening test at the check point. Further, any reduction in staff numbers on the check point could also lead to a reduction in the number of passive breath alcohol tests conducted by Police.

144. It is also unclear how this option would sit alongside the current framework for drug impaired driving – for example, whether the ability to require drivers to undergo a CIT can be as a result of a positive drug screening test, good cause to suspect being established, or a combination of the two.

145. A flowchart illustrating how testing could be conducted under a random roadside testing approach with a CIT incorporated is set out below:



QUESTION 12: If oral fluid testing was introduced in New Zealand, do you think there should be a requirement for a second drug screening test following a failed first test? Do you prefer another option for screening drivers?

QUESTION 13: Do you think that drug driving offences should be confirmed with an evidentiary blood test? If not, what evidence should be required to establish an offence of drug driving?

HOW SHOULD WE DEAL WITH PEOPLE CAUGHT DRUG DRIVING?

Available sanctions

146. Road safety offences in New Zealand are subject to two main types of penalties. Infringement offences are used for less serious offences. This involves an infringement fee and is not a criminal conviction. Sometimes, an infringement will involve demerit points as well as a fee. The accumulation of 100 or more demerit points within a two-year period will result in a three-month licence suspension.

147. Offences that are more serious involve criminal penalties, such as high-level drink-driving offences[37]. Courts consider these offences and a convicted offender will have a criminal record. As well as fines, penalties could include imprisonment and mandatory disqualification.

148. In New Zealand, the severity of drink-driving penalties depends on the amount of alcohol that a driver has in their system. At low levels, a driver will commit an infringement offence. At higher levels, penalties will be Court-based. Those with higher levels of alcohol in their systems will be more impaired and at greater risk of harming others on the road.

149. Drug-driving offences are currently set at the level of high-end alcohol offences. This reflects that the CIT has shown those drivers to be impaired. For a first and second offence, a drug driver could receive a prison term for up to 3 months, or a fine of up to $4,500; and a mandatory disqualification of 6 months or more. As well as punishing them for their behaviour, society wants to deter them from further offending and deter other potential drugged drivers.

150. The question of what penalty a driver should receive if they fail a roadside drug screening test is more difficult because it only shows the presence of a drug. A driver who fails a roadside screening test could be heavily or mildly impaired, or not impaired at all.

151. Presence-based drug testing schemes, where an offence is committed once a drug is identified, will generally place an onus on drivers to prove their innocence, rather than Police to disprove any potentially available defence. A reversal of the onus of proof in these circumstances will limit the right to be presumed innocent and, without adequate procedural safeguards and justification, is likely to be inconsistent with section 25(c) of the Bill of Rights Act. Relevant considerations will include the nature of any defences, and the potential penalty level.

[37] Adult drivers detected with over 80 milligrams (mg) of alcohol per 100 millilitres (ml) of blood will receive a criminal penalty. Adult drivers detected between 50 mg and 80 mg receive an infringement offence.

152. One possible means of addressing this could be to follow a positive presence based test with a cognitive impairment test (CIT) to assess whether the driver is in fact impaired by the drug in their system.

153. Another way of addressing this issue is to set the penalty for failing a presence-based drug test at the lower end of potential penalties. For example, the penalty for failing a presence based test could be set at the same level as a low-level alcohol offence - a $200 infringement fee and 50 demerit points. While not criminal, this penalty would still be moderately severe. A second offence within 2 years could see the driver's licence suspended for 3 months. This could have an impact on a driver's employment opportunities or their ability to travel, for work or leisure, including internationally.

154. Drivers who are convicted following a CIT are currently subject to criminal penalties and this could continue to be the approach under the CIT scheme.

155. The current drug driving scheme prevents drug testing in the land transport context from feeding into offences under other drug-related legislation. Measures to enhance the current scheme could be constructed with a similar architecture. In this way, detection of illicit drugs from roadside testing would not lead to criminal liability under the Misuse of Drugs Act 1975 or the Psychoactive Substances Act 2013.

Advantages and disadvantages of infringement offences

156. Police believe an infringement offence could lead to a risk of drug-driving being seen as a minor offence. This may depend on the infringement penalties applied. An infringement fee coupled with demerit points could offer a reasonable deterrent, proportionate with the nature of the offence and the social harm caused.

157. Operating a drug screening scheme with an infringement offence and the impairment scheme with a criminal offence would produce quite different legal consequences for a driver. These consequences would depend on what testing method the Police officer chose to use. For example, a driver subjected to a presence-based screening test could receive an infringement offence and not have a criminal record. However, they could be charged with a criminal offence if they were tested under the impairment scheme, although there is a higher evidentiary threshold for that scheme.

158. A possible mitigation to this potential inconsistency is to allow the Police, under certain conditions, to switch from the presence-based screening process to the impairment testing process. A switch could be made, if after starting the screening process, a Police officer formed good cause to suspect a driver had used drugs. For example, a driver passed the first screening test but admitted to the Police they had taken drugs or they appeared to be under the influence of drugs. This would allow a driver to face the more serious criminal penalty if they are impaired, regardless of which testing process the officer started with. The risk of an impaired driver avoiding a sanction would be reduced when they had used a drug that the screening device could not detect.

