

Coversheet: Enhanced drug driver testing

Advising agencies	<i>Ministry of Transport</i>
Decision sought	<i>Agreement to introduce roadside oral fluid testing of drivers to complement existing measures for detecting and deterring drug driving¹</i>
Proposing Ministers	<i>Associate Minister of Transport</i>

Summary: Problem and Proposed Approach

Problem Definition
What problem or opportunity does this proposal seek to address? Why is government intervention required?

Many illicit, recreational and prescription drugs impair driving ability and increase crash risk. Drivers in New Zealand are using these drugs and driving.

Data from the NZ Transport Agency's (NZTA's) Crash Analysis System (CAS) shows that in 2018, 95 people were killed in crashes where a driver had consumed impairing drugs before driving. In comparison, 123 people were killed in crashes where drivers had alcohol in their system².

Though we cannot say to what level the drivers were impaired by the drugs or alcohol consumed, or whether drugs or alcohol caused the crashes, we can infer that drugs and alcohol may have been a contributing factor in the crashes.

Our current approach to drug driver testing (a compulsory impairment test or 'CIT') has limitations. The Ministry of Transport and Police consider that not enough CITs can be conducted to effectively deter drivers from driving while they are impaired by drugs. New measures are needed to prevent deaths and serious injuries from drug driving.

Proposed Approach
How will Government intervention work to bring about the desired change? How is this the best option?

Complementing the current CIT approach with random roadside oral fluid testing, under the model proposed in this regulatory impact statement (RIS), will significantly improve the visibility of drug testing, heighten the risk of being caught and enable sanctions to be delivered more swiftly – key elements of effective deterrence.

The proposed scheme would be supported by comprehensive public education campaigns highlighting the dangers of drug driving and the 'certainty' of detection and punishment under the scheme. A focus area would be programmes directed at medicine dispensers, aimed at ensuring they provide adequate warnings when prescribing or issuing drugs, and that the packaging of medicines is adequately labelled.

¹ In this document "drug driving" means driving while impaired by illicit, recreational or prescription drugs.
² Eighty drivers were above the legal limits and 43 were below.

Section B: Summary Impacts: Benefits and costs

Who are the main expected beneficiaries and what is the nature of the expected benefit?

The main beneficiary of the proposal is the New Zealand driving public. The proposal is expected to deliver a reduction in deaths and serious injuries from crashes involving impairing drugs. The Ministry's cost-benefit analysis (CBA) predicts harm savings from the preferred option in the range of \$239M to \$778M over ten years (37 to 123 lives).

Where do the costs fall?

The majority of direct costs fall to government. Police costs will include the purchasing of drug testing equipment and police time for training, testing and processing drivers. There will be additional costs for the Department of Corrections (sentence costs), the Ministry of Justice (processing and collecting fines) and NZTA (promotion of the proposed scheme one-off system change costs and licensing costs).

Drivers will bear some costs. The main costs will be time detained at the roadside for oral fluid testing. In addition, a driver who chooses to dispute the results of positive (failed) oral fluid tests may elect to provide a blood sample for an evidential blood test. If the evidential blood test proves the presence of drugs above legislated limits (and a medical defence does not apply), the driver will be liable for the cost of the blood test. This cost recovery requirement is consistent with the current approach to elected evidential blood tests for drink driving.

The proposed scheme provides for voluntary and compulsory health referrals to mental health and addiction services. There will be associated costs for government if these services are government funded or subsidised.

What are the likely risks and unintended impacts, how significant are they and how will they be minimised or mitigated?

Regulatory failure

There is a low risk that the measures do not produce the predicted impact of a reduction in deaths and serious injuries. However, research shows that deterrence-based approaches can create lasting behavioural, attitudinal and cultural changes in regard to high-risk driving behaviour³. 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-testing⁴ 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 2017⁵. The Ministry proposes that the impact of the policy is evaluated after one year and three years, to provide Government with early insights into the effectiveness of the policy.

False-positive results from oral fluid testing devices

There is a low risk that roadside oral fluid testing devices do not perform as expected. For example, if there are a significant number of 'false-positive' results (failed tests where a driver has not consumed drugs), public support for the scheme will be undermined.

Independent studies of the accuracy of oral fluid drug testing devices have produced

³ Davey, J. & Freeman J. (2011). *Improving road safety through deterrence-based initiatives: a review of research*. Sultan Qaboos University Medical Journal.

⁴ New Zealand introduced random stopping in 1984 and compulsory breath testing in 1993.

⁵ Reported where a driver's blood sample tested over the applicable legal limit or driver refused a blood test.

mixed results. However, countries that have been conducting roadside oral fluid testing for a number of years report low to very-low false-positive results. In Australia, where roadside oral fluid testing has been operating for 15 years, some states report false-positive rates as low as one percent⁶.

A 2017 study of the performance of a pool of drug screening devices⁷ available in Canada found that, considering all drugs/drug categories tested for together, the screening devices collectively performed as follows⁸:

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

A 2019 study of roadside drug testing devices widely used in Australia found the devices reported false-positive results for THC ranging between five and ten percent⁹. The proposed scheme in this (RIS) includes several mitigations for the risk of false-positives, which include:

- using oral fluid testing devices that are calibrated to levels of sensitivity that make them more likely to accurately identify a drug, because more of a drug is present
- requiring two consecutive positive (failed) oral fluid tests before a driver can be liable for an offence – to reduce the mathematical probability of two false-positive results.

Other safeguards built into the proposed scheme, to reduce the impact, if false-positive results do occur, are:

- the ability to elect an evidential blood test, which will be subject to laboratory analysis
- the offence for producing two failed oral fluid test results is an infringement offence only – meaning that drivers will not receive a criminal record.

Manufacturers of devices currently available for purchase report close to 100 percent accuracy for the drugs they test for. The manufacturers advise that a significant proportion of false-positives are due to operator error rather than device error. The Ministry's CBA assumes the accuracy of drug testing devices is 95 percent.

Drug use patterns

There is a potential risk that drivers who choose to consume drugs and drive may 'switch' drugs (for example to more dangerous synthetic drugs) in order to avoid detection by oral fluid testing devices, which detect a limited range of drugs. However, these drivers may still be processed through the CIT scheme if a police officer forms good cause to suspect the driver has consumed drugs before driving. Drivers impaired by any kind of drug will continue to be detected and sanctioned through the CIT process.

⁶ RJ Baldock, PG Palamara, SJ Raftery, TJ Bailey, *Optimising Drug Driving Regimes*, Austroads (2019).

⁷ Douglas J. Bierness & D'Arcy R. Smith (2017) *An assessment of oral fluid drug screening devices*, Canadian Society of Forensic Science Journal.

⁸ Results presented are averages and vary by drug type.

⁹ 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*.

Identify any significant incompatibility with the Government's 'Expectations for the design of regulatory systems'.

There is no significant incompatibility with the Government's 'Expectations for the design of regulatory systems.' The proposal conforms to established legal and constitutional principles and supports compliance with New Zealand's international and Treaty of Waitangi obligations.

The scheme is risk-based, informed by the evidence available (evaluated in Section C below), responsive and structured to respond proportionately to the different degrees of risk presented by different levels of drug prevalence. It is also aligned with New Zealand's existing drink driving regime - aligning the drug driving and drink driving regimes will make the drug driving scheme easier to understand, which is expected to support compliance.

The New Zealand public will be provided with a reasonable time to become familiar with the new regulatory requirements. Police will test key operational processes before implementing the new measures.

Bill of Rights Act 1990

The proposal will limit some rights and freedoms affirmed in the New Zealand Bill of Rights Act 1990 (BORA). The BORA 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)).

Taking a sample of bodily fluid, will 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.

Detaining drivers at the roadside to determine whether they have consumed drugs will constitute a detention for the purposes of section 22. A detention is considered arbitrary if it is capricious, unreasoned or without good cause¹⁰.

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.

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

A final assessment of the consistency of the proposed approach with the BORA will be undertaken by the Attorney-General when a bill to implement the proposed regime is available. 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.

¹⁰ Good cause is "a reasonable ground of suspicion upon which a reasonable person may act", [1972] NZLR 233.

Agency rating of evidence certainty?

Evidence of the impairing effects of drugs

Our rating of evidence certainty is medium to high. There is a large body of international research on the impacts of drugs on driving ability. Overall, the research shows that, in contrast to alcohol, there is not a clear linear relationship between dosages of drugs, when they are taken, and impairment. People respond to individual drugs, combinations of drugs and different dosages of drugs in different ways.

Different drugs are metabolised at different rates, meaning that evidence of some drugs can be detected a considerable time after they have been ingested, while in other cases evidence dissipates very quickly. To a lesser extent, this is also the case with alcohol, except there is a clearer correlation between use and impairment that makes it possible to set limits at which any person can be considered to be impaired.

However, though researchers do not all agree about the exact degree to which amounts of particular drugs or combinations of drugs impair driving ability, systematic reviews of research papers provide a consistent and reliable picture of the impairing effects of illicit, recreational and prescription drugs on driving related tasks. These effects and the elevated crash risk they create are discussed in Section 2.1 below.

Evidence of prevalence of drug use by drivers

Our rating of evidence certainty is medium. Evidence on the extent of drug-driving in New Zealand is limited to interviews from the Ministry of Health's New Zealand Health Survey 2012/2013¹¹, phone and internet surveys undertaken by the University of Waikato in 2017¹², laboratory testing by the Institute of Environmental Science and Research (ESR) of the blood samples of drivers who are killed or hospitalised from crashes, or who fail a CIT, and data from NZTA's Crash Analysis System.

