Weeding Out the Issues with the Land Transport (Drug Driving) Amendment Bill

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Introduction

In recent years there has been an increasing focus from both governments and communities, on the devastating effects that drug based impairment can have on people's driving abilities. Research shows that drivers under the influence are affected in a number of ways, including with slowed reaction times, increased risk taking and also increased fatigue, all of which are factors that increase crash risk.[1] In 2009 provisions were introduced to the Land Transport Act 1998 to address drug driving.[2] These provisions made it an offence for a person to drive while impaired and with evidence of drugs in their blood.[3] These amendments also created the Compulsory Impairment Test process to assess a person's impairment on the roadside.[4] Despite this, in the last six years there has been an increase in the annual number of deaths on the roads involving drugs. In 2014, 18 people died in crashes which involved drugs[5] and in 2019, 103 people died in crashes where the driver tested positive for drugs.[6] Even more concerningly, research shows that New Zealanders do not think they will be caught drug driving. A 2017 survey by the University of Waikato, found that only 26 percent of people surveyed thought they were likely to be caught for drug driving, compared with 60 percent of people who thought they were likely to be caught for drink driving.[7]

It is only recently that New Zealand has begun to consider whether to update the way that drug driving is regulated. In 2018, a member's Bill, was introduced by National Member of Parliament, Alastair Scott.[8] It proposed introducing roadside oral fluid testing, but was

[1] See discussion in Chapter 1 at 9.

[2] Land Transport Amendment Act 2009.

[3] Land Transport Amendment Act 2009, s 6.

[4] Land Transport Amendment Act 2009, s 7.

[5] Cabinet Economic Development Committee Paper "Approval for an Proposed Enhanced Drug Driver Testing Regime in New Zealand" (11 December 2019) DEV-19-0360 at 4.

[6] Ministry of Transport, "Questions and Answers" 30 July 2020 < https://www.transport.govt.nz/multi-modal/keystrategiesandplans/road-safety-strategy/drug-driving/questions-and-answers/>.

[7] Nicola J Starkey and Samuel G Charlton *The prevalence and impairment effects of drugged driving in New Zealand* (School of Psychology University of Waikato, NZ Transport Agency research report 597, 2017) at 9.

[8] Land Transport (Random Oral Fluid Testing) Amendment Bill 2018 (59-1).

voted down by the House of the Representatives. There were a number of reasons for this, including concerns about the lack of a detailed testing scheme being outlined, and also because the Attorney-General's report identified that the Bill breached a number of provisions in the New Zealand Bill of Rights Act 1990, namely ss 21, 22, and 25(c), and that these breaches could not be justified.[9]

Although the member's Bill failed, it did bring the issue to the forefront of the government's agenda. In 2018, Associate Minister of Transport Julie-Anne Genter sought Cabinet approval for investigating the introduction of a government bill on roadside oral fluid drug driving testing.[10] Following Cabinet approval to investigate, a discussion paper was circulated outlining the policy reasons for introducing an enhanced drug driving scheme, and seeking public feedback on how drug driving should be regulated in New Zealand.[11]

The submissions on this were overwhelmingly supportive of introducing a randomised oral fluid drug driving testing scheme. Based on this, a paper entitled Approval for a Proposed Enhanced Drug Driving Scheme sought Cabinet approval for the introduction of a randomised drug driving testing scheme through the use of roadside oral fluid testing.[12] Cabinet approved this in December 2019, with the Land Transport (Drug Driving) Amendment Bill being introduced to the House in July 2020, and passing its first reading in August 2020.[13] Although there are still a number of steps to be taken in the legislative process, the Bill as it stands provides an important insight into the way that drug driving is likely to be regulated in the future.

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[9] Cabinet Economic Development Committee Paper "An Enhanced Drug Driver Testing Regime" (17 September 2018) DEV-18-0453 at 1.

[10] Cabinet Economic Development Committee Paper "An Enhanced Drug Driver Testing Regime, above n 9.

[11] See discussion in Chapter at 19.

[12] Cabinet Economic Development Committee Paper "Approval for a Proposed Enhanced Drug Driver Testing Regime in New Zealand" above n 5.

[13] Land Transport (Drug Driving) Amendment Bill 2020 (317-1).