159. Infringement penalties would not put as much pressure on the Justice sector as criminal-based sanctions and would result in much lower costs, as infringements do not generally result in a court hearing unless the driver requests a defended hearing. Infringement penalties offer a swifter way of sanctioning drivers than a court prosecution.

Advantages and disadvantages of criminal penalties

160. A criminal penalty for a drug-driving offence detected by a roadside screening test would mitigate the concern of two individuals being treated differently under the law, depending on whether they went through the oral fluid testing process, or the impairment process. Both offences would have the same penalty. Police also believe that criminal sanctions would act as a strong deterrent to drug-driving.

161. However, under the Bill of Rights Act, a driver has the right to be presumed innocent until proven guilty. Criminal penalties, under a presence-based scheme, would impose harsh penalties on drivers who may not be impaired, and are not a road safety risk.

162. Another disadvantage of criminal-based sanctions is the workload and cost they will place on the justice system. There would also be cost pressure on the Department of Corrections for their management of sentences. There would also be increased costs for Police, in support of prosecutions.

Other possible approaches to penalties

163. There is a range of other possible approaches to penalties, including different combinations of penalty levels. The penalties for an infringement offence could be raised to send a stronger signal. Alternatively, criminal offence penalties could be lowered to better align with the presence-based offence. Changing penalty levels will not affect the criminality of the offence - even with a higher infringement fee, an infringement offence would still not constitute a criminal conviction.

164. Victoria, Australia operates a combination of the two approaches based on a driver's previous offences. A first offence for drug driving with illicit drugs in their system results in an infringement fee and a licence suspension of 6 months. A second offence results in a court appearance and possible conviction, and licence cancellation of at least 12 months.

165. In Canada, where there are legal limits for THC, there are different penalties based on the level of THC detected, and whether THC is present in blood together with alcohol. A driver with between two and five nanograms of THC per millilitre of blood faces a fine of $1,000 but does not commit a criminal offence.

166. A driver with five or more nanograms, or with a blood alcohol level of 50 mg of alcohol per 100 ml of blood combined with a THC level of 2.5 nanograms, commits a criminal offence. The penalty for the offence is $1,000 for a first offence, a minimum of 30 days

imprisonment for a second offence, and a minimum of 120 days imprisonment for a third offence.

Rehabilitation and support services

167. At the core, drug use, is a health issue and penalties or other responses to people caught drug driving should be considered in that context. The National Drug Policy 2015 – 2020 has an overarching goal to minimise alcohol or other drug-related harm, and promote and protect heath and wellbeing. The Policy emphasises a proportionate response to minimise drug-related harm and promotes alternatives to the criminal justice system for dealing with low-level offenders.

168. Non-enforcement tools or approaches are available. How they can be accessed and utilised in the drug driving context is an important consideration. An example could be referring drug drivers to drug education or drug rehabilitation programmes, mental health services or counselling, with or without proceeding to the processing of an offence.

169. In Victoria, Australia, drivers who commit drug driving offences are required to complete a Drug Driver Behaviour Change Programme. Drug driver testing presents an opportunity to educate drivers about the harms of drug driving, and illicit drugs generally.

170. New measures to address drug driving could include requirements for drivers who are caught driving after using illicit drugs to attend programmes designed to help them to identify the underlying reason for their drug-driving offence and identify ways to reduce the risk of re-offending. These programmes could be a gateway to referrals for additional support for drug addiction or related issues.

171. Currently, the Courts have powers to require a driver to attend an assessment centre approved by the Chief Executive of the Ministry of Health, as a mandatory penalty for repeat drink or drug driving offences[38]. However, this engagement with a health provider comes at a stage when the driver is already in the Justice system.

QUESTION 14: Do you think an infringement offence (an instant fine and demerit points) or a criminal penalty (mandatory licence qualification, fines and possible imprisonment) is appropriate for the offence of drug driving?

QUESTION 15: Is there any other penalty or action in response to the offence of drug driving that you think should be considered?

QUESTION 16: Do you think it is reasonable to penalise drivers who have used drugs, but may not be impaired?

QUESTION 17: Do you have anything else you would like to say about drug driving?

[38] Section 65 of the Land Transport Act 1998

WHAT ARE THE NEXT STEPS?

172. This discussion document seeks feedback on the options for enhancements to New Zealand's current drug driving scheme. Along with the questions asked above, any other relevant information or feedback you may provide will be appreciated. Details on making a submission are provided at the beginning of this document.

173. The Government will consider whether to make changes to drug-driving detection and enforcement following consultation. A Bill would need to be presented to Parliament to amend the Land Transport Act 1998 to make any changes. Public submissions would be sought on the Bill.