New Zealand Drug Foundation submission on the Land Transport (Drug Driving) Amendment Bill

Submitted to the Transport and Infrastructure Select Committee on 29 August 2024.

We request the opportunity to make an oral submission to this Bill.

The Drug Foundation is a charitable trust. We have been at the forefront of major alcohol and other drug debates for over 30 years, promoting healthy approaches to alcohol and other drugs for all New Zealanders.

Tēnā koutou,

Thank you for the opportunity to provide feedback on the Land Transport (Drug Driving) Amendment Bill.

We support the intent of this Amendment Bill to reduce serious crashes and road fatalities. People who are impaired due to substance use – or for any other reason – should not be driving. We are grateful to see ongoing efforts to reduce the harm resulting from impaired driving caused by illicit drug or medication use.

However, we do have concerns about the unintended consequences of rolling out the oral fluid screening regime as outlined in the Amendment Bill. Attempts to identify a technology that can accurately differentiate between impairment and non-impairment are frustrating. Unfortunately, despite technological advances, there is still no gold standard device for measuring impairment by detecting substances using oral fluid. Currently available testing technology will create problems for some drivers who, despite careful attention to follow their doctor's advice, may be inadvertently caught up in this new regime.

That said, in our submission we offer some suggested changes to the Bill to mitigate the unintended impacts. As we understand it, the Compulsory Impairment Test (CIT) is the best measure of whether a driver is safe to be behind the wheel, and it is not reliant on testing for a specific substance. We recommend that an abridged CIT should be developed, and then should follow two failed oral fluid screening tests before implementing a 12-hour driving ban.

Rolling out roadside oral fluid screening tests via checkpoints which stop every driver, or if police see evidence of impaired driving (as opposed to testing without reasonable cause for suspicion), will go some way to alleviating the concerns raised in the Attorney-General's report that this legislation will unjustifiably intrude on people's right to bodily privacy, and result in arbitrary detention.

We note that 19 out of 25 qualifying drugs are registered medicines approved for use in New Zealand. While in some cases, drivers using these medicines may be impaired and not fit to drive, in many other cases, they are not impaired, and they will be advised by their doctor they are safe to drive. This means that many patients who have been driving safely while taking their medication may suddenly be subject to an automatic 12-hour driving ban. Instead of this, we recommend allowing drivers with a valid prescription in their name to present this as evidence on demand to police, instead of having to prove themselves after the fact using the medical defence model. If there are reasons to believe that the driver is impaired, police could still progress with an abridged CIT, and prevent the driver from driving.

We have concerned that this Amendment Bill will disproportionately affect disabled people. Disabled people are more likely than non-disabled people to use certain medications on the qualifying drugs list (such as certain ADHD medications), are more likely to use some illicit substances, and face more access barriers to public transport than non-disabled people. Ensuring testing is carried out in a non-discriminatory manner, and using testing devices that accurately measure specific substances will

mean fewer people are unfairly penalised. We therefore welcome regular reviews of this legislation as outlined in Part 9 (Schedule 1) to ensure that disproportionate impacts are not being felt by some of our most vulnerable people.

Unlike alcohol breath tests, currently available oral fluid tests will result in an appreciable number of false negatives and positives. This means some people will be penalised unfairly, and others will be sent on their way despite being unfit to drive. We recommend a model that streamlines the existing CIT, making it practical for police to carry out roadside alongside oral fluid screening tests.

We are aware of emerging technologies which can measure impairment in a range of settings, and could work well for roadside impairment testing. We need to continually assess rapidly emerging technology that tests for impairment from any cause, and allow for it to be approved for use outside the three-yearly review cycle. We would especially support piloting new technology to measure drivers' impairment. This could become the gold standard for improving road safety.

Thank you for considering our submission.

Nāku noa, nā

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NZ Drug Foundation Te Puna Whakaiti Pāmamae Kai Whakapiri

