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AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa

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

Submitted to the Transport and Infrastructure Committee on 23 April 2021

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 koe

We heartily support efforts to deter drug driving and reduce the harm caused on our roads. However, this Bill is based on imperfect science. Saliva tests do not test for impairment and for most drugs it is impossible to set accurate threshold limits for impairment.

Under the proposed methodology, false negatives and positives are inevitable - meaning some people will be penalised unfairly and others will be sent on their way despite being unfit to drive.

We would prefer a model that streamlines the existing compulsory impairment testing, making it more appealing for police to carry out at checkpoints alongside alcohol testing.

Alongside this we would like to see efforts made to develop some kind of portable technology that could accurately test for impairment from any cause. This would be the gold standard for improving road safety. Regardless of whether this Bill is passed, efforts should be made to develop such a test as quickly as possible, and this will require investment from the Government.

If the government decides that saliva testing is a useful tool despite its failings, we would prefer a model where a single failed saliva test is followed by a 'lite' or quick version of the compulsory impairment test. If this is also failed, a full impairment test could be carried out.

It is worrying that we do not have robust data on the extent to which drug driving contributes to road traffic accidents or deaths in New Zealand, nor as to whether the problem is increasing, or at what rate. This makes it hard to allocate resourcing appropriately. Improving our data gathering must be an essential part of any new model of drug driving detection.

Finally, we are concerned about equity issues resulting from the ability to test people without cause, and recommend testing takes place at roadside checkpoints only, where it can be applied to all drivers without the need to exercise discretion about who takes the test.

Thank you for considering our submission.

Sarah Helm

Executive Director

Introduction - We support initiatives to improve road safety but have concerns about this model

1. This Bill establishes a new random road-side oral fluid testing regime to test for drug driving. This would sit alongside the current compulsory impairment test (CIT) approach, where a driver can be asked to undertake an impairment test if a police officer has good cause to suspect they are impaired.
2. Under the new regime, a police officer would be able to stop any driver of a motor vehicle and administer an oral fluid test, without needing to show good cause. This would make the scheme more consistent with the existing approach to drink driving enforcement.
3. Whilst we support initiatives to make our roads safer we note here our significant concerns, shared with others in the health and public health sector, about the flawed science that lies behind oral fluid testing. Most specifically we are concerned about its inability to test for impairment, or even to determine how much of a drug a person has taken.
4. For most illicit substances, there is no clear established linear correlation between when a person takes a drug, how much they take and their level of impairment. This makes saliva testing for drugs quite different to alcohol breath testing.
5. We are concerned that implementing saliva testing as proposed may make us heavily reliant on a system that does not test whether a person is fit to drive or not. The proposed system may lead to inequities, undermine trust in the system and not have the desired impact on road safety.

We acknowledge the Bill has positives which help balance some of our concerns

6. Despite the limitations of oral fluid testing, we appreciate the efforts that have been made in this Bill to reduce as much as possible the chance of inequitable outcomes. These efforts do go some way towards balancing the need for deterrence with the need to protect individuals from unjust outcomes.
7. In particular we note that:
    a. the proposed model will hopefully deter some drivers from driving under the influence of drugs (although the research on this is not clear),
    b. two tests must be given before an infringement fee will be issued, to minimise the chance of a false negative or a false positive,
    c. the amount of the infringement fee has been kept relatively low. If it remains unpaid, this cannot result in a criminal conviction,
    d. a route of referrals to assessment for drug education or rehabilitation has been built into the Bill,

e. the compulsory impairment test will still be available and remains a valuable tool to detect impairment,

f. criminal penalties are only applied where the drug is at a concentration in the blood that is likely to impair driving. We note that it is not possible to set such limits with a high degree of surety, but we appreciate the effort that has gone into attempting to set fair levels.