The evidence has some limitations. The University of Waikato's survey of drivers involved a relatively small sample size (2000 phone surveys and 434 internet users). Regarding the ESR data, not all deceased drivers are tested for drugs, and not all drivers who are tested are tested for all possible substances. For example, of the 1,000 drivers who died between January 2014 and May 2018, 845 blood samples were tested by ESR, and 763 received a full drugs screen¹³.

It is also currently Police policy not to test drivers for drugs if they fail a breath alcohol test. Therefore, some drivers who may have driven under the combined influence of alcohol and drugs, are not tested for drugs.

Evidence about the accuracy of roadside drug testing devices

Our rating of evidence certainty is medium to high. There has been recent laboratory testing of oral fluid testing devices currently available for purchase¹⁴ (discussed in Section B above).

¹¹ www.health.govt.nz/publication/cannabis-use-2012-13-new-zealand-health-survey.

¹² Starkey, N., and Charlton, S., *The prevalence and impairment effects of drugged driving in New Zealand*, University of Waikato, (2017).

¹³ Poulsen H, *Drug use by New Zealand Drivers*. Institute of Environmental Science and Research (2018). A full drug screen can prove the presence of over 200 illicit and medicinal drugs.

¹⁴ Bierness (note 7) and Arkell (note 9).

Effectiveness of deterrence

Our rating of evidence certainty is low. There is limited empirical evidence on drug-driving deterrence, as evaluation of the road safety impacts of roadside drug testing has generally been poor in jurisdictions that operate the schemes. One of the main reasons for this is jurisdictions have not undertaken random roadside surveys to build a baseline prior to introducing new measures. While most researchers agree that drug driver testing must be performed at scale in order to be an effective deterrent, the actual scale remains unknown.¹⁵ To address this weakness in evidence the Ministry’s CBA assumes a conservative deterrence impact from the proposed measures of 25 percent (e.g. drivers that use drugs and drive reduce their drug driving by 1 out of 4 trips).

To be completed by quality assurers:

Quality Assurance Reviewing Agency:

Ministry of Transport

Quality Assurance Assessment:

The Ministry of Transport’s RIA QA panel has reviewed the *RIA: Enhanced drug driver testing* prepared by the Ministry of Transport and considers that the information and analysis summarised in the RIA partially meets the QA criteria.

Reviewer Comments and Recommendations:

The RIA QA panel recognises the limitations of the available evidence base, and for that reason, strongly recommends that before implementation, baseline evidence of drug driving should be established, including through undertaking a random roadside testing survey against which the efficacy of this policy can be monitored in future reviews.

¹⁵ Goldsmid, S., Coghlan, S., & Patterson, E. *Findings from the DUMA program: drink and drug driving among police detainees*. Research in practice No.39 (2015) and Davey, J., Armstrong, K., & Sheldrake, M. *Roadside drug testing scoping study, final report* (2017).

Impact Statement: Enhanced drug driver testing

Section 1: General information

Purpose
The Ministry of Transport is solely responsible for the analysis and advice set out in this RIS, except as otherwise stated. This analysis and advice has been produced for the purpose of informing key policy decisions to be taken by Cabinet.
Key Limitations or Constraints on Analysis
<p>Evidence certainty</p> <p>Discussed in Section C above. The evidence certainty about the impairing effects of drugs and the accuracy of roadside drug testing devices is medium to high. Evidence certainty about the prevalence of drug use by drivers is medium. It is low regarding the effectiveness of roadside drug testing for deterrence.</p> <p>Range of options to be considered</p> <p>The Government has committed to retaining the current CIT process¹⁶. Policy development is limited to operating within that context.</p> <p>Assumptions underpinning analysis</p> <p>It has been necessary to make a number of assumptions about operational aspects of the proposed oral fluid scheme, for example, the time it will take to conduct tests, the cost of tests and the number of drivers who will elect blood tests. Where possible, these assumptions have been informed by advice and experience from other jurisdictions that have implemented oral fluid testing.</p> <p>Public consultation</p> <p>Public consultation on measures to enhance drug driver testing in New Zealand took place in May and June 2019. Some of the material in the public discussion document covered complex issues. This resulted in some individual submitters engaging with the material at a high-level. For detailed analysis of the results of consultation refer to section 2.5 below.</p>
Responsible Manager (signature and date):
Brent Johnston Manager, Mobility & Safety Ministry of Transport

¹⁶ CAB-18-MIN-0453

Section 2: Problem definition and objectives

2.1 What is the context within which action is proposed?

Road safety context

In 2018, there were 377 road deaths on the road network. This was up from 253 in 2013. Thousands more received serious injuries. New Zealand’s road death rate is now 7.8 per 100,000 people, compared to leading jurisdictions with rates between 2 and 4 per 100,000. Figures from 2017 show that we are in the bottom quarter of OECD countries when it comes to the number of road fatalities per capita.

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, it 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, it elevated safety to one of two key funding priorities. The Government has also committed to the development of a new road safety strategy, *Road to Zero*. The strategy is underpinned by a vision of a New Zealand where no one is killed or seriously injured in road crashes. It targets a 40 percent reduction in deaths and serious injuries by 2030.

The strategy is built around focus areas addressing infrastructure improvements, speed management, vehicle safety, work-related road safety, road user choices and system management. The proposed initial action plan for the strategy includes strengthening the detection and deterrence of drug driving.

Evidence of the impairing effects of illicit, recreational and prescription drugs

There is a significant body of international research on the impacts of drugs on driving ability. Large-scale, multi-country, multi-year projects such as the DRUID (Driving while under the Influence of Drugs, Alcohol and Medicines) project in Europe¹⁷ and the European drug research project SafetyCube¹⁸ found that a number of the most used illicit, recreational and prescription drugs have a significant negative impact on driving ability. 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 greater.

Table 1 below, illustrates how a number of the most commonly used drugs affect a range of driving-related brain functions¹⁹.

Table 1: Impacts of drug use on brain function

Drug	Drowsiness	Cognitive function	Motor function	Mood	Vehicle control	Time perception	Balance
Cannabis	x	x	x	x	x	x	x
Cocaine		x	x	x			
Methamphetamine		x	x	x		x	x
Ecstasy		x		x			x
Hallucinogens		x	x	x		x	x
Opioids	x	x	x	x	x		x
Synthetic drugs	x	x	x	x	x	x	x

¹⁷ European Monitoring Centre for Drugs and Drug Addiction, *Driving under the influence of Drugs, Alcohol, and Medicines in Europe – findings from the DRUID project – Thematic Papers* (2012).

¹⁸ Leblud, J (2017), *Driving Under the Influence: Legal and Illegal Drugs, European Road Safety Decision Support System*, developed by the H2020 project SafetyCube - review of over 80 papers on drugs and driving performance.

¹⁹ World Health Organisation (2015).

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

However, a number of case-control studies in Europe and North America have examined the relationship between the consumption of impairing drugs and crash risk²⁰. Table 2 below illustrates the increased risk associated with drug driving identified by one study that is reflective of the body of research.²¹

Table 2: Risk of death and serious injury while driving

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 Alcohol < 1.2 g/L	5-30	Highly increased risk
Alcohol > 1.2 g/L Drugs combined with alcohol	20-200	Extremely increased risk

Prescription drugs

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” and/or “restrict or avoid alcohol”²².

Research undertaken for the NZTA’s *Substance Impaired Driving Project* in 2015 found that 25 percent of all prescriptions issued in New Zealand are for medication that can impair driving²³ and nearly 65 percent of drivers are unaware that it is illegal to drive while impaired by medication²⁴.

²⁰ Mathijssen, R., & Houwing, S. (2005). *The prevalence and relative risk of drink and drug driving in the Netherlands: A case-control study in the Tilburg police district*, Gjerde, H., Christophersen, A., Normann, P., & Mørland, J. (2013). *Associations between substance use among car and van drivers in Norway and fatal injury in road traffic accidents: a case-control study*, Li, G., Brady, J., & Chen, Q. (2013). *Drug use and fatal motor vehicle crashes: A case-control study*, Compton, R., & Berning, A. (2015). *Drug and alcohol crash risk traffic safety facts: Research Note* and Jamt, R., Gjerde, H., Romeo, G., & Bogstrand, S. (2019). *Association between alcohol and drug use and arrest for driving under the influence after crash involvement in a rural area of Norway: A case-control study*.

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.

²² Anaesthetics, analgesics, antidepressants, anti-epilepsy, antipsychotics, anti-anxiety agents, sedatives and hypnotics.

²³ NZ Transport Agency (2015). For NZTA Substance Impaired Driving Project. *Memo: Analysis of summary data from the pharmaceutical collection year to July 2014*.

²⁴ NZ Transport Agency (2015). For NZTA Substance Impaired Driving Project. *Memo: Baseline Driver Survey*.

Evidence of the prevalence of drug driving in New Zealand

Laboratory testing by ESR

In New Zealand, ESR carries out toxicological analysis of blood samples submitted by the Police, a pathologist or the coroner. ESR's analysis of the blood samples, over the period from January 2014 to May 2018, of drivers stopped by Police and determined to be impaired by drugs, shows that 59 percent used cannabis and 41 percent used methamphetamine.