Making new law will always be a trade-off, and in this case it is a trade-off between public safety and people's right not to be arbitrarily detained, and not to fall within the coercive powers of the state without proper justification. Often the powers given to police in relation to land transport are overlooked in literature, and while the penalties are often at the lower end of the criminal spectrum it still an important area to consider within the context of civil liberties. Whilst powers to randomly stop road users may not be the most coercive use of state power, they still have significant effects on a significant number of people, particularly because in addition to random police stopping, the Bill would also allow a bodily search to be carried out. It is therefore important to consider this scheme carefully, given its potential to interfere with a large number of people's daily lives.

This dissertation seeks to assess whether the proposed New Zealand approach is justifiable from the scientific literature and from a rights perspective, or if there are approaches in other jurisdictions that New Zealand should consider.

Chapter 1 explains why drug driving is problematic, and will consider the different theoretical approaches to solving it, and different types of drug driving testing that exists. Chapter 2 outlines the current scheme, the issues with it, and analyses the proposed Bill in its current form, before any potential amendments are made during the select committee process. There will also be an initial assessment of issues that arise prima facie from the proposed scheme.

Chapter 3 considers New Zealand Bill of Rights Act 1990 implications, and analyses the disproportionate harm that the scheme may have on Māori. In Chapter 4 a comparative approach will be taken, by considering the schemes in Australia, Canada and the United Kingdom. All of these jurisdictions have some form of roadside oral fluid testing, but there is variation around whether a presence or impairment based approach is taken

Lastly, recommendations will be made on the changes that could be made to the Bill that would make it justifiable from a science and rights perspective.

I Chapter One – Background Context

A Drugs and Driving

An estimated 271 million people worldwide had consumed illicit drugs at least once during 2017, according to the World Health Organisation.[14] Worldwide, drug use is common, and with a significant portion of the global population consuming drugs, there has been significant research interest in how those drugs affect people's bodies.[15] One potential harm from drug use is road traffic accidents caused by drugged driving, and with increased use there has also been more awareness of drugged driving. In 2013, it was estimated that illicit drug use was responsible for just over 39,600 road traffic deaths around the world.[16] Amphetamine use was estimated to cause around half of these deaths, while cannabis was estimated to cause one fifth of them.[17] This is compared to just over 188,000 deaths due to drink driving in the same year.[18] Although there were more deaths due to drink driving worldwide in the same year, the risk of death from drug driving remains high considering alcohol is legal. With growing recognition of drugged driving as a significant contributor to the preventable road toll, so too is the growing interest from researchers in understanding the causes and consequences of drugged driving, and developing strategies for its prevention.

There are three different classifications of drugs that can impair people's driving. Illicit drugs, like cocaine, heroin, methamphetamine and cannabis; prescription drugs like antidepressants, benzodiazepines and opioid analgesics; and lastly, new synthetic psychoactive substances like synthetic cannabinoids.[19] These three categories of drugs can affect brain functioning in many different ways, and the extent to which a person is affected depends on dose of drug, the way the drug has been taken and individual factors such as

[14] World Health Organisation *World Drug Report 2019* (June 2019) at 7.
[15] World Health Organisation *Drug use and road safety: a policy brief* (2016) at 1.
[16] World Health Organisation *Drug use and road safety: a policy brief*, above n 15, at 4.
[17] World Health Organisation *Drug use and road safety: a policy brief*, above n 15, at 4.
[18] World Health Organisation *Drug use and road safety: a policy brief*, above n 15, at 4.
[19] World Health Organisation *Drug use and road safety: a policy brief*, above n 15, at 1.

prior drug use experience and body size.[20] However from current research, it is known that cannabis, benzodiazepines, opioids, other depressants and synthetic cannabinoids can all affect levels of alertness, cognitive functions, motor functions, mood, lateral vehicle control and balance.[21] Cocaine, amphetamines, MDMA and hallucinogens are all known to affect cognitive functions, mood, motor functions (other than MDMA) and balance (other than cocaine).[22] Amphetamines and hallucinogens have also been found to affect time estimation.[23]

There are significant limitations on research into drugged driving; it is difficult to design ethical randomised controlled studies on driving while impaired (particularly involving illicit substances), and so studies are usually observational and reliant upon self-reporting. Studies of this nature provide lower quality data because they cannot control for factors such as participant bias, confirmation bias, and selection bias. Relying on self-reported drug use after the fact means researchers generally cannot control for dosing or the way the drug was taken. Thus, although it is accepted that drug use is associated with impaired driving, the magnitude of this effect is not well understood.