Introduction

1. Without question, there are far too many road fatalities in New Zealand each year. We support the intention behind this Amendment Bill, to prevent accidents caused by people impaired by medicines or illicit substances.
2. However, we are concerned that passing this Amendment Bill will result in unintended consequences.
3. We propose some amendments, which we recommend in this submission, to mitigate unintended impacts.
4. We are conscious that this legislation may have a disproportionately negative impact on Māori, Pasifika people, and disabled people. While we welcome the regular three-yearly review to understand these impacts, they can be prevented or mitigated by the way in which the regime is legislated and rolled out in the first place. This includes conducting oral fluid screening tests in a less discriminatory manner, consistent with the existing approach of universal screening at drink driving checkpoints. This would also go some way to alleviating the incentive to meet the annual target in an inappropriate way.
5. The proposed oral fluid screening regime does not penalise driving while impaired by drugs. Instead, it penalises prior ingestion of certain qualifying substances – the majority of which are prescription medicines. Critically, it risks penalising drivers who are not impaired and may have taken a qualifying substance (or a substance within its wider family) many hours or even days before driving. The current process of a 'medical defence' does not adequately safeguard the rights of people with chronic conditions who drive without impairment, and we make some recommendations for amendments.
6. New Zealanders need assurances that the tests will have high sensitivity and specificity, to avoid unjust and unnecessary driving bans.
7. The Police already have methods to assess impaired driving, such as the Compulsory Impairment Test (CIT). We acknowledge that currently, CITs have a limited deterrent effect despite criminal penalties for failing a test. They may also not detect impairment from all substances. We need to be aware of rapidly advancing non-invasive technologies to detect impairment, which in a few years, are likely to be used more often. Such technologies rightly put the focus on detecting impairment for any reason.
8. We share the concerns of the Attorney-General that testing drivers via an oral fluid screening device is not easily justified without suspicion of impairment. This is more concerning if penalties or driving bans are administered without proof of impairment. We propose that people are not banned from driving for 12 hours unless there is evidence of two positive oral fluid screening tests, plus an indication of impairment by an abridged version of the CIT. Following this, a lab confirmation of test results should be the benchmark for issuing infringement notices and demerit points.

A. We need an enhanced regime for impairment testing.

9. The Regulatory Impact Statement on the Land Transport Amendment Bill 2022 notes that in order to be an effective deterrent, roadside oral fluid screening would need to be done in a highly visible way, and at large scale, testing a significant number of drivers a year. The initial cost-benefit analysis assumed a 'conservative' deterrence impact on the proposals in that Amendment Bill (Ministry of Transport & NZ Police, 2023).

10. Considering the state of technology, at the moment, CITs remain the best available way for police to establish if a person is impaired, and whether they should be driving or not. We understand that despite the serious criminal penalties for failing a CIT, there is limited evidence that they are effective at deterring impaired driving.

11. Available research suggests that Standardized Field Sobriety Tests (SFSTs) (similar to the CIT used in New Zealand) are effective at detecting alcohol impairment among drivers, and that they can be a useful screening tool at detecting impairment from illicit drugs such as THC and methamphetamine. However, they are not failsafe at detecting impairment from all drugs, especially new psychoactive drugs (Downey et al., 2016). We acknowledge that CITs are time consuming, cannot be easily carried out roadside, and require significant training, meaning that very few are carried out each year.

12. In the absence of more advanced technology to measure impairment in a roadside setting, our first preference is to make a variant of CITs more visible and streamlined. For example, an abridged screening version of the test could be developed and validated, which could be safely carried out without needing to return to a police station. To increase their deterrent effect, abridged CITs could be carried out at roadside checkpoints after two failed oral fluid screening tests, before the driving ban is issues.

13. New technologies are emerging which can accurately test for impairment, whether that be from consuming drugs, drinking alcohol, tiredness, stress, or other causes. These include wearable or vehicle-mounted devices that collect observable information about the operator to make real-time assessment of their capacity to perform driving tasks. There are also apps in use overseas that test for impairment from any cause in workplace settings. We acknowledge that the regular three-yearly review proposed in the Amendment Bill will examine new technological capabilities. However, we believe the legislation should allow for new technologies that can effectively measure impairment to be approved as evidence of effectiveness emerges.

14. We want to see technologies piloted and tested in a roadside setting, instead of focusing on oral fluid testing. Such tests could become the gold standard for improving road safety.

Patients using a range of therapeutic medicines are typically not impaired, but they may still test positive on oral fluid tests.

15. We note that 19 out of 25 substances with legal blood thresholds under the Amendment Act are prescription medicines approved and available for use in New Zealand. These include prescription opioids for pain or used for opioid substitution therapy (OST), benzodiazepines used a range of conditions, certain formulations and dosing regimens of medicinal cannabis, stimulants for ADHD treatment, and others.

16. For example, NZTA's *Medical aspects of fitness to drive: a guide for health practitioners* (currently under review) states that 'an individual on an oral methadone treatment programme may continue to drive if the individual is stable on the programme and their methadone treatment is unlikely to affect their ability to drive safely.' They would not be considered impaired despite their blood and oral fluid levels potentially showing concentrations of opioids that would be considered extremely high for opioid-naïve individuals (NZTA, 2014).