Over the same period, analysis of the blood samples of drivers killed in crashes, where drugs analysis was requested by a pathologist²⁵, found the presence (not necessarily indicative of impairment) of the following drugs²⁶:

- 29 percent had used alcohol²⁷
- 27 percent had used cannabis
- 10 percent had used methamphetamine
- 15 percent had used other drugs²⁸.

Of the drivers caught drink driving in New Zealand who submit a blood sample for laboratory analysis, over a quarter also test positive for recent cannabis use²⁹.

It can be inferred from the laboratory evidence that driving under the influence of recreational drugs is a potentially widespread behaviour in New Zealand. Table 3 reports blood sample results for deceased, hospitalised, and failed-CIT drivers for the last two calendar years.

*Table 3: ESR analysis of drugs (%) present in NZ driver blood samples**

Drug	2017			2018		
	Deceased	Hospitalised	Failed CIT	Deceased	Hospitalised	Failed CIT
Number of samples	191	531	415	197	700	468
Any drug**	57	N/A	89	50	N/A	92
Drugs combined	32	N/A	33	35	N/A	32
Cannabis	31	37	55	27	37	57
Methamphetamine	12	25	42	11	28	42
Opioids	6.3	7.3	8.2	6.6	12	14
Sedatives	6.3	9.4	16	6.1	10	13
Stimulants	3.7	1.9	2.9	3.0	3.3	2.6
Alcohol	26	N/A	N/A	28	N/A	N/A

*Reports only samples that received a full drugs screen and excludes crashes not included in NZTAs Crash Analysis System (CAS)

**Excludes alcohol.

²⁵ In this period, 845 samples from 1000 deceased drivers were submitted for analysis. Ninety percent (743) were subject to a full drugs screen.

²⁶ Drivers may have used more than one of the identified drugs.

²⁷ 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.

²⁸ Most common among 'other drugs' are medicinal drugs such as codeine and tramadol and sedatives such as zopiclone, clonazepam and diazepam.

²⁹ Cannabis use was identified by a presumptive method but not confirmed.

The ESR data shows that in 2017 and 2018 at least 50 percent of drivers killed in crashes had drugs in their system compared to 26 and 28 percent for alcohol respectively³⁰. Of 3,050 drivers who failed a breath alcohol test between 2012 and 2015 and provided a blood sample, drugs were detected in 40 percent of the samples.

Further data recently received from ESR from the first half of 2019 shows a 50 percent spike in the number of blood samples from deceased drivers that showed the presence of methamphetamine.

Data from the NZTA’s Crash Analysis System (CAS)

Data from CAS shows that the number of fatalities from crashes where a driver has been found to have used drugs before driving has increased.

Table 4 below illustrates the number of people killed from crashes (e.g. drivers and passengers) where a driver had consumed impairing drugs or alcohol before driving. The ‘involvement’ of drugs or alcohol in a crash does not mean that the drugs or alcohol caused the crash but it does mean it may have been a contributing factor. There can also be multiple contributing factors for any single crash

The data shows that in 2014, 18 people were killed in crashes where a driver had consumed impairing drugs before driving. In 2018, 95 people were killed. This compares to 123 people who were killed in crashes in 2018 where a driver had consumed alcohol³¹.

Table 4: Road deaths involving drugs or alcohol

Year	Deaths involving drugs	Deaths involving alcohol	
		Above legal limits* or refused test.	Below legal limits*
2018	95	80	43
2017	88	74	75
2016	61	67	69
2015	27	66	56
2014	18	48	41

*Alcohol legal limit of 50mg/100ml

This reported increase from 2015 to 2018 may be partly due to an increased Police focus on detecting drug impaired drivers in mid-2015, which saw an increase in the number of samples subject to drugs analysis. However, the data nevertheless shows an increasing trend since 2015 and that fatalities involving drivers who have used drugs are now more than two-thirds of those involving drivers who have consumed alcohol, and more than the number of fatalities involving drivers who have exceeded drink drive limits.

Driver surveys

For the New Zealand Health Survey 2012/2013³², the Ministry of Health interviewed 13,000 people aged 15 years and over. Of the 11 percent of drivers who reported using cannabis, 36 percent reported driving under the influence of cannabis at least once – suggesting that approximately four percent of adults have driven while under the influence of cannabis in their lifetime.

30 Drivers in ‘detrable road crashes’ whose blood sample was subjected to a full drugs screen analysis by ESR. The term ‘detrable road crashes’ excludes accidents the proposed policy could not deter because they occurred due to medical events, suicide or off-road incidents.

31 These figures vary from the figures presented in the Discussion Document, *Enhanced Drug Impaired Driver Testing, released for public consultation in May 2019. The figures have been updated to exclude non-detrable accidents from medical events, suicide and off-road incidents.*

32 Ministry of Health (note11).

In 2017, the University of Waikato surveyed 2,000 people by phone and 434 via the internet, to identify what drugs New Zealanders were consuming, and how many people drove within three hours of consuming those drugs³³. Table 5 below illustrates the findings of prevalence of drug driving for the main drugs of interest in New Zealand (based on aggregation of prevalence of use by drivers and elevated crash risk).

Table 5: Drug driving prevalence in New Zealand

Drug	Telephone respondents		Internet respondents	
	Used	Within 3 hours of driving	Used	Within 3 hours of driving
Cannabis	6.6%	2.5%	25.6%	14.2%
Sedatives	11.9%	0.2%	12.8%	2.6%
Ecstasy	1.1%	0.1%	6.7%	1.3%
Meth	0.4%	0.1%	3.7%	2.4%
Hallucinogens	1.3%	0.1%	5.7%	2.1%
Opiates	0.5%	0.2%	1.0%	1.0%
Cocaine	0.4%	0.1%	1.0%	0.5%
Alcohol	83.8%	45.3%	88.9%	N/A

New Zealand's current approach to deterring and detecting drug driving

Under the current CIT regime, a police officer must have 'good cause to suspect' a driver has used a drug or drugs before the driver can be required to undergo the test. A trained police officer carries out the test, which comprises eye, walk and turn, and one-leg-stand assessments.

Drivers who fail the CIT are required to provide an evidential blood sample, which is analysed for the presence of a qualifying drug³⁴ by ESR. It is an offence to drive impaired, with evidence in the blood of a qualifying drug³⁵.

Further detail about the legislative arrangements for the CIT is set out in Section 2.2 below. Analysis of the limitations of the CIT is set out in Section 2.3 below.

Previous government consideration of the current scheme

A report back on the overall fitness-for-purpose of the drug driving system took place in 2012, three years after the CIT regime was introduced. At that time it was found that the regime was working well and Police found the legislation to be effective and workable. In 2012, the use of oral fluid drug testing devices was not supported as they were considered to be too unreliable, time consuming (3-5 minutes per test) and costly (\$50 per test).

In 2014, the Ministry reviewed the extent of drug driving in New Zealand and the effectiveness of the current drug-driving enforcement model under the Safer Journeys Action Plan 2013-15. At that time the review estimated the social cost of drug driving had escalated to between \$96.8 million and \$731.4 million per annum, with a central estimate of \$250.5 million. This was equivalent to 23 people dying, 112 serious crashes, and 304 minor crashes per year.

Following the review in 2014, Cabinet considered a proposal in April 2016 to introduce random oral fluid drug testing³⁶. At that time, Cabinet invited the Minister of Health to

³³ Starkey (note 12)

³⁴ These are drugs categorised under Schedule 1, 2, and parts of Schedule 3 of the Misuse of Drugs Act 1975, as well as prescription medicines defined in section 2 of the Land Transport Act 1998

³⁵ Section 57A Land Transport Act 1998

³⁶ CAB-16-MIN-0151

consider the proposal in the context of the National Drug Policy 2015-2020 and report to the Cabinet Strategy Committee. In June 2016, the Associate Minister of Health advised that he did not support the proposal as the National Drug Policy emphasised a proportionate response to minimise drug-related harm, whereas a driver who returned a positive oral fluid test for the presence of drugs did not necessarily represent a risk to road safety³⁷.

In November 2016, Cabinet considered a modified proposal for oral fluid drug testing following an incident comprising either a suspected driving offence or a driver's involvement in a motor vehicle crash³⁸. Cabinet directed the Associate Minister of Transport to provide further advice on the options and to prepare a draft document for public consultation on the proposed options. This was not completed before the General Election in 2017.

2.2 What regulatory system, or systems, are already in place?

New Zealand's current drug-driving regime was introduced in 2009. It is set out in the Land Transport Act 1998 (LTA). The approach to drug-driving enforcement is based on proving a person is both: impaired and cannot drive safely; and has drugs present in their blood.

Section 71A of the LTA authorises a (trained) police officer to require a person to undergo a CIT. If a driver's performance on the CIT is unsatisfactory, a police officer can require a driver to undergo a blood test for a qualifying drug. Section 57A of the LTA states that it is an offence to drive while impaired, with evidence in the blood of a qualifying drug.

Section 64 of the LTA provides a medical defence for a person who can prove that they have a current and valid prescription from a health practitioner for the drug(s) they have consumed before driving and were using the drug(s) in accordance with the health practitioner's or manufacturer's instructions.

The current regime also includes a 'presence-based' offence. Section 58(1)(b) of the LTA applies to drivers who are hospitalised because of a crash and because of their injuries, cannot undergo a CIT. If the driver's blood test, taken in a hospital, shows the presence of a Class A drug³⁹ (for example, methamphetamine), they can be prosecuted.