8. Despite these efforts, areas of significant concern about inequitable outcomes remain, and these are covered below.

We would have preferred an enhanced model of impairment testing

9. In our opinion, impairment tests carried out on the side of the road by Police remain the most accurate way to establish if a person should be driving or not. We acknowledge that these tests are expensive, time consuming and require significant training. Consequently, very few are carried out each year and they have a limited deterrence effect.

10. Our preference would have been first to make efforts to streamline and make more visible the compulsory roadside impairment testing (CIT) that already takes place. For example, a shorter version of the test could be developed, and a failure to pass this successfully could led to a requirement to undertake the full (time consuming) test.

11. To increase the deterrence effect of the CITs, shorter versions of these could be carried out at roadside checkpoints alongside alcohol testing as an initial screening instead of saliva testing.

We would like to see efforts made to develop a portable impairment test

12. We would like to see efforts made to develop some kind of portable technology that could accurately test for impairment – whether that be from consuming drugs, drinking alcohol, tiredness, stress or any other cause. Such a test would be the gold standard for improving road safety, and could also be used in workplaces.

13. Regardless of whether this Bill is passed, efforts should be made to develop such a test as quickly as possible. This will require investment from the Government.

The Bill is based on imperfect science

Neither saliva nor blood tests can accurately show impairment

Saliva testing tests for presence of a drug, not impairment. Cannabis and methamphetamine may be detected in saliva several days after last use.

14. Because alcohol is water soluble, goes 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 blood alcohol reading - and thus that they were more likely to cause an accident behind the wheel. This is not possible with saliva tests.
15. Saliva-based drug tests can test for the presence of a drug, but cannot tell us the amount a person has consumed – meaning they cannot tell us if the person is likely to be impaired from that use, or how significantly they are likely to be impaired.
16. Substances can also be detected by saliva testing long after they have stopped causing impairment. That means people who have used a substance, but are no longer impaired, could be fined and potentially charged with a drug driving offence.
17. As one example, in a study of 30 chronic cannabis users[1], it took ten days of abstinence before their blood THC concentration levels fell below 2 ng/mL. At this level they would still be penalised with an infringement fee, ten days after last using cannabis.
18. Oral fluid THC concentrations can also remain high for several days. One study[2] tested THC in subjects who use cannabis heavily. They found the drug at levels that would result in an infringement fee 150 hours (six days) after last use.
19. Even someone who has never used cannabis before may test positive in a saliva test up to 12 hours after consuming the substance.[3]
20. Similarly, methamphetamine may still be detectable in saliva 24 hours or longer after use. Although there have been no controlled methamphetamine smoking studies, long-term users are likely to have detectable levels in saliva for several days after dosing.[4]

[1] Bergamaschi MM, Karschner EL, Goodwin RS, Scheidweiler KB, Hirvonen J, Queiroz RHC and Huestis MA. 'Impact of prolonged cannabinoid excretion in chronic daily cannabis smokers' blood on per se drugged driving laws' Clinical Chemistry 59(3) (2013) 519-526.

[2] Odell MS, Frei MY, Gerostamoulos D, Chu M and Lubman DI. 'Residual cannabis levels in blood, urine and oral fluid following heavy cannabis use' Forensic Science International 249 (2015) 173-180.

[3] 'Interim Report 3. Setting Statutory Limits for Blood Drug Concentrations Relating to Impaired Driving', Drug Driving Advisory Panel, 26 November 2020.

[4] Ibid.

The issue of THC appearing in saliva tests where impairment is not present may cause particular issues for medicinal cannabis patients.

21. Thousands of people in New Zealand use cannabis as a medicine, for a range of health issues, but do not have a prescription from their doctor. There are a number of reasons for this, including doctor reluctance to prescribe and the stigma which prevents patients seeking help. Many patients source products illegally and this is likely to continue for several years or longer, as the new medicinal cannabis regime takes effect.

22. Because THC threshold limits are so dependent on a range of different factors outside an individual's control, the introduction of saliva tests may have a big impact on whether patients feel they can continue to drive – even if the use of their medication does not actually make them impaired.