17. Similarly, patients with a medicinal cannabis or benzodiazepine prescription are given instructions on when to take their medication, to ensure they are not impaired while performing complex tasks. If a patient is taking their medication as per their doctor's instructions, they are not expected to be impaired. However, they may still return a positive oral fluid screening test.

18. It is difficult to apply a blanket threshold that applies to all drivers equally for some medications. For example, qualifying benzodiazepines available in New Zealand including diazepam, lorazepam, clonazepam, and temazepam, are eliminated from different people's systems at vastly different rates. Clonazepam has a half-life of between 19 to 60 hours, while diazepam has a half-life of between 12 to 24 hours in the blood.

19. Recent Australian research involving drivers who used either orally ingested or inhaled prescribed medicinal cannabis found no notable evidence of driving impairment. This is despite drivers recording blood concentrations of THC which would be above the 'high-risk' blood concentration level of 3 ng/ml up to six hours after taking their medication. This study suggests that medical cannabis, used as prescribed, has a negligible impact on simulated driving performance. Additionally, despite no observable driving impairment in one simulated driving study, medicinal cannabis patients had detectable concentrations of THC in their oral fluid for a duration of up to six hours (Manning et al., 2024).

20. If oral fluid testing is not accompanied by a reliable impairment assessment, it will have an inequitable effect on a number of patients. We do not believe this is outweighed by the potential benefits of enacting roadside testing.

21. We would especially urge caution when communicating messages to medicinal cannabis patients, prescribers and pharmacists, about whether or not the use of their medicine may result in a positive test for THC. Some types of medicinal cannabis are 'full spectrum CBD', which means they mainly contain CBD, but also

trace amounts of THC which are not psychoactive. Tests for THC have been found to return a positive on some urine screening devices (Dahlgren et al., 2021). Whether or not this will also be the case with oral fluid screening devices is as yet unknown.

B. Testing for drugs cannot measure impairment alone, and is not an exact science

Neither oral fluid nor blood tests can definitively measure impairment.

22. Oral fluid screening tests for the presence of a drug, not impairment. Some substances can be detected using this method long after they have stopped causing impairment, for example cannabis and methamphetamine. That means people who have used a substance, but are no longer impaired, could be fined and potentially charged with a drug driving offence.
23. Because alcohol is water soluble, passes through the body quickly, and is exhaled in predictable amounts, it is possible to judge with a reasonable degree of accuracy if someone is impaired based on their breath alcohol reading - and thus that they were more likely to cause an accident behind the wheel. This is not possible with oral fluid screening tests for drugs.
24. THC, for example, can be detected in oral fluid up to 78 hours (three days) after use among chronic cannabis users (Odell et al., 2015). Even someone who has not used cannabis before may test positive in an oral fluid screening test up to 12 hours after consuming the substance (Drug Driving Advisory Panel, 2020).
25. Similarly, methamphetamine may still be detectable in oral fluid 24 hours or longer after use, despite a much shorter duration of action. Although there have been no controlled methamphetamine smoking studies, long-term users are likely to have detectable levels in their oral fluid for several days after using (Drug Driving Advisory Panel, 2020).

Threshold limits will be wrong much of the time, meaning some people will still face unjust outcomes.

26. We note that the blood threshold limits per drug under Schedule 5 of the Amendment Act, set in March 2023, are largely arbitrary. While an effort to set evidence-based limits for different drugs has been made, many of the limits are no more than an educated guess.
27. How a person is affected physically and cognitively by the use of a drug will be determined by the physical characteristics of the person, the method of ingestion, the dosage, whether or not the person uses that substance regularly, whether they have consumed other substances, and their underlying physical state - whether they are tired, ill, or hungry for example.

28. For most illicit substances, there is no linear association between when a person takes a drug, how much they take and their level of impairment. Two people may take the same amount of a drug at the same time, but their blood test results could be significantly different. Their impairment levels may also differ and would not correlate consistently with their blood test results.