A 2013 systematic review and meta-analysis of 66 studies with a total of 264 estimates of drug driving associated risk, synthesised the current evidence on the relative risk of road accidents with the use of drugs.[24] Systematic reviews and meta-analyses are the most robust source of scientific evidence because they review all the current relevant data and their quality. They are, however, limited by the quality of the source material they review. In this case, issues with study quality meant that the reviewer was unable to conclusively establish that the association between drug driving and road crashes was causal.[25]

[20] World Health Organisation *Drug use and road safety: a policy brief*, above n 15, at 1.

[21] Fiona J Couper and Barry K Logan *Drugs and human performance fact sheets* (National Highway Traffic Safety Administration, Report No. DOT HS 809 725, 2004) at 7 and 91.

[22] Couper and Logan, above n 21, at 19, 51, 61 and 67.

[23] Couper and Logan, above n 21, at 61.

[24] Rune Elvik "Risk of road accident associated with the use of drugs: A systematic review and meta-analysis of evidence from epidemiological studies" 60 (2013) Accident Analysis and Prevention 254 at 255.

[25] Elvik, above n 24, at 265.

Nevertheless, there were statistically significant associations between drug use and crashes. Drivers, on amphetamines had a relative risk of between 2.56-10.42 for fatal crashes, and a relative risk of 3.46-11.06.[26] This means that drivers on amphetamines are between 2.56 and 10.42 times as likely to have a fatal crash, and 3.46 to 11.06 times as likely to have a crash causing injury, when compared to drivers not on amphetamines. Drivers on benzodiazepines are 1.59-3.32 times as likely to have a fatal crash and 1.08-1.28 times as likely to have a crash resulting in an injury.[27] People driving after consuming opiates have a relative risk of a fatal crash of 1.01-2.81 and a relative risk of injury of 1.48-2.45.[28] The review found no statistically significant increased risk of crashes with cannabis use.[29]

Furthermore, the combination of multiple drugs or drugs and alcohol can cause more harm. The DRUID Project was undertaken in 2012 by the European Union, and over five years conducted a range of studies to understand the scope of the problem in Europe and to make recommendations.[30] The summation of this research showed that a combination of drugs can increase the relative risk level of being seriously injured or death to 5-30 times, and that alcohol in combination with drugs can increase the relative risk of serious injury or death to between 20-200 times.[31] This shows that driving while under the influence of drugs increases risk, but there is a need for more specific and applicable drug impairment data.

B Road Safety – Vision Zero and the Impairment Paradigm

Drugs have become a road safety issue because of the impairment effect that they have on driving. Globally there has been a significant change in how road safety is approached with the influence of Vision Zero, which was a road safety strategy first implemented in Sweden

[26] Elvik, above n 24, at 262.
[27] Elvik, above n 24, at 262.
[28] Elvik, above n 24, at 262.
[29] Elvik, above n 24, at 262.
[30] Horst Schulze and others *Driving Under the Influence of Drugs, Alcohol and Medicines in Europe – findings from the DRUID Project* (EMCDDA, December 2012) at 10.
[31] Schulze, above n 30, at 25.

in 1997.[32] Vision Zero brought together stakeholders, with a goal of reducing road deaths to zero, and in 20 years the number of road deaths in Sweden has halved.[33] Vision Zero has become a global movement, which has been adopted in places like London, Canada, Victoria and New South Wales, and in 2019 it was announced as the key theoretical underpinning of New Zealand's Road Safety Strategy for 2020-2030.[34] Part of New Zealand's Vision Zero approach is to reduce drug driving.

This overarching approach to road safety also reflects two competing paradigms for driving under the influence, a zero tolerance approach or an impairment approach. The most common approach taken to drink driving has been an evidence-based impairment paradigm. Internationally the approach to drink driving has been evidence based, with jurisdictions around the world basing their penalties and laws on what research suggests are the levels at which the average person is too impaired to drive.[35]

However, the approach internationally in relation to drug driving has differed from this impairment paradigm and instead rested upon a zero tolerance one, despite no additional evidence that this type of presence-based paradigm is any more effective at preventing drug driving. The key argument for these presence-based schemes has been deterrence.[36]

Classical deterrence theory suggests that general deterrence occurs when there is a perception among the populace that there is a high likelihood of apprehension, which is

[32] Kim, Muennig and Rosen, "Vision zero: toolkit for road safety in the modern era" 4 (2017) Injury Epidemiology 1 at 2.