23. Saliva testing, if it is not accompanied by an impairment test, will have an inequitable effect on patients which we do not believe can be justified by the potential benefits of the new regime.

We support criminal limits being placed on evidentiary blood tests as this is better than the status quo

24. Currently, if a person fails a compulsory impairment test they are required to take a blood test. This will continue under the new regime. In addition, a person may request a blood test if they fail two saliva tests.

25. An attempt has been made, as set out in the Government's Supplementary Order Paper, to set thresholds at which a person would be liable for a criminal offence based on the level of drugs in their blood. Under this level they would receive an infringement fee only.

26. We support this. The current impairment system tests for *presence* of drugs only, which could lead to unjust outcomes in some cases. A person might fail an impairment test for a range of reasons, yet they would still receive a criminal conviction for drug driving if traces of drugs were found in their blood - even if the drugs had been consumed several days previously.

27. The new system is an improvement because it attempts to ensure this does not happen.

But we note that the threshold limits will be wrong much of the time, meaning some people will still face unjust outcomes

28. We note that the threshold limits that have been set are still likely to be wrong much of the time. While the expert advisory group have made a thorough effort to set evidence-based limits for different drugs, many of the limits set are no more than an educated stab in the dark.

29. How a person is affected physically and cognitively by use of a drug will be determined by the size and other physical qualities of the person, the method of ingestion, the dosage (which is not standardised in an unregulated market), whether or not the person uses that substance regularly, whether they have

consumed other substances, and the underlying physical state of the person - whether they are tired, ill, or hungry for example.

30. For most illicit substances, there is no linear correlation 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 against their blood test results.

A few specific examples of the difficulty of setting threshold limits

31. 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 fatal overdose.[5]
32. 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[6]. 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's not clear how they have set this limit and it appears to be largely a guess.
33. Methadone: Methadone is a synthetic opioid used in the treatment of opioid dependence. The panel has recommended a statutory blood methadone limit of 200 ng/mL and a blood threshold limit of 50 ng/mL. Yet the range of blood test results from those who use methadone is huge. 10 mg doses are sufficient to cause impairment in some users, whereas those receiving maintenance doses of methadone as a treatment for opioid dependence may show concentrations of 440 – 820 ng/mL.[7]
34. It becomes even more difficult to guess at impairment levels where someone has consumed a combination of different drugs and alcohol.
35. 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,
    b. a person may receive a criminal conviction for drug driving where that person was in fact not impaired by that substance,
    c. some impaired people will be sent on their way without penalty.

[5] 'Interim Report 3. Setting Statutory Limits for Blood Drug Concentrations Relating to Impaired Driving', Drug Driving Advisory Panel, 26 November 2020.

[6] Ibid.

[7] Ibid.

False positives and false negatives are inevitable

False negatives can increase rates of drug driving

36. As many as 13% of tests will return a false negative test.[8] 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.

37. This could undermine faith in the system. Research indicates that such false negatives may actually increase rates of drug driving amongst those people who have wrongly avoided punishment.[9]

False positives can lead to unjust outcomes, affecting lives and employment

38. False positives may occur in as many as 10% of samples.[10] though the proposal to require a second saliva test will reduce this risk. A false positive could lead to an unjust outcome for an individual who has not consumed drugs but has received two positive tests.

39. The infringement offence consists of a fine of $200 and 50 demerit points. If a person were to receive two such infringement offences within two years they may lose their licence for three months – a heavy burden, especially for those who rely on driving for their employment.

40. Although infringement notices will not appear on normal employment police checks, 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 a false positive result appear on an employment check could mean a person misses out on employment, or loses their job unfairly.

Oral fluid testing devices do not detect all drugs

41. The saliva tests will only identify the presence of a maximum of six of drugs. Focusing on some substances to the exclusion of others does not lead to safe roads. Nor is it equitable, as some substances are used more by different sectors of society.