Examples of the difficulty of setting threshold limits:

29. **MDMA.** No clear correlation exists between MDMA blood concentrations and effects. There is a significant overlap between concentrations causing minimal toxicity and concentrations associated with overdose (Drug Driving Advisory Panel, 2020).
30. **Ketamine**: there is no direct correlation between ketamine concentrations and behaviour. In blood samples, impairment sets in somewhere within the range of 50-200 ng/mL (Drug Driving Advisory Panel, 2020). The expert advisory panel has set a limit of 50ng/mL at which a criminal penalty will apply and a blood threshold limit of 10ng/mL at which an infringement will apply. It is not clear how this limit has been set.
31. **Methadone:** Methadone is a synthetic opioid used in the treatment of opioid dependence. There is a statutory blood methadone limit of 200 ng/mL and a blood threshold limit of 50 ng/mL. Yet, there is a very wide range of blood test results from those who use methadone. 10 mg doses leading to a blood concentration of 43 ng/mL are sufficient to cause impairment in opioid-naïve users. However, those receiving maintenance doses of methadone as OST may show concentrations of 440 – 820 ng/mL (Drug Driving Advisory Panel, 2020).
32. **Benzodiazepines:** a standard dose of diazepam is between 2 and 10 mg three times daily, and a dose greater than 5 mg can be enough to cause impairment. However, a standard 10 mg dose has been found to show very different blood test levels in healthy individuals, from 250 to 590 ng/mL. The blood threshold limit is just 100 ng/mL which means that for most people who use this medicine regularly and are used to its effects, they may be committing an offence even though they may not be impaired (Drug Driving Advisory Panel, 2020).
33. Because it is not possible to be sure at which level a person will be impaired by a specific drug, or combination of drugs, we risk the following:
    a. a driver may be issued an infringement notice for a non-impairing level of a qualifying drug, and/or family of qualifying drugs, or
    b. some impaired people will be sent on their way without penalty.

Oral fluid screening devices will not detect all impairing drugs, creating a risk that some people will use more dangerous drugs to avoid detection.

34. Because we still don't know which devices will be approved for use, we don't yet know how many drugs an oral fluid screening test will be able to detect at once. Still, focusing on some substances to the exclusion of others does not lead to safer roads.

35. Illicit drug supply in Aotearoa is subject to an increasingly volatile international market that is driving the production of increasingly potent substances. These substances may be more difficult to detect using traditional screening devices. Due to their novelty, they are commonly not identified with standard tests and are active at miniscule amounts making them more challenging to detect.

36. There is a risk of unintended consequences arising from testing for certain drugs, whereby someone is incentivised to take a new or more potent substance. Some motorists may switch to using some of these more harmful substances to avoid being caught, as can happen in workplaces that test for a narrow range of drugs.

37. For example, synthetic cannabinoids ('synnies') such as AMB-FUBINACA and 5F-ADB, which are controlled drugs, are unlikely to be picked up by oral fluid screening tests. Synthetic cannabinoids can be highly impairing and are well-known to carry health risks that are substantially greater than cannabis, including fatal overdose. We have concerns that some people may choose to use synthetic cannabinoids rather than cannabis to avoid detection through testing.

38. Other substances that people may choose to use instead of qualifying drugs include novel stimulants like synthetic cathinones; novel benzodiazepines such as bromazolam; and highly potent novel synthetic opioids such as nitazenes.

39. The only way to avoid this kind of perverse incentive is to continue to use established ways of testing for impairment such as the CIT, and to encourage discovery of novel impairment testing methods that are not reliant on testing for specific drugs.

False positives and false negatives are inevitable and can lead to unjust outcomes, affecting lives and employment.

40. As many as 13% of oral fluid tests will return a false negative (Beirness & Smith, 2017). This means that a person may be sent on their way even though they had consumed one of the drugs tested for, at a level that was impairing, undermining the deterring effect of the drug testing.

41. False positives may occur in as many as 10% of samples (Arkell et al., 2019), though a second oral fluid test will reduce this risk. A false positive could lead to an unjust outcome for an individual who has not consumed drugs but has returned two positive tests.

42. Some completely unrelated substances have been found to provide a false positive result on a range of different testing devices. For example, chewing

tobacco has been found to return false positive results for either methamphetamine or opioids on five different oral fluid testing devices (Buzby et al., 2021).

43. Current infringement penalties for positive oral fluid tests range from a fine of $200 - $400, and 50 - 75 demerit points. Two infringement offences within two years will therefore lead to loss of license for three months, which would be a heavy burden, especially for those who rely on driving for their employment.

44. Although infringement notices will not appear on criminal record checks for most employment purposes, we understand that they will appear on more detailed police checks of the kind carried out if a person wishes to work with young or vulnerable people. Having an infringement offence as a result of a false positive test appear on an employment check could have devastating effects for an individual or their whānau. We expect that most people would not have the means to dispute a positive test result.