[33] New Zealand Government *Road to Zero: New Zealand's Road Safety Strategy 2020-2030* (Ministry of Transport, December 2019) at 22. See general Kim, Muennig and Rosen, above n 32, at 3-5 on road strategies that make up Vision Zero which includes things like installing median barriers and speed bumps, to create better system road designs, which in turn make it easier for road users to drive responsibly.

[34] New Zealand Government *Road to Zero,* above n 33, at 22.

[35] See Andrea Roth "The Uneasy Case for Marijuana as Chemical Impairment Under a Science-Based Jurisprudence of Dangerousness" (2015) 103 Calif L Rev 841 at 844-845.

[36] Julia Quilter and Luke J McNamara "'Zero tolerance' drug driving laws in Australia: A gap between rationale and form?" (2017) International Journal For Crime, Justice and Social Democracy 47-71 at 51.

then followed by severe and swift punishment.[37] Although the literature on general deterrence theory suggests that this approach does not always work in practice, Australian research into the effect that randomised drink driving testing had on drink driving rates provides some evidence that it does achieve a deterrent effect.[38] In New Zealand, statistics show that with increased breath testing from the 1990s, there was a decrease in alcohol related crashes. In 1990, there were 268 fatal crashes, out of a total of 638 (42 per cent) involving alcohol, compared to 74, out of 342 (20 per cent) in 2017.[39] In order for deterrence to be effective, there must be a high volume of drug driver testing to create a high likelihood of apprehension. There are a number of different approaches to drug driver testing that have been adopted.

C Approaches to Testing

The World Health Organisation in 2018 found that there was insufficient evidence on the effectiveness of legislation limiting or prohibiting drug driving to establish a best practice criteria, despite 156 countries having a national drug-driving law in place.[40] The inability to develop a best practice partly rests on the fact that there is a significant lack of data on how frequently drivers use or are impaired by drugs while driving.

For several decades, jurisdictions all over the world have been using a wide variety of coordination tests, carried out by police officers, to determine whether or not a person is impaired by drugs or alcohol. A specific programme was created in the United States and recognised in 1979. The Drug Recognition Expert programme or Drug Evaluation and Classification programme has a twelve step process to ascertaining if a person is impaired

[37] Jeremy D Davey and James E Freeman "Improving road safety through deterrence-based initiatives: a review of research" 11 (2011) Sultan Qaboos University Medical Journal 29 at 2.
[38] Davey and Freeman, above n 37, at 31.
[39] Ministry of Transport *Discussion Document: Enhanced Drug Impaired Driver Testing* (May 2019) at 16.
[40] World Health Organisation *Drug use and road safety*, above n 14, at 64.

by a drug following special training.[41] All fifty states of the United States, Canada, Hong Kong and the United Kingdom have all recognised it as a tool for police in their attempts to assess if a person is impaired by a drug.[42] Parts of this testing process are similar to the CIT that is used currently in New Zealand to address drug driving, however this programme is more detailed.[43] The process usually takes between 30-45 minutes to complete, and recent studies show that some of the indicators are effective at predicting whether a person has used illicit drugs.[44] The study found that aspects of the test that were successful at determining whether a person had taken a drug, and what class they had taken, were clinical indicators like body temperature, performance on the psychophysical tests, appearance and physiological response of the eyes, and observations and self-reported statements from the subject.[45] This is important because it shows that a more focussed approach can be used to determine if a person is impaired by a drug, as well as the type of drug a person is impaired by.

However, more recently countries have begun to move away from this type of testing and instead moved towards roadside oral fluid (saliva) testing, which is used Australia, Canada and the United Kingdom.[46] Oral fluid testing has gained popularity because of roadside practicability and suggestions that it is more accurate than the above approach.[47] Depending on the purpose of the oral fluid test, new concerns are raised. There is evidence to suggest that oral fluid is not a good way to measure drug impairment for certain drugs, and also that it cannot be used to sufficiently detect all drugs. For example, detection of

[41] Amy J Porath-Waller and Douglas J Beirness "An Examination of the Validity of the Standardized Field Sobriety Test in Detecting Drug Impairment Using Data from the Drug Evaluation Classification Progam" 15 Traffic Injury Prevention 125 at 125.