Penalties for drug impaired driving

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 12 hours if their performance on a CIT is unsatisfactory. This is to ensure that any risk that the impaired driver may pose to other road users is effectively managed.

Agencies with an interest in the drug driving scheme

Other than the NZ Police, who administer the scheme at an operational level, the Ministry of Health has an interest as the owner of New Zealand's National Drug Policy 2015 – 2020. The National Drug Policy 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 health and wellbeing. The Policy's objectives are:

- delaying the uptake of alcohol and other drugs (AOD)
- reducing illness and injury from AOD

³⁷ STR-16-MIN-0002

³⁸ CAB-16-MIN-0606

³⁹ Class A drugs are drugs that carry a very high risk of harm. Listed in Schedule 1 of the Misuse of Drugs Act 1975.

- reducing hazardous drinking of alcohol
- shifting attitudes towards AOD.

The Policy emphasises a proportionate response to minimise drug-related harm and promotes alternatives to the criminal justice system for dealing with low-level offenders⁴⁰.

If a driver is convicted by the courts under section 65 of the LTA for repeat driving offences involving drugs, they can be indefinitely disqualified and required to prove they have dealt with their drug problem by attending an approved drug and alcohol assessment centre, before their licence can be reinstated. The NZTA is responsible for the process of reinstatement.

The Ministry of Justice is responsible for policy on cannabis reform. This work is linked to but not dependent on the Ministry's work on drug driving.

Non-government organisations with an interest in drug driving policy include providers of drug education and rehabilitation courses offered by NGOs, funded by District Health Boards. The NZ Drug Foundation is a registered charitable entity that is supported by government funding, corporate and private grants and donations, and members to advocate for drug policies and practices.

2.3 What is the policy problem or opportunity?

Research demonstrates that many illicit, prescription and recreational drugs have negative impacts on driving ability and increase crash risk. When combined with alcohol the negative effects can be even larger.

Evidence from surveys of drivers, and analysis of crash data and blood samples from deceased drivers (refer Section 2.1 above) shows that drivers in New Zealand are using drugs that can impair driving performance and cause deaths and serious injuries. Indications are that the number of 'drug drivers' is increasing despite the existing CIT scheme.

The CIT behavioural tool currently available to the Police to detect drug driving is useful - it is an impairment-based test that can be applied regardless of the drug or substance that has been consumed by a driver. In 92 percent of the cases where a driver fails a CIT, subsequent laboratory analysis of the driver's blood sample by ESR confirms the presence of a qualifying drug.

However, the CIT has limitations. Its key limitation is that it cannot be performed in large enough numbers to provide general deterrence of drug driving. Police records show that 473 blood specimens were analysed following drivers completing a CIT unsatisfactorily in 2017/18. While the Police do not have data on how many drivers satisfactorily complete CITs, or how many CITs are conducted overall, the number of tests carried out is very low (estimated at less than one percent of drivers) in comparison to the around 1.75 million compulsory alcohol breath tests carried out each year (47 percent of drivers).

Good cause to suspect

Under the CIT regime, a police officer must have 'good cause to suspect' a driver has used a drug or drugs before that driver can be required to undergo the test. Good cause to suspect can be established by a police officer if they witness behaviours such as erratic driving or swerving across lanes, through a driver's personal demeanour when they are stopped and spoken to by a police officer, or from external cues such as the smell of cannabis.

⁴⁰ For example, people found in possession of illicit drugs for personal use.

Compared to the random testing approach used for alcohol in New Zealand, the core problem with the 'good cause to suspect' threshold is that it limits the number of drivers police officers can test because they are required to identify observable signs of drug use. The time it takes to complete a CIT may disincentivise police officers from committing resources to conducting a CIT when their initial assessment of good cause is marginal. The requirement to establish good cause also means it is likely there are drug drivers who are not tested because they show no observable signs of drug use.

Time taken to conduct a CIT

A CIT takes, on average, 52 minutes to complete. For safety reasons, CITs cannot be conducted by the roadside, so drivers are usually brought back to a Police station to be tested. If a CIT is failed, it takes an additional 40 minutes, on average, to complete an evidential blood test. Overall, this limits the number of drivers that can be processed through a CIT. The process also requires police officers to withdraw from frontline activities for the time it takes to complete the CIT and blood test.

Other limitations

Police are frequently unable to require drivers who have been injured in a crash to undertake a CIT because they are injured or in a state of shock or emotional distress following a crash.

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.

Police officers need special training to be able to conduct a CIT. The cost of training every police officer is prohibitive, meaning sufficient trained officers may not be available at all times to conduct a CIT.

Summary

The factors discussed above limit the capacity of the CIT regime to achieve a general deterrence effect (discussed below), meaning that the perceived and actual risk of detection of drug driving is minimal. A University of Waikato survey of drivers in 2017/18⁴¹ 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 drugged driving.

Drug driving deterrence

There are two forms of deterrence, general deterrence and specific deterrence. General deterrence refers to the impact of enforcement on those not directly impacted, via mechanisms such as advertising and word-of-mouth. Specific deterrence, on the other hand, refers to the impact of enforcement on people directly, via personal experience of checkpoints and/or penalties.

Deterrence theory proposes that the key to reducing offending is lifting the level of detection and enforcement⁴². This is achieved when the mere threat of being caught and sanctioned deters the majority of drivers from committing an offence.

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-testing⁴³ and a corresponding decrease in alcohol-related road crashes. In

41 Starkey (note 12).

42 Davey, J. & Freeman J. (note 3).

43 Above note 4.

1990, there were 268 fatal crashes, out of a total of 638 (42%) involving alcohol, compared to 74, out of 342 (20%) in 2017⁴⁴.

In the drug driving context, deterrence theory suggests highly-visible testing of drivers at sufficiently intense levels to increase the public's perception of the risk they will be caught drug driving. The consequences that follow for a drug driver are also important. The swift delivery of sanctions, such as through an infringement offence regime, versus court-based processes, promotes deterrence.

2.4 Are there any constraints on the scope for decision making?

Cabinet has agreed to a drug driving scheme for New Zealand that retains the current CIT process⁴⁵. This precludes the development of an entirely bespoke system.

2.5 What do stakeholders think?

Stakeholders and their interests

The primary stakeholder of the proposed policy is the New Zealand driving public. Key government stakeholders are the NZ Police, the Ministries of Transport, Health and Justice, the Department of Corrections and NZTA. The collective interest of all stakeholders is reduced harm (deaths and serious injuries) from drug driving.

Government stakeholders

The NZ Police has collaborated with the Ministry of Transport in the development of the proposed policy and support all aspects of the policy, except the threshold at which the level of drugs in blood denotes a criminal (as opposed to infringement) offence. Police support a level equivalent to a blood alcohol level of 50mg/100ml. The proposal in this RIS is for a threshold of 80mg/100ml, which is consistent with the criminal threshold for drink driving in New Zealand.

Other government stakeholders have considered new measures to address drug driving on several previous occasions. These include two Cabinet papers and RISs seeking to introduce oral fluid testing in 2016 and papers seeking permission to consult on drug driving measures in 2017 and 2018.

Consultation with agencies during policy development in 2019 on the proposed scheme highlighted residual concerns about disproportionate impacts for Māori and human rights limitations. Agencies were positive about the inclusion of drug concentration limits as a basis for offences and the incorporation of prescription drugs in the scheme, but were cautious about the introduction of offences for driving after consuming combinations of drugs and/or alcohol.

The Ministry of Justice noted that the proposal will limit rights affirmed under the BORA (discussed in Section 5.4) but acknowledged that previous advice on BORA impacts had been considered in the design of the scheme. The Ministry of Justice requested that it be consulted in the development of the new offences created for the scheme.

The Ministry of Health queried the extent to which levels of drugs in blood can be correlated with blood alcohol levels. It also expressed concerns about criminal offences for driving after consuming combinations of drugs.

⁴⁴ Reported where a driver's blood sample tested over the applicable legal limit or driver refused a blood test.

⁴⁵ DEV-18-MIN-0193.

The Ministry of Health considered that more could be done to support a health approach to drug driving, to take advantage of public education and advertising, and to take account of disproportionate impacts for Māori.

Te Puni Kōkiri (TPK) noted concerns about the limitations of the science about the impairing effects of drugs, and that the proposal was likely to have an over-representative effect on Māori. TPK suggested that the Ministry of Transport consider:

- how the health-based approach could be strengthened
- training for Police to mitigate concerns about unconscious bias
- fines based on income levels.

Public consultation

Public consultation on drug driving took place in May and June 2019⁴⁶. The consultation document was hosted on the Ministry of Transport's website. It received significant attention in news media, in particular because its release coincided with the one-year anniversary of a crash involving drug driving that resulted in seven deaths. In total, 88 submissions were received from the public consultation as follows:

- 60 were from individuals
- 4 were from local government
- 6 were from health sector organisations and health professionals
- 2 were from Māori health advocates
- 7 were from drug advocacy/interest groups
- 3 were from motor vehicle industry organisations
- 4 were from unions or organisations representing employees
- 1 was from a researcher/academic
- 1 was from a drug testing equipment manufacturer

The overarching message from submitters to the public consultation on enhanced drug driver testing was that they support the Government taking action to reduce the deaths and serious injuries that result from drug driving⁴⁷.