42. Surveys of New Zealand drivers have found the substances most commonly taken within three hours of driving are strong painkillers, antidepressant medication,

[8] 'An assessment of oral fluid drug screening devices', Canadian Society of Forensic Science Journal, Douglas J. Bierness & D'Arcy R. Smith, 2017.

[9] "Deterrence of drug driving: the impact of the ACT drug driving legislation and detection techniques', Kerry A. Armstrong, Christopher N. Watling, Jeremy D. Davey, Elsevier, 2018.

[10] Thomas R. Arkell, Richard C. Kevin, Jordyn Stuart, Nicholas Lintzeris, Paul S. Haber, Johannes G. Ramaekers, Iain S. McGregor (2019), Detection of THC in oral fluid following vaporized cannabis with varied cannabidiol content: An evaluation of two point of collection testing devices.

anti-nausea medication, cannabis and anti-anxiety medication. Many of these can impair driving, especially in combination with other substances or alcohol.[11]

43. Those who are impaired by substances other than the six tested for may be sent on their way without repercussion. One example of a highly impairing drug used in New Zealand that is not covered by saliva tests (nor usually by blood tests unless requested), is gamma-hydroxybutyrate (GHB).

Some may use more dangerous drugs to avoid detection

44. There is also a danger that motorists may switch to using more harmful substances to avoid being caught, as happens in workplaces that test for a narrow range of drugs. One particularly dangerous example could be that a drug supplier may push eutylone as a substitute for MDMA because it will not be picked up in driving tests. Eutylone is a far more dangerous substance than MDMA.

45. The only way to avoid this kind of perverse incentive is to find a way to test for impairment that is not reliant on testing for specific drugs.

We recommend researching and developing a roadside impairment test

46. It is in all our interests to fund the development of a roadside test that can accurately, quickly and inexpensively measure impairment – whether that be caused by drugs, alcohol, tiredness or stress.
47. Such a test would improve road safety in New Zealand, because it would not rely on testing a narrow range of substances, at great expense, while missing impairment caused by other factors.
48. We recommend investigating technological solutions, such as a handheld device that could test for cognitive and psychomotor skills. In the meantime we would also like to see more streamlined CIT tests developed that any police officer could carry out at a roadside checkpoint.

[11] Starkey, NJ and SG Charlton (2017) The prevalence and impairment effects of drugged driving in New Zeal Some may use more dangerous drugs to avoid detection and. NZ Transport Agency research report 597. 105pp.

It's not clear how much the Bill will serve as a deterrent

We don't know how many deaths or accidents are due to drugs

49. Tragically, we don't have robust data on the extent to which drug driving contributes to road traffic accidents or deaths in New Zealand, nor as to whether the problem is increasing, or at what rate.

50. While the number of people charged with driving under the influence of drugs has been increasing since 2014,[12] at least part of that increase is due to a policy change that made it easier for Police to collect blood samples for drug impairment. This has then corresponded to an increase in prosecutions.

51. Research attempting to compare the use of drugs and alcohol on our roads usually compares the number of people who are found to have impairing levels of alcohol with the number who are found to have any traces of drugs in their system. The presence of drugs in the blood may or may not show impairment was caused by those drugs in that instance (as discussed at length above).

52. So while we can measure the number of deaths caused by people with drugs in their system, we don't know how many of these deaths were likely to have been caused by the drug use. This makes it hard to assess the scale of the problem compared to the problems caused by drunk driving.

53. In Europe, roadside surveys analysing blood or oral fluid samples from 50,000 drivers showed that alcohol was present in 3.48 percent of the samples, illegal drugs in 1.9 percent, medicines in 1.36 percent, combinations of drugs or medicines in 0.39 percent and alcohol combined with drugs or medicines in 0.37 percent.[13]

54. After alcohol, the most frequently found substance among injured drivers was THC (tetrahydrocannabinol) followed by benzodiazepines. But among drivers killed in accidents, benzodiazepines were the most frequently found.