[42] International Association of Chiefs of Police "The International Drug Evaluation & Classification Program" <https://www.theiacp.org/projects/the-international-drug-evaluation-classification-program>.

[43] See discussion in Chapter 2 at 18-19.

[44] Porath-Waller and Beirness, above n 41, at 129.

[45] Amy J Porath and Douglas J Beirness "Predicting categories of drugs used by suspected drug-impaired drivers using the Drug Evaluation and Classification Program tests" 20 (2019) Traffic Injury Prevention 255 at 260.

[46] The respective legislative regimes for each will be explained fully in Chapter 4 from 43.

[47] Dayong Lee and Marilyn A Huestis "Current Knowledge on Cannabinoids in Oral Fluid" 6 Drug Test Anal 88 at 90.

THC in oral fluid is largely reported to be due to the contamination of the oral cavity following smoking.[48] Therefore, traces of cannabis can accumulate in a person's mouth and produce elevated concentration in oral fluid for several hours after ingestion.[49] This means that the method of administration of cannabis directly relates to the effectiveness of the oral fluid test. People who ingest the cannabis through eating will not have high levels of THC in their saliva even though they may still be experiencing the high, and people who ingest through smoking may continue to have quantities of THC in their mouth and saliva hours after they have consumed it, meaning they will test positive despite no longer experiencing the effects.[50] Blood sampling is the most effective way to measure the concentration of THC in the body, but it must occur as quickly as possible, as the rapid metabolism of THC means blood concentrations can decrease markedly within a few hours.[51] In relation to oral fluid testing, a 2015 review of oral fluid testing devices for cannabis recommended that because of the different factors that change drug levels and accuracy of sampling, like passive environmental exposure, collection procedure and drug stability, cut off criteria should be established for the purpose of the drug testing.[52]

For cocaine, oral fluid is adequate for detection purposes but is problematic at determining the blood concentration levels because of variability in collection methods, so once again blood testing has been found to be the most effective way to measure the concentration of cocaine in the body.[53] A study into the accuracy of specific testing devices, the Securetec DrugWipe 6S and Drager DrugTest 5000 (the most commonly available devices), found false positives occurred in only 0.7 per cent of cases, however there was a false negative rate of 15 per cent.[54] Oral fluid testing for methamphetamine can be useful for detection but there is a risk of false positives, due to cross-reactivity with other amphetamine like

[48] Wolff and others, *Driving Under the Influence of Drugs: Report from the expert driving panel* (March 2013) at 65.
[49] Wolff and others, above n 48, at 65.
[50]Lee and Heustis, above n 47, at 93.
[51] Wolff and others, above n 48, at 65.
[52] Lee and Heustis, above n 47, at 109.
[53] Wolff and others, above n 48, 79.
[54] Douglas J Beirness and D'Arcy R Smith "An assessment of oral fluid drug screening devices" 50 Canadian Society of Forensic Science Journal 55 at 60.

substances such as the prescription medication phentermine.[55] For MDMA the proportion of drug in the saliva and blood changes based on the total exposure, a product of dose and time. This means that to accurately predict the level of drug in the blood, and thus degree of impairment, it must be known how long ago the drug was taken.[56] There are no portable testing devices that can detect all opioids and their metabolites, and some opioids, like tramadol, are difficult for even fully equipped toxicology laboratories to detect.[57] Lastly, for benzodiazepines Wolff concluded that oral fluid cannot confirm that the individual is currently likely to be suffering from impairment due to drug ingestion, and that only a blood sample can confirm this.[58] The study into accuracy of testing devices found that the devices produced a false negative in 59.2 per cent of cases, again illustrating the issues with using oral fluid for detection for benzodiazepines.[59]