Testing for 'families' of drugs will have a dragnet effect which unfairly penalises people taking a variety of medications

45. We are seriously concerned about the amendments to Part 1 in the Amendment Bill that specify testing devices can be approved when they are simply accurate enough to detect 'families of drugs that individual qualifying drugs are members of'. As written, this includes drugs that

> *(a) share a substantially similar chemical structure (for example, benzodiazepines and amphetamine); or*
>
> *(b) have a similar effect, including a pharmacological effect, if consumed, smoked, snorted, or injected by any person, or used in any other manner intended to have a pharmacological effect on the user (for example, opiates)*

46. We think these criteria are far too broad and will penalise people for using medications within some classes of drugs, which is later confirmed in a laboratory, but in the immediate term, may mean they are disqualified from driving for 12 hours.

47. If the testing devices which are approved are only able to detect 'families' of drugs, there needs to be clear and detailed information disseminated to prescribing doctors, pharmacists and patients so they can understand exactly which medications could return a positive test for a qualifying drug.

48. In particular, this will directly affect those who are prescribed stimulant medication in the amphetamine family for the treatment of ADHD. Dexamfetamine and lisdexamfetamine are prescribed to people with ADHD in New Zealand. Dexamfetamine sulfate can also be prescribed to treat narcolepsy (a chronic sleep disorder). In 2022, 3,842 people were prescribed dexamfetamine (Te Whatu Ora, 2023). Dexamfetamine and lisdexamfetamine are 'structural amphetamines', that is, they are in the amphetamine family of drugs.

49. People who are prescribed medication to treat ADHD symptoms are not typically given directions to take care when driving or operating heavy machinery, as the medications are not known to cause impairment while performing complex tasks. In fact, people with ADHD who take their medication as prescribed may display improved driving performance (Barkley & Cox, 2007; Surman et al., 2017).

C. The medical defence should be streamlined to avoid negative impacts on non-impaired drivers with chronic conditions

50. We note that under the Land Transport Act 1998, in order to apply for a medical defence to dispute a drug driving penalty, applicants are already required to submit a copy of their 'current and valid prescription' for the qualifying drug(s) they returned a positive blood test for.

51. The word 'current' has no timeframe attached to it, and may be interpreted to only cover 3 months post medicine prescribing (as is the usual period for which medicine are prescribed). However, it is common and accepted practice for patients not to finish a course of medicine, for several reasons. One possibility is that they find their symptoms have improved for a time. The majority of medications on the list of qualifying drugs, for example zopiclone and some opioids, may be prescribed as PRN (to be taken as needed for symptom relief)[1]. If symptoms return, patients will typically return to using medication from a previous prescription instead of obtaining another doctor's prescription, which costs time and money.

52. We strongly recommend that section 64 (1AB) (a) of the Land Transport Act which describe the conditions for medical defence is amended, to allow for a prescription in a driver's name alone to be allowed as evidence in a medical defence, regardless of the date of the prescription. This would also remove the confusion surrounding the phrase 'current prescription'.

53. An alternative would be to specify a period of time where this should be accepted as evidence and educate the prescribers, pharmacists and patients about this period. This period should be established by consulting with prescribers and patients.

54. Given that police will have expanded powers under this Amendment Bill to prevent someone driving for 12 hours based on an oral fluid screening test, we believe this Amendment Bill is an opportunity to refine s64 of the Land Transport Act to give greater allowances for a medical defence. We reiterate the point that 19 out of 25 of the listed qualifying drugs are available via a doctor's prescription.

[1] Medicines that are commonly prescribed as PRN (to be taken as needed) on the list of qualifying drugs include: alprazolam, clonazepam, diazepam, lorazepam, temazepam, zopiclone, codeine, oxycodone, tramadol, dihydrocodeine, morphine, and THC. We note that oxazepam, nitrazepam and triazolam have been recently made unavailable for use in New Zealand.

A 12-hour driving ban will be costly and disruptive for many patients who can drive safely after taking their prescribed medication.

55. For those drivers who have a prescription for a qualifying drug, we recommend that provisions are written into the legislation which remove the necessity of a medical defence post factum. This should include drivers being able to carry a letter from their prescriber, or prescription details or labels that would mean they do not need to be banned from driving for 12 hours – especially if no CIT is carried out.

56. We suggest an alternative proposal for drivers holding a valid prescription. Those drivers who return two positive oral fluid screening tests, but pass an abridged CIT and are able to produce a valid prescription, should be allowed to continue driving instead of being banned and then having later to go through the medical defence application process.