The majority of submissions supported the introduction of roadside oral fluid testing under a zero-tolerance, presence-based approach under which drivers would be penalised without impairment being proven. Some submissions raised concerns about the accuracy of oral fluid testing devices, or the potential for a presence-based approach to disproportionately affect disadvantaged groups, such as Māori, who are more frequent users of cannabis.

The majority of submitters supported random drug testing, regarding it as a reasonable and proportionate response to the harm of drug driving. Very few submitters expressed any concern about the proposed 3 to 5 minutes it could take to complete an oral fluid screening test. Most submitters that addressed this point argued it was a minor inconvenience in order to save lives.

Submitters acknowledged that the CIT scheme was important and needed to be retained to detect drugs that oral fluid testing devices could not detect, for example synthetic drugs.

⁴⁶ Ministry of Transport, *Discussion Document: Enhanced Drug Impaired Driver Testing* (May 2019)

⁴⁷ Ministry of Transport, *Summary of Submissions: Enhanced Drug Impaired Driver Testing* (May 2019)

Submitters were divided about the implementation of blood concentration limits (*per se* limits) for drugs. A number of submissions noted that limits could be used to address concerns about drivers being unfairly penalised for taking medicines in accordance with a prescription. However, most submitters that discussed limits had concerns about whether the evidence base for the impairing effects of different drugs, and drugs in combination, was advanced enough to support setting levels that were reasonable and not arbitrary.

A significant minority of submitters had reservations about whether a presence-based approach should apply to prescription drugs. Most submitters that discussed options related to prescription drugs argued that people who are impaired by illicit or prescription drugs should be treated the same, as they both present a road safety risk. However, the majority of those submitters had reservations about penalising drivers, under a presence-based approach, if they had taken medicines at prescribed levels and were not impaired.

Most submitters supported a medical defence, provided a driver had taken medicines in accordance with a prescription that did not include a warning not to drive, or where the driver had not been warned of the impairing effect of the drugs they were taking.

Most submitters supported a penalty structure that aligns, to the extent possible, with drink driving penalties.

Health sector organisations, Māori health advocates and the councils who submitted to the consultation recommended health-based, non-enforcement options for first time or low-level offending. Almost every submission that discussed penalty options acknowledged the need to support drug drivers with access to some form of drug education and rehabilitation, counselling or mental health support.

Section 3: Options identification

3.1 What options are available to address the problem?

The following options have been identified to address the problem identified above.

Option 1: Status quo or enhanced status quo

Under the status quo option, Police will continue to conduct CITs with the existing level of trained staff, identifying drivers who are impaired by drugs on the basis of good cause to suspect. A similar prosecution success rate of 92 percent of drivers can be assumed. Under this option, Police might conduct around 500 CITs per annum.

Under an enhanced status quo option, Police could train more police officers to conduct CITs, so that the reach of testing is extended. Police advise that this would be a significant financial investment for a relatively low return as police officers would still be limited in the number of drivers they could process by the requirement to establish 'good cause to suspect'. Police estimate they might perform up to 1,000 drug tests per annum with more trained officers. While this is double the current rate of testing it is still a very low number of tests compared to the roughly 1.75 million breath tests for alcohol undertaken each year.

The low number of tests that can be completed under the status quo and enhanced status quo options are unlikely to be sufficient to provide the desired deterrence effect. A study by Monash University in Australia concluded that, to achieve optimal levels of general deterrence, ten percent of licensed drivers should be tested for drugs each year.

Roadside oral fluid testing options

Oral fluid testing schemes are able to deliver highly-visible testing of drivers at sufficiently intense levels to increase the public's perception of the risk they will be caught if they drive after using drugs.

Many jurisdictions with drug testing regimes like the CIT have supplemented them with oral fluid testing over the last decade to lift their level of drug driving detection and enforcement. This includes over a dozen jurisdictions in Europe and North America. Our nearest neighbour, Australia has been conducting roadside oral fluid testing for 15 years.

Oral fluid testing is undertaken because it is the quickest, least invasive and most practical method of roadside drug testing (e.g. compared to urine or blood testing). Oral fluid testing 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 (more recent devices require a single swipe of the tongue). The device then shows either a positive result for drugs or a negative result.

Oral fluid testing devices are manufactured with 'cut-off' thresholds for the detection of drugs. The thresholds vary from device to device. The purpose of the thresholds is to reduce the risk of false-positives by ensuring there is a sufficient amount of a drug present in a blood sample to accurately determine a result.

Drug screening devices can take less than one minute to produce a result⁴⁸, which is considerably less than it takes to undertake a CIT but significantly longer than an alcohol breath test, which takes a few seconds. An oral fluid test is likely to cost between \$20 and \$45, compared to a few cents for an alcohol breath test.

The disadvantage of oral fluid testing is that, unlike alcohol breath tests, oral fluid screening devices can only detect the presence of drugs, not 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.

A number of jurisdictions that have implemented oral fluid testing have also developed blood concentration limits to transition their schemes (in part) into impairment-based regimes. Limits are discussed in detail later in this section.

Three options for roadside oral fluid testing are considered below.

Option 2: Roadside oral fluid testing with a 'good cause to suspect' threshold

Under this option, roadside oral fluid testing would be conducted by a police office after they have formed good cause to suspect a driver has consumed drugs before driving. The advantages of this approach are that drivers who are identified for testing would be subjected to a much shorter roadside 'detention' than for a CIT test, and drivers who are not exhibiting symptoms of drug use would be unlikely to be stopped and tested for the presence of drugs.

Of the options considered in this RIS, this option would have the least overall impact on drivers' rights and freedoms under the BORA. However, as stated above in relation to Option 1, Police would be limited in the number of drivers they could test - up to 1,000 drug tests per annum.

Canada retained the good cause to suspect approach when it introduced roadside oral fluid testing as a complementary option to CIT testing in 2018. The Canadian government decided that, compared to the few seconds it took to screen a driver for alcohol, the few minutes it took to screen a driver for drugs, when they had potentially not consumed any drugs, was an unjustifiable breach of the Canadian Charter of Rights and Freedoms.

⁴⁸ Timing may vary depending on the number of and type of drugs being tested for.

In 2016, Cabinet considered but decided not to proceed with an option for roadside oral fluid testing with good cause to suspect. This option has not been costed in the Ministry's CBA.

Option 3: Random oral fluid testing with an infringement offence scheme (preferred option)

Random testing model

Under Option 3, the legal power of the Police to test drivers would be similar to the power they now have to test drivers for drink driving. A driver could be stopped on a road and tested at any time, without there being any suspicion the driver had used drugs before driving.

Police operational procedures for the delivery of oral fluid testing will be developed to maximise the use of resources to achieve the objectives of the proposed policy. This would be dependent on factors such as the availability of equipment and the number of trained staff - training in the use of oral fluid devices is less expensive and more accessible than training for the CIT. In practice, Police would likely conduct oral fluid testing through high visibility checkpoints and/or mobile vehicle stops. The process could be operated in tandem with drink driving operations.

Deterrence theory⁴⁹ proposes that random testing is the most effective for achieving an increased general deterrence effect, because it provides the greatest increase in the public perception of the possibility of being caught drug driving anytime, anywhere (refer discussion in Section 2.3 above).

Of the options considered in this RIS, random drug testing would have the greatest impact on drivers' rights and freedoms under the BORA, 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 are not likely to have used any drugs.

The majority of submitters to the public consultation on drug driving supported a random drug testing approach, considering that it was a reasonable and proportionate response to the harm of drug driving.

Infringement offence scheme

Under Option 3, there will be a rebuttable presumption that drivers who produce two positive (failed) oral fluid tests commit an infringement offence 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.

Creating an infringement offence scheme for drivers who fail roadside drug tests would deter drug driving behaviour without criminalising drivers who have not been proven to be impaired. An infringement approach is likely to be more effective in socialising a change in drug driving policy than would be achieved by a solely criminal approach that could alienate the public if it resulted in perceived injustices.

An infringement approach would support the Government's commitments to taking steps to, where appropriate, avoid criminalising drug use. This is reflected in, among other things, the National Drug Policy 2015-2020. 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.

49 Davey, J. & Freeman J. (note 3).

Infringement penalties would put less pressure on the Justice sector than 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, which is a key requirement for deterrence. The issue of an infringement notice also provides an opportunity to provide drivers with information about drug-related health services.

A disadvantage of an infringement offence scheme is that it could lead to a risk of drug driving being perceived as a minor offence. It would also mean New Zealand's scheme for drug driving operated with two different penalty regimes - an infringement offence under a presence-based oral fluid testing scheme and a criminal offence under the existing CIT impairment-based scheme. There is a risk that drivers with the same level of impairment could receive different penalties depending on the testing path Police employ – the CIT path leads to the taking of a blood sample that could result in criminal penalty, whereas the oral fluid testing path can only result in an infringement penalty.

The presumption that an offence has been committed once a drug is identified by an oral fluid test, places 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 which is affirmed in section 25(c) of the Bill of Rights Act.

An infringement offence option aligns with the drink driving scheme in New Zealand, which also includes infringement and court-based penalties. This makes the scheme simpler for drivers to understand, which supports compliance. Most submitters to the public consultation supported a penalty structure that aligns, to the extent possible, with drink driving penalties.

Ability to elect to provide an evidential blood sample

To address the risk of false-positives, drivers who fail two oral fluid tests will have a right to elect to provide an evidential blood sample, analysed in a laboratory, to demonstrate that they do not have drugs in their system.