55. From what limited evidence we have, it is reasonable to infer that drug use causes harm on our roads. As such we welcome evidence-informed measures to deter drug driving and make our roads safer. We do however caution about the need to continue to prioritise efforts to reduce drunk driving.

[12] Ministry of Justice (2020). Drug-related criminal justice data [Data File]. Obtained 21 September 2020 from the Ministry of Justice Analytics & Insights team.

[13] add footnote

'Deterrence' is an inexact science

56. The Ministry's regulatory impact statement rates the evidence for the deterrence effect of the saliva testing proposals in the Bill as 'low'.[14] If it is not clear that the proposed policy measure will act as a deterrent to drug driving, we should be less forgiving of any potential negative impacts.

57. A 2018 study in ACT Australia did find that results suggested a decline in drug driving since the introduction of roadside drug testing there.[15]

58. But concerningly, results also indicated an *increased* likelihood of future drug driving among drivers who had either direct or vicarious experiences with avoiding punishment for drug driving (that is, they'd been tested or knew someone who had, and 'got away with it', despite having used drugs).

59. The 'deterrence effect' of saliva testing will no doubt be influenced by the number of tests carried out each year, how visible these are (for example, check points as opposed to single tests on random drivers), and other factors including how many false positives and negatives are returned by the devices chosen for use. A significant factor will also be how much funding is put towards advertising the existence of the new scheme.

We recommend good research and other measures to improve deterrence:

60. Carry out a baseline study before the law comes into effect to determine the number of drivers who are currently driving after using drugs.
61. Monitor the deterrent effects of the law. A good deterrent effect will need to be shown to justify the inevitable negative impacts of the law especially regarding false positives.
62. Fund ongoing public information campaigns about the existence of the roadside tests, alongside targeted behaviour change campaigns for people who use drugs. We would be happy to help identify target audiences for behaviour change campaigns.
63. Ensure the testing regime is as visible as possible, by using it regularly at checkpoints. The tests could be alternated with alcohol breath testing, to limit the cost.

[14] https://www.treasury.govt.nz/sites/default/files/2020-04/ria-transport-edd-apr20.pdf

[15] add footnote

The Bill may have an inequitable impact

Allowing Police discretion means Māori and Pasifika are more likely to be stopped

64. Though recent efforts have been made to improve matters, the New Zealand Police have a long history of both conscious and unconscious bias relating to treatment of Māori and Pasifika communities.

65. A *Stuff* investigation in 2020 found Māori were more than four times more likely to be targeted with a warrantless stop-and-search, and Pasifika 1.2 times more likely, compared with Pākehā.[16]

66. Introducing another legal way for police to stop an individual without cause, and invade a person's privacy with a physical test is unfortunately most likely to impact negatively on those who are young, brown and male.

67. In addition, there is risk that saliva-testing checkpoints will more frequently be organised in areas with higher socioeconomic deprivation levels, meaning some demographic groups are likely to be tested more than others.

68. Getting a positive saliva test may lead the Police to search a car or otherwise highlight a person as 'of interest'. This would be outside the scope of a law focused on reducing impairment from drug driving impairment.

The proposed fee is not much for some, but a week's income for others

69. We appreciate that infringement fees have been kept at a level that is affordable for most, and that receiving one cannot lead on to a criminal penalty. We support this, especially given that the science behind saliva testing is not robust. However, we note that for many people - especially younger people or those on a benefit - a $200 fine could be simply unaffordable.