57. We believe that the current medical defence model goes against the principles of natural justice. Should this roadside drug testing programme go ahead, we strongly recommend developing a clear and equitable system where non-impaired patients are not penalised.

D. The provisions in the Amendment Bill do not justify the intrusion on bodily privacy, and constitute arbitrary detention under the Bill of Rights Act.

58. The Attorney-General's report, assessing whether the Amendment Bill is consistent with the rights and freedoms affirmed in the NZ Bill of Rights Act 1990 (the Bill of Rights Act), states that requiring drivers to undergo compulsory oral fluid screening tests, without suspicion of impairment, is inconsistent with s21 of the Bill of Rights Act, and is an unjustifiable "intrusion on bodily privacy."

59. We urge serious reconsideration of the provisions in the Amendment Bill which allow officers to test any driver without cause to believe they are impaired. We want to see oral fluid screening tests carried out in the least discriminatory manner possible, for example at police checkpoints which stop all drivers for testing. Alternatively, if an officer suspects impairment, as they do now, that should continue to be a cause to stop them and assess impairment.

60. The evidence suggests that tests will take around 10 – 15 minutes each. We agree with the Attorney-General's conclusion that this constitutes arbitrary detention under the Bill of Rights Act.

61. Likewise, we are concerned that the Police will have the power to carry out a blood test simply because someone is not able to complete an oral fluid screening test (for example, they cannot produce enough oral fluid). We feel these grounds are too invasive. Currently, Police may choose to require a blood test following failure of a CIT, which is much stronger grounds for suspecting impairment from substances, and much more justifiable. We encourage an alternative regime by

which police can only order a blood test after two failed oral fluid screening tests, **or** when someone is unable to complete them, **plus** a failed, abridged version of the CIT.

62. We also recommend that oral fluid screening tests should be carried out alongside an abridged CIT. Combining oral fluid screening with an impairment test would go some way to ensure that impairment was also being tested, not simply the presence or absence of a substance in sample.

63. Oral fluid testing is more intrusive than a breath test for alcohol. Oral fluid screening is usually carried out in a medical or workplace setting by a medical or trained professional, with informed consent required beforehand.

64. As it is currently written, this Amendment Bill will give Police the power to take a bodily fluid sample themselves on the side of the road. Without needing to be accompanied by a reasonable suspicion of impairment, the Attorney-General's report called this 'disproportionate', and possibly 'constitut[ing] an unreasonable search and seizure.'

65. We note that the Minister of Police will have discretion to approve oral fluid screening devices, and that devices do not necessarily have to meet the current Standard AS/NZS 4760:2019 Procedure for specimen collection and the detection and quantification of drugs in oral fluid. However, if devices do meet the Standard, then we would want to see the Amendment Bill refined to more accurately describe the procedure for carrying out tests.

The Amendment Bill still does not prevent officers using the premise of an oral fluid screening test to search a person or vehicle, or seize evidentiary material.

66. We acknowledge the proposed amendments in clause 24, to s73A of the Land Transport Act, which state that a positive roadside oral fluid screening test result, positive laboratory test result, or positive blood specimen sample must not be used as evidence of the use of a controlled drug in a prosecution for an offence under the Misuse of Drugs Act 1975.

67. However, we remain concerned that a positive oral fluid test may be used as a justification to attempt to gather evidentiary material from a person or their vehicle for drug possession or press charges under the MoDA.

68. It is clear that the purpose of the drug driving provisions is to deter driving while impaired, and not to ramp up prosecution for simple drug possession. We strongly recommend clarifying that positive oral fluid tests on their own do not constitute reasonable grounds to conduct a warrantless search under s20 or s22 of the Search and Surveillance Act 2012.

E. There will likely be a disproportionate impact on Māori and Pasifika drivers.

69. The new Part 9 of the Amendment Bill, to be inserted into Schedule 1 has already considered that this legislation may have a disproportionate impact on Māori and Pasifika people, by listing this as a specific matter for independent review. Evidence tells us that this legislation is likely going to impact Māori and Pasifika people more than other ethnicities.

70. We acknowledge the August 2024 report *Understanding Policing Delivery* and its description of several instances of historical and recent 'inequitable police actions in relation to the use of force'. The report acknowledges the over-representation of Māori in police apprehensions, use of force incidents and police prosecutions.

71. We agree that it is important to understand that police do not operate in a vacuum and that the police response is shaped by the fact that they are 'often responding to people who have been failed by other parts of the system, including care and protection, health, mental health and education' (Independent Panel, 2024).