To facilitate 'access to justice' the proposal will provide for deferred payment of any fee for electing a blood test (currently set in legislation at \$668.94). This is because this fee is likely to be prohibitive for many drivers and may act as a disincentive to making the election. Drivers that elect a blood test would pay the fee once the results of the blood test or a medical defence were confirmed. In the latter case this would be at a court hearing. The fee would be waived if a driver's blood sample did not show the presence of drugs, or if the drugs were legitimately prescribed and a medical defence was available (discussed below).

Police officers may switch to the CIT process

To manage the risk of heavily impaired drivers that are a high road safety risk receiving a lower level infringement penalty, police officers will be able to 'switch' from the oral fluid testing process to the CIT process if they form good cause to suspect a driver has consumed drugs before driving.

Under the current law, 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 six months or more.

Other options relating to 'switching' are discussed further below under the heading of *Other scheme design elements*.

Cost benefit analysis for this option

The Ministry's CBA predicts a BCR of 12.36 for its preferred option (with a range of 6.8 to 24.3). It predicts harm savings over ten years of \$415 million using a central estimate within a range of \$238 million to \$779 million (or 65 lives within a range of 37 to 123).

The final cost of the scheme will depend on the detail of the statutory regime eventually enacted by Parliament and the results of the procurement processes undertaken by Police for oral fluid testing devices. The cost of this option is estimated in the CBA at \$34 million over ten years.

Option 4 Random oral fluid testing - with criminal penalties only

As for Option 3, under Option 4, the legal power the Police will have to test drivers will be very similar to the power they have to test drivers for drink-driving. A driver could be stopped and tested on a road at any time without there being any suspicion the driver has used drugs before driving.

Under Option 4, drivers who produce two positive (failed) oral fluid tests would be treated the same as drivers who fail a CIT under the current scheme and would be subject to criminal penalties. Criminal penalties send a strong message that drug driving cannot be tolerated and can act as a strong deterrent to drug driving. A criminal penalty for a drug driving offence detected by a roadside oral fluid 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 CIT process.

However, under a presence-based scheme, criminal penalties would be harsh on drivers who are not proven by blood analysis to be impaired. As many more drivers will be subjected to oral fluid testing, more drivers will potentially face criminal penalties. This approach would have significant BORA impacts for drivers.

Under a criminal penalty approach there would be increased costs for Police, in support of prosecutions, and the Department of Corrections for managing sentences. Compared to an infringement scheme model, the Ministry's CBA predicts Police costs would rise from \$26.3 million to \$62.6 million. Corrections costs would rise from a low \$3.2 million to \$81 million.

There would also be social costs for criminalised individuals and their families, such as of reduced access to employment and/or education. A criminal penalty regime for oral fluid testing would not support the Government's commitments to, where appropriate avoid criminalising drug use and would exacerbate adverse impacts for Māori who are disproportionately represented in drug use and criminal population statistics.

Cost benefit analysis for this option

The Ministry's CBA predicts a BCR of 4.83 for this option. Though the CBA predicts more lives would be saved under this option than an infringement scheme option (114 versus 65), the costs of the scheme are nearly five times higher (\$150 million compared to \$34 million).

Other scheme design elements common to Options 2, 3 and 4

The following design elements are common to each of the options for roadside oral fluid testing discussed above. They represent checks or safeguards in the scheme that protect its integrity and mitigate the BORA impacts of the proposals.

Two consecutive positive oral fluid tests

Two consecutive positive (failed) oral fluid tests will be required to establish an offence. Conducting two oral fluid tests reduces (but does not eliminate) the mathematical probability of false-positive results from the two tests.

Undertaking two oral fluid tests would mean more time stopped at the roadside for the small percentage of drivers who are subject to an initial false-positive but would provide an important safeguard in the system.

Based on Police conducting 66,000 tests per annum⁵⁰ (the number conducted in Queensland with a similar population of drivers to New Zealand) the Ministry's CBA predicts only a minor decrease in scheme costs (0.4 million approx.) if a single oral fluid test was used, meaning that there is little value in removing the safeguard for the savings offered.

Switching between the CIT and oral fluid testing pathways will be restricted in some circumstances

The ability of police officers to switch to the oral fluid testing process after they have commenced the CIT process will be restricted. This is because drivers who have been subjected to the more stringent and lengthy CIT process, and been determined not to be impaired, should not be further detained for the purposes of oral fluid testing.

In addition, enforcement officers would only be able to switch from the oral fluid testing process to the CIT process if:

- a driver had passed the first oral fluid test, but the enforcement officer had good cause to suspect a driver has consumed drugs that the device may not be able to test for
- a driver had failed the first oral fluid test and passed the second oral fluid test, but the officer had good cause to suspect the driver has consumed drugs.

This approach maintains the integrity of the two testing pathways and addresses concerns about perceived fairness. It is also simpler for enforcement officers to administer but still allows an opportunity for enforcement officers to act if they have good cause to suspect a driver has consumed drugs.

The current medical defence for prescription drugs will be retained

Section 64 of the Land Transport Act 1998 provides a medical defence for drivers who fail a CIT test but have consumed drugs in accordance with a valid prescription. The purpose of the medical defence is to avoid discouraging drivers from taking prescription medicines, noting that not taking medicines can create other road safety risks, such as might be the case with heart medication or anti-epilepsy medication.

The medical defence will be available to drivers who have provided a blood sample for an evidential blood test because they have failed a CIT or because they have elected to provide a blood sample after failing two oral fluid tests.

Harm minimisation approach supporting drug drivers

Currently, the Courts have the power 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 offences⁵¹. Under the options considered above, a court will be required to issue a compulsory referral to a drug education or rehabilitation programme for second and subsequent criminal offences. Ministry of Transport officials will work with the Ministry of Health to understand and address any capacity constraints that may impact the ability of drivers to complete these programmes.

⁵⁰ For example, testing 63,000 drivers (3.6 percent of drivers) on an assumption 5 percent of drivers fail tests.

⁵¹ Section 65 of the Land Transport Act 1998

Limits for the concentration of drugs in blood

Limits will be applied to the blood samples of drivers who fail a CIT and are required to provide an evidentiary blood sample and of drivers who elect to provide a sample following two failed oral fluid tests. The samples will be analysed by ESR against limits specified in primary legislation. Introducing limits will align the scheme with drink driving legislation and introduce an impairment assessment to the penalty regime for drivers.

There will be two limits for the drugs of interest in New Zealand for which research and evidence allows limits to be identified. The first limit is a low ‘threshold’ or ‘tolerance’ limit designed to avoid penalising drivers who have low levels of a drug(s) in their system because they have:

- been accidentally or passively exposed to drugs
- low residual levels of a drug in their blood that are unlikely to impair driving due to previous but not recent use (this can occur particularly with cannabis)
- consumed standard prescription doses of some medicines or over the counter medication that are unlikely to impair driving.

A second limit will be established beneath which the presence of a drug at that level will be an infringement offence and above which it will be a criminal penalty. Table 6 below illustrates the proposed scheme for limits.

Table 6: Limits for drug concentrations in blood

Limits	Penalty
‘Thresholds’ or ‘tolerances’ designed to avoid penalties for drivers who have: <ul style="list-style-type: none">• accidental or passive exposure to drugs• low residual levels of a drug in their blood due to previous use but have not recently used drugs• consumed standard prescription doses of some medicines	No penalty
Drug levels above the low-level ‘tolerance’ but beneath a level equivalent to a breath alcohol level (BAC) of 80mg/100ml	Infringement penalty
Drug level <u>above</u> a level equivalent to a BAC of 80mg/100ml	Criminal penalty

Independent expert panel to provide advice about limits

Overseas jurisdictions that have prescribed limits for drugs, such as Norway, the United Kingdom and Canada, established committees of medical and scientific experts to provide advice about the drugs that limits could apply to and what those limits could be. A similar process is proposed for New Zealand.

An independent expert panel will be established for a set term to provide initial advice to Government about the limits to be specified for drugs, the low-level tolerance thresholds to be applied to the detection of drugs by ESR, and the cut-off thresholds to be included in oral fluid testing devices. This will enable the Government to make informed decisions, based on the latest evidence and research, about the application of limits and thresholds for drugs.

The panel will be appointed by the Associate Minister of Transport, the Minister of Police and the Minister of Research, Science and Innovation in accordance with the Cabinet Fees Framework for advisory bodies.

Penalties for driving after consuming combinations of alcohol and/or drugs

International research shows that driving after consuming combinations of drugs, or drugs and alcohol, can increase crash risk by 20 times or more⁵². Of the drivers caught drink driving in New Zealand who submit a blood sample for laboratory analysis, over a quarter also test positive for recent cannabis use⁵³.

Some countries have addressed this by establishing combined drug and alcohol limits. For example, in Canada, where there are limits for THC, there are different penalties based on the level of THC detected, and whether THC is present in blood together with alcohol.

Under the options considered in this RIS there will be penalties for driving after consuming drugs and alcohol, including higher infringement penalties and criminal penalties based on the level of alcohol that is present in the driver's blood. The Ministry of Justice will be consulted during the development of drafting instructions for the proposed offences.

Drivers with prescriptions, who have taken drugs in accordance with their prescriptions and are eligible for a medical defence (see paragraphs 72 to 74 below) will not be subject to penalties for combined drug and alcohol use but will remain liable for any qualifying drink driving offences.

Stronger penalties for driving after consuming a combination of drugs rather than a single drug are also proposed, to reflect the increased risk of combined drug use. The structure of this offence will also be established in consultation with the Ministry of Justice during drafting.