[16] https://interactives.stuff.co.nz/2020/12/unwarranted-police-searches-racial-bias-justice/

We recommend mitigating the chance of inequitable outcomes:

70. Allow checkpoints where everyone is tested, or every third person (for example), but do not allow random testing of individuals without cause. This would lessen the risk of racial bias.
71. Require the Police to keep good records about the ethnic group, age and gender of those they have stopped, and where they have run checkpoints. Require records to be kept of any incidents where cars are stopped and non-driving related criminal charges are subsequently laid.
72. Ensure regular monitoring and evaluation of this data by including a legislative requirement to do so.
73. Offer other options for those who are unable to pay the infringement fee, such as:
    a) waiving fees for those who instead attend a brief intervention session or a tailored, evidence-based programme on drugs, in line with what was proposed in the Cannabis Legalisation and Control Bill,
    b) the option to have the fee reduced where financial hardship can be shown.

Saliva testing is very costly. It must not divert resources from roadside testing for alcohol

Saliva testing is more expensive and energy-intensive than alcohol testing

74. We note that NZ Police is currently conducting far fewer roadside alcohol tests than it has in the past. Just 1.3 million breath tests were carried out in 2018-19, down from more than 3 million in 2013-14.[17] We would like to see these rates increased substantially. We are concerned that introducing a new regime may further pull resources away from this essential work.

75. Whereas breath testing for alcohol takes only a few minutes, completing two oral fluid tests would usually take around 20 minutes, but may take as many as 30-40 minutes, according to the Attorney General's report.[18] Police will only be able to test a fraction of the drivers they could screen for alcohol in the same time period.

76. Similarly, whereas each alcohol test costs a matter of cents, a saliva test is expected to cost between $20 and $45 per test.[19]

Alcohol is by far our most popular drug and is highly impairing

77. Alcohol is the most consumed drug in New Zealand, with 80.3% of New Zealanders consuming alcohol each year, compared with 1% consuming methamphetamine, and 15% consuming cannabis.[20]

78. Alcohol is one of the most impairing substances, with only methamphetamine having a similarly impairing effect. Alcohol consumed alongside other drugs magnifies the impairment level exponentially. The table below sets out the potential risks of death and serious injury while driving with multiple drugs and drugs and alcohol.[21] This shows the importance of continuing to ensure resources go towards alcohol testing.

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[17]. https://www.stuff.co.nz/national/122696945/number-of-roadside-breath-tests-plummet-as-road-deaths-continue-to-rise

[18] Report of the Arttorney-General under the NZ Bill of Rights Act 1990 on the Land Transport (Drug Driving) Amendment Bill, 2020.

[19] Ministry of Transport's enhanced drug driver testing regulatory impact statement, at https://www.treasury.govt.nz/sites/default/files/2020-04/ria-transport-edd-apr20.pdf

[20] New Zealand Health Survey 2018/19, Ministry of Health.

[21] Schulze, H., Schumacer, M., Urmeew, R., Auerbach, K., Alvarez, J., Bernhoft., I.,Zlender, B. (2012). *Driving under the influence of drugs, alcohol and medicines in Europe: Findings from the DRUID project*. European Monitoring Centre for Drugs and Drug Addiction.

Drug/Alcohol	Relative risk	Risk level
Cannabis Alcohol < 0.5 g/L	1-3	Slightly increased risk
Cocaine Benzodiazepines Opioids Alcohol < 0.8 g/L	2-10	Medium increased risk
Amphetamines **Combination of drugs (not alcohol)** Alcohol < 1.2 g/L	5-30	Highly increased risk
Alcohol > 1.2 g/L **Drugs combined with alcohol**	20-200	Extremely increased risk

We recommend:

79. Increase levels of alcohol testing and set a yearly target for testing.
80. Combine alcohol and drug testing at the same checkpoints, testing every third or fifth person for drugs, and every driver for alcohol, to give the same level of deterrence but save costs.
81. Collect data from test results (where carried out at checkpoints) on how many people use drugs then drive, and which substances they are caught using. Use this information to prioritise spending on alcohol versus drug testing.