72. Despite this, the Amendment Bill gives the police total discretion over which drivers are selected for roadside oral fluid screening tests. Police already have autonomy over who they stop and speak to, investigate, or charge with an offence (Latu & Lucas, 2008; Linkhorn & Dawson, 2019). There is evidence of 'over-policing' Māori communities, leading to disproportionately high rates of convictions and imprisonments among Māori people compared to non-Māori (Cunneen & Tauri, 2016; JustSpeak, 2020; Latu & Lucas, 2008; Maxwell & Smith, 1998).

73. Historically, Māori have reported that the police disproportionately target rangatahi Māori for 'stop and search' procedures without just cause. Pasifika people have likewise expressed the perception that they are unfairly targeted, surveyed and profiled by police because of their race (Tuiburelevu et al., 2023).

74. We understand that Māori and Pasifika people are already overrepresented in charges for driving under the influence of alcohol or drugs. Māori people have a rate of 564.8 convictions per 100,000 population, and Pasifika people have a rate of 328.5 convictions per 100,000 population. This is compared with European people's rate of 173.9 per 100,000 population. (Ministry of Justice, 2023; Statistics New Zealand, 2024).

75. We therefore particularly want to see the regular reviews assess the high likelihood of the Amendment Bill having a disproportionate effect on Māori and Pasifika people. A baseline study should be carried out, which analyses the rate of penalties, charges, convictions and sentences for driving under the influence for Māori and for Pasifika people compared with other ethnicities. When future reviews are carried out, we strongly recommend engagement with iwi and

kaupapa Māori organisations, especially those that work with rangatahi Māori, to understand the real-world impacts of this legislation on Māori and Pasifika people's lives.

76. It is imperative that we understand the real-world impacts of this legislation on drivers, and the police should be monitored on fair delivery of the programme.

We are concerned about a disproportionate impact on disabled people.

77. Disabled people have a higher prevalence of use of some medicines and substances than non-disabled people. Disabled people are 5.14 times more likely to use amphetamines; 3.54 times more likely to use opioids, and 3.79 times more likely to use cannabis weekly (Ministry of Health, 2023).

78. These disproportionately high rates are likely due to poor health care access, which forces people to self-treat their symptoms with illicit drugs. Because of their drug use, their underlying health needs are often not investigated properly.

79. We have serious concerns about the principle of penalising individuals for the 'presence' of qualifying drugs in this Amendment Bill, instead of (appropriately) penalising driving while impaired.

80. This Amendment Bill insufficiently protects the rights of people who receive medical treatment with 'qualifying drugs' (such as opioids, benzodiazepines, stimulants, or medicinal cannabis) and who may be seriously disadvantaged by currently limited medical defence provisions. In our view, the current provisions are insufficient, do not follow natural justice principles, and are discriminatory to disabled people.

81. We are particularly concerned about the automatic 12-hour driving ban for people receiving medical treatment with a qualifying drug, regardless of whether they are impaired or not.

82. The flawed process of claiming medical defence evidenced by a 'current' prescription ignores the medical realities of people with chronic illnesses who often, and in line with the medical advice they receive, continue to use leftover medicine beyond the prescription period. We outlined some detailed recommendations in the previous sections.

83. In addition, disabled people are more likely to have lower incomes than non-disabled people. This impacts on their ability to pay fines or find alternative transport at short notice. They are less likely to have access to public transport, along with other key public facilities (Stats NZ, 2020). We urge future independent reviews to include a thorough assessment of the impact of this Amendment Bill on the disabled community.

F. Regular review of testing technology, methodology and real-world impact will be vital

84. Because of the highly likely disproportionate effects of the Amendment Bill on disabled people, Māori and Pasifika people, we want to see the procedures and impacts of this Amendment Bill regularly evaluated.

85. As scientific research into new impairment testing technology develops, it is imperative that new impairment testing methods are regularly assessed for potential approval by the Minister of Police. This should be considered at any stage, without having to wait for the three-yearly review period.

86. We welcome the requirements listed in Part 9 in Schedule 1, which direct a regular independent review of the implementation of this Amendment Bill. We strongly urge that each review includes all of the elements listed in section 29 (3). We recommend that in order to properly assess the impact of the amendments, there needs to be a baseline study before the Amendment Bill is enacted to determine the number of drivers who are currently driving after using drugs.