To support establishing criminal offences, and ensure that no driver receives a criminal penalty without having blood analysis, police officers will be authorised to require a blood sample from drivers who are found to have consumed combinations of drugs and/or alcohol. The existing offence for failing to permit a blood specimen to be taken will be extended to these drivers⁵⁴.

Drivers with prescriptions, who have taken drugs in accordance with their prescriptions and are eligible for a medical defence will not be subject to differential penalties but will remain liable for any qualifying drink driving offences.

There will be additional penalties for third and subsequent convictions for drug impaired driving designed to target repeat offenders in the same way that the LTA currently imposes heavier penalties for repeated impaired driving offences (alcohol or otherwise). Similarly, section 65AD of the LTA and section 129 of the Sentencing Act will apply to persons convicted of repeat drug driving offences as is currently the case with repeat drink drivers.

To support the criminal offence, police officers will be authorised to require a blood sample from drivers whose oral fluid tests reports the presence of two or more drugs. The existing offence for failing to permit a blood specimen to be taken will be extended to these drivers.

Non-enforcement measures to support the drug driving regime

Research and academic writing on measures to address drug driving highlight the critical importance of education and public messaging in support of, but not in place of highly visible testing procedures, in order to achieve a general deterrence effect.

⁵² Schulze, H., Schumacher, 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.

⁵³ Above the detection threshold applied by ESR for the presence of THC.

⁵⁴ Section 60 of the LTA

In the context of the proposed scheme for New Zealand, education campaigns will be needed to highlight the dangers of drug driving and the 'certainty' of detection and punishment under the new scheme. A particular focus area will be prescription drugs, given research by the NZTA's Substance Impaired Driving Project found that 65 percent of drivers are not aware it is illegal to drive while impaired by medication. This will include programmes directed at medicine dispensers aimed at ensuring they provide adequate warnings when prescribing or issuing drugs, and that packaging is adequately labelled.

3.2 What criteria, in addition to monetary costs and benefits, have been used to assess the likely impacts of the options under consideration?

The primary criterion is achieving maximum deterrence and detection of drug driving (to achieve the greatest road safety benefit). Other important criteria are:

- consistency with the Bill of Rights Act 1990
- operational deliverability for Police and other affected agencies
- alignment, to the extent possible, with well-established drink-driving measures
- alignment with a harm minimisation approach to drug driving.

Meeting these criteria involves balancing sometimes competing considerations. For example, random roadside testing will deliver a greater general deterrence effect than testing with a threshold of good cause to suspect. However the latter, overall, has a lesser impact on the rights and freedoms affirmed under the BORA. The key trade-offs to consider when evaluating the options for an enhanced drug driving regime are:

- estimated road safety benefits
- BORA impacts
- the operational practicalities of implementing a new enforcement regime.

3.3 What other options have been ruled out of scope, or not considered, and why?

Evidential blood testing under the oral fluid scheme

Under this approach, drivers who produce two positive (failed) oral fluid tests would be treated the same as drivers who have failed a CIT and would be required to provide a blood sample. Subsequent laboratory blood analysis of the sample demonstrating the presence of a specified drug(s) would confirm an offence.

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. In the United Kingdom, a positive oral fluid test is followed by the taking of a blood or urine sample.

This approach would be more consistent with the right under the BORA to be presumed innocent until proved guilty (section 25(c)), as oral fluid testing devices carry a risk of false-positives.

However, evidential blood tests would add, on average, forty minutes to the detention of each driver tested. The time taken to process blood tests (an average of three weeks) would also delay the delivery of the drug driving penalty – the swift delivery of penalties is a key element of deterrence.

If roadside oral fluid testing is undertaken in sufficient numbers to achieve general deterrence, the Ministry's CBA predicts that Police costs will increase from \$26.3 million to

\$46.3 million.

Oral fluid testing as a screening tool before conducting a CIT

Under this approach, oral fluid testing could be undertaken on a random basis or with good cause to suspect, to screen drivers for a subsequent impairment test. While this approach would ensure that only impaired drivers are subject to penalties for drug 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 deterrence value of the enforcement activity.

For example, if a drug screening test was delivered through a check point – a highly visible deterrence activity - police officers' time could quickly become appropriated to conducting CITs, which would reduce the number of drivers who could subsequently undergo a drug 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 and evidential breath alcohol tests conducted by Police.

Public education and advertising only

A non-enforcement approach was considered, under which comprehensive public education campaigns would highlight the dangers of drug driving. However, without the fear of actually being caught and penalised, this approach provides limited deterrence. Since the introduction of the CIT test in 2009 to the present, New Zealand has consistently operated a public advertising campaign. There have been four phases to the campaign:

- 2009 – 2010, advertising to inform people that Police could now check drivers for drug impairment (TVC *Surprise*).
- 2012 – 2013, advertising and education asking and showing people how much how much of a problem is drugged driving (*Social Conversations*; TVC *Taxi*).
- 2013 – 2015, advertising targeting drivers using cannabis, highlighting their reduced concentration and reactions (TVCs *Shopkeepers* and *Blazed*).
- 2016 – 2018, advertising targeting drivers using cannabis, again highlighting their reduced concentration and reactions (Social *Tinnyvision*; TVC *Thoughts*; outdoor *Driving High*).

Despite these campaigns, the University of Waikato survey of drivers in 2017/18⁵⁵ 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 drugged driving.

⁵⁵ Starkey (note 12)

Section 4: Impact Analysis

Marginal impact: How does each of the options identified at section 3.1 compare with the counterfactual, under each of the criteria set out in section 3.2?

	Option 1: Status quo/enhanced status quo	Option 2: Oral fluid testing with 'good cause to suspect'	Option 3: Random oral fluid testing with an infringement scheme	Option 4: Random oral fluid testing with criminal penalties
Detection and deterrence	0 Low number of tests insufficient for general deterrence.	0 Twice as many tests as current regime but insufficient volume for general deterrence.	++ High-visibility, high volume testing with swift delivery of sanctions.	++ High-visibility high volume testing. Criminal penalty strong deterrent but delayed sanctions due to court-based criminal process.
Operational deliverability	0 Requires specialised training. Time consuming test.	+ Time spent on CITs saved (90mins on average).	++ Time spent on CITs saved. No requirement for 'good cause to suspect'.	+ Time spent on CITs saved. No requirement for 'good cause' but increased Police time on prosecutions.
Cost	0	- Higher cost for diminished return due to low deterrence value.	++ Higher cost but significant harm reduction benefits. BCR 12.83	+ Higher harm reduction benefits but significantly higher costs due to prosecutions. BCR 4.88.
Alignment with drink driving	0 Not aligned.	0 Not aligned	++ Most aligned option with random testing and infringement and criminal penalties	+ Aligned. Random testing but with criminal penalties only
BORA consistency	0 Impairment-based scheme has least adverse BORA impacts.	- Retains 'good cause to suspect' threshold but is a presence-based scheme (albeit with mitigations).	- Presence-based scheme (but with mitigations). Does not criminalise low-level drug-driving.	-- Presence-based scheme (but with mitigations). Criminalises drivers for presence-based offence
Health approach	0 Criminal offence is the only penalty.	+ More points of contact (and potential interventions) with drug users. Does not criminalise lower level drug-driving.	+ More points of contact (and potential interventions) with drug users. Does not criminalise lower level drug driving.	+ More points of contact (and potential interventions) with drug users. Does not criminalise lower level drug driving.

Section 5: Conclusions

5.1 What option, or combination of options, is likely best to address the problem, meet the policy objectives and deliver the highest net benefits?

The Ministry’s preferred option is Option 3: Random oral fluid testing with an infringement scheme. The option is preferred because:

- a random testing regime will deliver high-visibility, high-volume testing and the swift delivery of sanctions via an infringement offence regime – key requirements for deterrence
- it is operationally simpler for Police 4- it removes requirements for police officers to make ‘good cause to suspect’ judgements and to conduct time consuming CITs
- it balances benefits and costs to achieve the highest BCR of all options considered
- it is most aligned with the current drink driving regime, which is simpler for drivers to understand and promotes compliance
- it includes safeguards and mitigations for BORA impacts, such as the ability to elect to provide a sample, a medical defence, limits for drug concentrations in blood
- the proposed infringement penalty scheme is consistent with the Government’s commitment to reduce prison populations and to not criminalise lower lever offending
- infringement notices will be used to deliver information about drug related health services and there will be compulsory referrals to health services for repeat offenders.

5.2 Summary table of costs and benefits of the preferred approach

The approach adopted for the CBA

The primary benefit of the proposed policy is a reduction in casualties and serious injuries due to a decrease in road accidents from deterred drug-driving. In order to estimate the benefits of the policy, the Ministry’s CBA utilises the ‘attributable fraction for the population’ method, an epidemiology concept. ‘Attributable fraction’ measures the proportion of risk in a population that can be attributed to a specific factor, in this case drug drivers.

The CBA applies the formula to six different drugs or drug classes, each with their own unique combination of prevalence and relative risk.

The benefits and costs set out in the table below are modelled on a medium figure of Police testing 66,000 drivers per annum. This number is based on the number of drivers tested in 2017/18 in Queensland, which has a similar population to New Zealand. It is not expected that Police would achieve this number of tests in years one or two of the scheme.