Recommendations on health interventions and behaviour change

Improve health interventions throughout

82. The Bill includes a harm minimisation approach to drug driving, including compulsory health referrals for recidivist drug drivers at sentencing. These are proposed for second criminal offences in some situations and all third and subsequent criminal offences.
83. While we welcome this harm minimisation approach, we note that a health referral is given late, and only in those cases where a criminal offence has been proven.
84. Health advice or assistance could be offered much earlier on, at the first infringement offence. This should include:

a) Information on how drugs, alcohol and other factors can impair driving.

b) Information on when to seek help for drug or alcohol issues, and how to do this.

c) A referral pathway for a screening and brief intervention for those who wish to take that up.

85. Ideally, Police and Health should work together to design the information given out, and ensure referral pathways are in place. This would require extra funding and may take time to implement but it could have a long-term positive impact on road safety and public health.

Behaviour change campaigns are also needed

86. 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-stigmatising - which means targeting audiences appropriately. We are happy to advise on this.

Ensure people understand the dangers of prescription medicines

87. Over 200 medications prescribed in New Zealand come with warnings about possible impairment, yet nearly 65 percent of drivers are unaware that it is illegal to drive while impaired by medication.[22]

88. 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 number of unaware patients this appears not to be happening consistently.

89. We recommend standardised packaging and warnings for all medications with risk of impairment, along with behaviour change campaigns to ensure patients are aware of the risks and act on that.

[22] For NZTA Substance Impaired Driving Project. Memo: Baseline Driver Survey, NZ Transport Agency, 2015.

Final Recommendations

In acknowledgement of the flawed science behind saliva testing:

1. Focus on improving the compulsory impairment testing model rather than introducing saliva testing.
2. If saliva testing is to be introduced, follow a single failed saliva test by a 'lite' or quick version of the compulsory impairment test. If this is also failed, a full impairment test should be carried out.
3. Fund the development of a roadside test that can accurately, quickly and inexpensively measure impairment – whether that be caused by drugs, alcohol, tiredness or stress.
4. Ensure the law is sufficiently flexible to allow for future changes in technology or testing methodology.

To ensure the Bill works as a deterrent to drug driving:

5. Carry out a baseline study before the law comes into effect to determine the number of drivers who are currently driving after using drugs.
6. Evaluate the deterrent effects of the law over time to establish whether they justify the negative impacts - especially regarding false positive tests.
7. Fund ongoing public information about the existence of the tests, and targeted behaviour change campaigns for people who use drugs.
8. Ensure the testing regime is as visible as possible, by using it at checkpoints.

Mitigate the risk of inequitable outcomes from this law:

9. Do not allow random testing of individuals without cause. Instead, allow the use of the technology only at checkpoints where everyone is tested. This would reduce the risk of racial bias.
10. Require the Police to keep good records about the ethnic group, age and gender of those they have stopped, and where they have run checkpoints. Require records to be kept of any incidents where cars are stopped, and non-driving related criminal charges are subsequently laid.
11. Ensure regular monitoring and evaluation of this data by including a legislative requirement to do so.
12. Offer other options for those who are unable to pay the infringement fee, such as:
    a) waiving fees for those who instead attend a brief intervention session or a tailored, evidence-based programme on drugs,
    b) reducing the fee where financial hardship can be shown.

Ensure the new regime does not divert resources away from alcohol roadside testing:

13. Increase levels of alcohol testing and set a yearly target for testing.
14. Combine alcohol and drug testing at the same checkpoints, to give the same level of deterrence but save costs.

Improve the health interventions in the Bill:

15. Offer health advice and referral pathways for drug-related health interventions much earlier on, at the first infringement offence.

Implement behaviour change campaigns:

16. Include a 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, non-stigmatising and targeted to appropriate audiences.

Ensure people understand the dangers of prescription medicines:

17. Require medical practitioners and pharmacists to ensure that patients prescribed psychoactive medicines know when they must not drive.
18. Fund behaviour-change campaigns to ensure patients are aware of the risks of driving after taking some prescription medications.