87. We particularly look forward to seeing whether the review finds that police are taking steps to implement the applicable recommendations in the *Understanding Policing Delivery* report. Some pertinent recommendations include prioritising ethical collection of ethnicity, gender and disability data, and reviewing the current fines system from an equity lens.

G. The public must be made aware of the impact of the legislation being enacted.

88. We are concerned that the driving public may not be aware of the list of qualifying substances, and their corresponding legal limits permitted under the law.

89. The 25 drugs listed under Schedule 5 (1) and (2) of the Amendment Act which may be tested for contain a range of licit and illicit substances, 19 of which are available on prescription. Over 200 medications prescribed in New Zealand come with warnings about possible impairment, yet nearly 65 percent of drivers are unaware that it is already illegal to drive while impaired by medication (NZTA, 2015).

90. Medical practitioners and pharmacists should be required to ensure that patients prescribed psychoactive medicines know when they must not drive, and they should give advice on how to manage the risk of impairment. Based on the high proportion of unaware patients, this appears to be happening inconsistently. Drivers should be enabled to carry a doctor's note or a card with the details of any prescription medication they might be using which can be tested for under the Amendment Bill.

91. We recommend standardised packaging and warnings for all medications with a risk of impairment, along with behaviour change campaigns to ensure patients are aware of the risks.
92. We strongly advocate for an education and awareness campaign to ensure that drivers are fully aware of their rights and responsibilities if they are tested for the presence of a qualifying drug.
93. We would like to see more focus on preventive public health and behaviour change around drug driving, similar to that seen for alcohol and seat belts. This must be evidence-based and non-non stigmatising, as well as targeting the right communities. We are happy to provide further advice on this.

Summary of our recommendations

A. Focus on impairment, not on testing:

i. Develop an abridged, streamlined version of the CIT, which can safely be conducted at the roadside, and use this in combination with oral fluid screening.

ii. Ensure that oral fluid testing technology is as robust and accurate as possible to ensure reliable results.

iii. Prioritise approval of oral fluid screening technology that can accurately detect specific qualifying drugs, not wider families of drugs.

iv. Trial emerging technologies that can test for impairment from any cause at the roadside, and allow them to be approved for use as soon as effectiveness is proven.

v. Amend the Bill to ensure that as suitable impairment technologies are made available, these are able to be deployed.

B. Ensure the new measures work as a deterrent to drug driving:

vi. Carry out a baseline study before the law is enacted to determine the number of drivers who are currently driving after using drugs.

vii. Evaluate the deterrent effects of the law over time to establish whether they justify the negative impacts, especially regarding false positive tests.

viii. Ensure the testing regime is as visible as possible, by using it at checkpoints.

C. Mitigate unintended consequences and the risk of inequitable outcomes:

ix. Conduct oral fluid screening tests at established roadside checkpoints, to ensure the legislation is applied equitably.

x. Affirm that the Police will not use a positive oral fluid test result alone as reasonable grounds to conduct a warrantless search under section 20 or section 22 of the Search and Surveillance Act 2012.

xi. Allow drivers who use a prescription medication which is also a qualifying drug to be allowed to carry evidence of their prescription, which would prevent them being banned from driving unless impairment was demonstrated via a failed CIT.

xii. Remove the ambiguous requirement for a 'current' prescription by changing section 64 (1AB) (a) of the Land Transport Act to allow for a prescription in a driver's name alone to be allowed as evidence in a medical defence, if used beyond the three months period.

xiii. Ensure regular independent reviews assess any disproportionate effect on Māori and Pasifika people, and disabled people.

D. Ensure people understand the risks of prescription medicines:

xiv. Require medical practitioners and pharmacists to ensure that patients prescribed psychoactive medicines, especially those on the qualifying drugs list, know when they must not drive.

xv. Roll out behaviour-change campaigns to ensure patients are aware of the risks of driving after taking some prescription medications.

xvi. Educate drivers so they are aware of their rights and responsibilities if they are tested for the presence of a qualifying drug, and make sure they know their rights to a medical defence.

E. Implement behaviour change campaigns:

xvii. Provide ongoing public information about the existence of the tests, and targeted behaviour change campaigns for people who use drugs.

xviii. Educate the public on drug driving risks and penalties, similar to public health campaigns around alcohol and seat belts. This must be evidence-based, non-stigmatising, and targeted to appropriate audiences.

xix. Include real-world advice on how substance use can lead to impairment, and implement an information campaign on how some substances (especially cannabis) may be detected in a test up to several days after consumption without necessarily implying impairment.

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