Affected parties (identify)	Comment: nature of cost or benefit (eg ongoing, one-off), evidence and assumption (eg compliance rates), risks	Impact \$m present value, for monetised impacts; high, medium or low for non-monetised impacts	Evidence certainty (High, medium or low)
------------------------------------	---	---	---

Additional costs of proposed approach, compared to taking no action over 10 years (Ranges are provided in brackets)			
Regulated parties	Individuals/NZ public -time detained at the roadside	1.2M (range 0.7-2.1)	High
Regulators	<i>NZ Police</i> -test kits, training, blood tests, prosecutions	\$26.3M (17.5-40.0)	Med
	<i>Ministry of Justice</i> -fine processing/collection	\$1.1M (0.5-1.9)	Low
	<i>Department of Corrections</i> -sentence costs	\$3.2M (1.2-6.3)	Med
	<i>NZ Transport Agency</i> -promotion, licence processing	\$1.8M (1.6-2.0)	High
Total Monetised Cost		\$34.0M (22-51)	
Non-monetised costs	-potential for increased costs to fund DHBs for health referrals -indirect costs associated with drug-driving penalties, such as reduced access to employment and/or education. -wider justice pipeline costs associated with increased prosecutions. -wider health sector costs associated with increased drug rehabilitation referrals.	Low	

Expected benefits of proposed approach, compared to taking no action			
Regulated parties	Individuals/NZ public -reduction in harm from fatalities and serious injury crashes	\$415M (239-778)	Med
Regulators			
Wider government			
Other parties			
Total Monetised Benefit		\$415M (239-778)	
Non-monetised benefits	Non-transport related benefits of reduced drug usage in society.	Low	

5.3 What other impacts is this approach likely to have?

Additional benefits of the proposed approach are that a large component of the public education supporting the policy will focus on drivers who are taking prescription medications and the health professionals who dispense them. This is expected to improve the overall understanding of how particular medicines affect driving related skills.

The policy is expected to contribute positively to the overall wellbeing of New Zealanders with drug use or dependence issues, through voluntary and compulsory health referrals.

5.4 Is the preferred option compatible with the Government's 'Expectations for the design of regulatory systems'?

There is no significant incompatibility with the Government's 'Expectations for the design of regulatory systems.' The proposal conforms to established legal and constitutional principles and supports compliance with New Zealand's international and Treaty of Waitangi obligations.

The scheme is risk-based, informed by the evidence available (evaluated in section C above), responsive and structured to respond proportionately to the different degrees of risk presented by different levels of drug prevalence. It is also aligned with New Zealand's existing drink driving scheme - aligning the drug driving and drink driving regimes will make the drug driving scheme easier to understand, which is expected to support compliance.

The New Zealand public will be provided with a reasonable time to become familiar with the new regulatory requirements. The NZ Police will test key operational processes before implementing the new measures.

Bill of Rights Act 1990

The proposal will limit some rights and freedoms affirmed in the BORA. Taking a sample of bodily fluid, will 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.

Detaining drivers at the roadside to determine whether they are impaired by drugs will constitute a detention for the purposes of section 22. A detention is considered arbitrary if it is capricious, unreasoned or without good cause.

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.

Generally speaking, the rights and freedoms affirmed by the BORA may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. 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. The Ministry and Police consider that protecting the public from the harm caused by drug drivers is a sufficiently important objective to warrant some limitation on the rights and freedoms affirmed in the BORA.

A final assessment of the consistency of the proposals with the BORA will be undertaken by the Attorney-General when a bill to implement the proposed regime is available.

Section 6: Implementation and operation

6.1 How will the new arrangements work in practice?

The scheme will be given effect through amendments to the LTA aligned to the extent practicable with existing provisions for drug driving and drink driving. Amendments to the LTA will be required to create new offences, specify drugs that are subject to blood drug limits and what those limits are.

Police will be responsible for the enforcement of the scheme. The Ministry will work closely with agencies (for example, Police and the NZTA) to develop guidance and education about the effect of the new provisions.

Police will require a minimum six-month lead-in time after legislation is passed, to procure oral fluid testing devices via a competitive tendering process, develop operational procedures and train police officers.

Other agencies with a substantive interest in the regulatory system will be involved in monitoring and evaluation of the scheme (the Ministries of Health and Justice and the Department of Corrections).

6.2 What are the implementation risks?

Accuracy of oral fluid testing

Anecdotal evidence from manufacturers is that main risk of false-positives results is incorrect usage of the oral fluid testing devices, for example they cannot be used in extreme temperatures and they must be held in a stable manner when processing a test. Manufacturers report very low rates of false-positives from their own testing though independent assessment of the devices is more mixed. Mitigations for this risk (calibration of devices, consecutive oral fluid tests) are discussed in Section B above.

Negative and inaccurate publicity

Various aspects of the theory and practice of roadside drug testing are controversial. The issues are complex. On the margins of the research on the impairing effects of drugs (especially THC) there are diverging views. After new drug driving measures are introduced there is likely to be a degree of negative and inaccurate reporting and commentary in mainstream and social media. Comprehensive messaging through promotion and education campaigns will mitigate this risk.

Disproportionate impacts for Māori

New measures to address drug impaired driving could have disproportionate impacts for Māori men and women. A 2007/08 survey of drug use in New Zealand by the Ministry of Health⁵⁶ found that cannabis is the drug that drivers in New Zealand use the most.

The survey found that 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. The Ministry of Health’s Cannabis Use 2012/13 New Zealand Health Survey⁵⁷ found that Māori were 20 percent more likely to have driven under the influence of cannabis in the last 12 months than non-Māori.

⁵⁶ Drug Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey. Ministry of Health (2010).

⁵⁷ www.health.govt.nz/publication/cannabis-use-2012-13-new-zealand-health-survey

Māori are significantly over-represented at all stages of the criminal justice system 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.

These factors have informed the development of the proposed infringement offence scheme, which mitigates the risk of Māori men and women receiving criminal penalties for drug-impaired driving. However, there remains the potential for unpaid fees to escalate drivers into the criminal justice system.

Under the proposed scheme, police officers will be authorised to stop and drug test drivers on any road at any time. Without the operational controls inherent in checkpoint type operations, there is a risk that unconscious bias could lead to disproportionately more Māori men and women being detained for drug testing.

Police acknowledge that any exercise of discretion in enforcement practices carries a risk of unconscious bias. Risks around the exercise of discretion apply to almost all offences and Police enforcement action. At a system level Police have recently commenced a programme of work to address unconscious bias.

There are operational practicalities associated with oral fluid testing (training in the use of devices, refrigeration of devices) that mean it is more likely to be delivered in checkpoint type settings where operational guidelines and visibility of testing will provide checks and balances.

Cabinet will have oversight of the operation of the scheme via proposed report-backs after 12 months and three years of data are available (refer Section 7 below).

Section 7: Monitoring, evaluation and review

7.1 How will the impact of the new arrangements be monitored?

The Ministry of Transport and Police will monitor the new arrangements with support from Justice sector agencies and the Ministry of Health, initially after one year and three years of data are available.

Some data relating to the implementation and operation of the existing CIT regime is already being collected but this is limited to the number of tests that result in prosecutions. To effectively evaluate and monitor the CIT aspect of the scheme, Police will be required to collect data that is not currently collected, such as the total number of CITs conducted and the numbers of and outcomes from medical defences. The feasibility of collecting this data is under consideration by Police.

Evidence to support an evaluation of the scheme will be available from the NZTA's CAS database and ESR data on drug prevalence in the blood samples of drivers who have killed or hospitalised from road accidents, or who have failed a CIT and been required to provide a blood sample. Further data will be collected by Police and the Ministry of Transport about the operation of the oral fluid testing regime. This will include the:

- number of individuals tested
- number of false-positives on first and second oral fluid tests
- number of blood tests
- drugs identified by the testing devices and laboratory analysis of blood tests

- number of infringement notices issued
- number of defended hearings
- number of evidential blood tests elected
- public perception of dangers of drug driving
- public perception of likelihood of being stopped and tested

The Ministry of Health will provide data about the uptake of drug education and rehabilitation services.

As part of the Ministry's regulatory stewardship role, we evaluate the transport regulatory system, how it is working, and whether improvements can be made. This is a growing priority for the Ministry. We are developing a separate tool which will enable us to systematically review the transport system, legislation and actors.

If the proposed scheme achieves its objectives there will be a reduction in the number of deaths and serious injuries associated with drug driving. However, the first three years of the policy are unlikely to be sufficient to realise the full benefits of the proposal, especially as this period coincides with the implementation phase of the policy.

There is limited empirical evidence on drug-driving deterrence, as evaluation of roadside drug testing has generally been poor in jurisdictions that operate the schemes. One of the reasons for this is researchers have not established baseline data before implementing drug driving policies.

If new measures to address drug driving are to be introduced in New Zealand, a random roadside testing survey could be conducted before the policy is implemented. This would enable a baseline prevalence statistic to be established for future comparison. To facilitate this, the Ministry of Transport could coordinate the construction and delivery of a survey, in consultation with New Zealand Police and the NZ Transport Agency.

7.2 When and how will the new arrangements be reviewed?

There will be an initial review of the scheme within a year of implementation, and a more detailed review three years after its implementation. The review will be undertaken by the Ministry of Transport and Police, with contributions from relevant Justice sector agencies and the Ministry of Health. It will evaluate the effectiveness of the oral fluid testing process in the drug-driving regime, including the adequacy of the penalties in deterring offending.

For further detail refer to Section 7.1 above.