D Overseas Developments

Despite the reservations that the scientific literature expresses about the use of oral fluid drug testing, a number of countries around the world use it in their drug driving regime. As mentioned above, the European Union undertook a five year research project into drug driving in Europe.[60] This report recommended that training of police officers in drug detection was required, and also that the use of screening devices was advised.[61] Furthermore the report emphasised that regulation should be based on scientific findings, and that impairment should be the key indicator for sanctions.[62] Some of these recommendations have been implemented in European countries, with oral fluid tests being used in countries like Belgium, Spain and Norway. These countries do however vary in the way that oral fluid testing is implemented in their respective schemes. In Belgium and

[55] Beirness and Smith, above n 54, at 60 and Wolff, above n 48, at 93.
[56] Wolff and others, above n 48, at 104.
[57] Wolff and others, above n 48, at 128.
[58] Wolff and others, above n 48, at 151.
[59] Beirness and Smith, above n 54, at 60.
[60] Schulze and others, above n 30, at 9.
[61] Schulze and others, above n 30, at 49.
[62] Schulze and others, above n 30, at 43 and 49.

Norway oral fluid testing is used as a means of screening, and it is then followed up with a blood test to determine impairment level.[63] Whereas, Spain uses the oral fluid test as the evidentiary basis for the offence and have adopted a zero tolerance approach.[64] There are clearly a number of different approaches to drug driving that are being implemented in Europe.

The United States of America has also been interested in the developments in drug driving screening. There is a lot of variation between the different states on the approach to drug driving. The National Highway Traffic Safety Administration has produced research reports on drug driving and oral fluid testing devices but have not recommended a specific approach to address the issue.[65] The AAA Foundation for Traffic Safety undertook a review of each states current drug driving laws in 2019.[66] They found that there are three states in the United States are currently collecting oral fluid.[67] Indiana allows law enforcement agencies to screen driver roadside and collect oral fluid, at which point use will be established, or a trained drug recognition expert will be brought in.[68] Michigan has also been undertaking oral fluid collection, but only the specially trained drug recognition officers can collect the oral fluid.[69] Alabama also allows for the collection of oral fluid, and uses it for both screening and evidentiary confirmation. A further six states have also been conducting roadside pilot tests.[70] The review made a number of recommendation for states to extend their current laws to allow oral fluid testing to be implemented.[71]

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[63] Law on Traffic Circulation, arts 35, 37bis (Belgium); Norway Road Traffic Act of 18 June 1965 No. 4, ss 21-22a, 31, 33 (Norway).

[64] Administrative Code Royal Legislative Decree 6/2015, of October 30, Law on Traffic, Motor Vehicle Circulation and Road Safety, art 14. (Spain).

[65] See National Highway Traffic Safety Administration *Traffic Safety Fact Research Note* (US Department of Transportation, DOT HS 812 117, February 2015).

[66] Eileen P Taylor, A Scott McKnight and Ryan Treffers *Enhancing Drugged Driving Data: State-Level Recommendations* (AAA Foundation for Traffic Safety, December 2019) at 19.

[67] Taylor, McKnight and Treffers, above n 66, at 29.

[68] Taylor, McKnight and Treffers, above n 66, at 29.

[69] Taylor, McKnight and Treffers, above n 66, at 29.

[70] Taylor, McKnight and Treffers, above n 66, at 29.

[71] Taylor, McKnight and Treffers, above n 66, at 28 and 31.

There is no settled approach to drug driving internationally, and it is against this backdrop that New Zealand's proposed scheme has been developed.

II Chapter Two – the Legislative Framework

A Current Scheme

In New Zealand, drug driving provisions are currently based on impairment, and are located in s 57A of the Land Transport Act 1998. This provision states that a person commits an offence if they complete a compulsory impairment test (CIT) unsatisfactorily, and if a blood test carried out following this shows the presence of drugs. The CIT can only be carried out by specially trained police officers,[72] and if they have "good cause to suspect" a person is driving while impaired by drugs.[73] The CIT can take between 25-60 minutes[74] and involves eye, walk and turn, and one-legged stand assessments.[75] If the driver performs these tests unsatisfactorily, a police officer can require them to undergo a blood test.[76] This takes an additional 30 minutes, on average, to complete.[77] The CIT is a lengthy process that uses a lot of police time and resources.[78]

B Effectiveness of the current scheme

There are number of positive aspects of the current regime, one of the most important being the high threshold that police officers must satisfy before any testing is carried out. The 'good cause to suspect' threshold has a legal basis that has been considered by courts on numerous occasions.[79] To an extent, this mitigates the fact that a person is detained for a

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[72] Land Transport Act, s 57A(1)(a).

[73] Land Transport Act, s 71A(1).

[74] Ministry of Transport *Discussion Document,* above n 39, at 12.

[75] Land Transport (Compulsory Impairment Test) Notice 2009, cl 5-8 describes the tests and steps involved in each one.

[76] Land Transport Act, s 72(1)(e)

[77] Ministry of Transport *Discussion Document,* above 39, at 12.

[78] Ministry of Transport *Discussion Document,* above 39, at 12.

[79] The courts have provided significant guidance on the meaning of good cause to suspect in the breath alcohol jurisdiction, as it was previously a requirement for breath screening testing. *Police v Anderson* [1972] NZLR 233 (CA) at 242 held that good cause to suspect means "no more than a reasonable ground of suspicion upon which the reasonable man may act". *Anderson* at 241 also held that good cause to suspect is a question of fact, but whether those facts show "good cause" is a question for the court, it is not whether the enforcement officer honestly believed he had good cause to suspect. The "good cause to suspect" threshold in relation to drug impaired driving was applied in *Ferris v Police* [2013] NZHC 456 which

significant period of time before there is any substantial proof of an offence being committed. Furthermore, literature within New Zealand suggests that the CIT process is effective; 92 percent of blood tests taken following the CIT show the presence of a drug.[80] However, there is potentially too much weight given to the correlation here without considering the causative factors. Given that there is a good cause to suspect threshold, it is unsurprising that the majority of blood tests do show a presence of drugs. Rather than the CIT producing particularly accurate results it is instead the threshold that acts as a mechanism for ensuring a majority of people undergoing the process do, in fact, have drugs in their system. Furthermore, police do not keep records on the amount of testing being carried out, which also makes it difficult to ascertain how many people are not identified as under the influence of drugs.[81] Only 473 blood specimens were submitted for analysis in 2017/2018 indicating that the number is in the hundreds not thousands.[82]

There are also a number of problems with the CIT process, one of the most significant being that only specially trained police officers are able to carry out the test. This may explain the low rates of testing and the fact it is not done consistently.[83] Moreover, it is also a significant time drain on police resources given that the testing can take between 20-60 minutes, plus additional time if a blood test is necessary. The testing can also take even longer if the CIT cannot be safely completed on the roadside, as the person has to be taken back to the police station.[84] Another problem is that there are a number of circumstances in which the test cannot be carried out – notably following a crash, because the person's shock and stress from being in a crash interferes with the ability to carry out the test.[85]

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confirmed that good cause to suspect was a lower standard and that the facts, including the police officers smelling cannabis, the defendant's slow speech and bloodshot eyes, were enough to meet the standard of good cause to suspect.

[80] Ministry of Transport *Discussion Document,* above 39, at 12.

[81] Ministry of Transport, *Discussion Document,* above 39, at 15.

[82] Cabinet Economic Development Committee "Approval for an Proposed Enhanced Drug Driver Testing Regime in New Zealand", above n 5, at 5.

[83] Ministry of Transport *Discussion Document,* above 39, at 15

[84] See Land Transport Act, s 71A(2)(b) which gives police power to require people to accompany them to a safe place for the CIT to be carried out.

[85] Ministry of Transport, *Discussion Document,* above 39, at 15.

Therefore, there are a number of issues with the way that the current system operates. Most significant is the lack of testing that is carried out. This has a number of flow on effects, including insufficient data to accurately indicate the frequency of drug driving.

C Proposed Scheme

In July 2020, the Land Transport (Drug Driving) Amendment Bill 2020 (the Bill) was introduced to Parliament. This Bill followed on from numerous discussion documents, and a commitment from Cabinet to introduce a random roadside oral fluid testing regime for drug driving. The new scheme has been designed to fit within the existing drink driving framework and to work alongside the existing CIT scheme. The basics of the proposal are that an infringement offence would occur following two positive (failed) oral fluid tests. This would then be followed with the option to elect for an evidential blood test (EBT). If the EBT shows that the drug is over a specified limit, criminal sanctions could occur. These criminal limits would be specified in Schedule 5. This is yet to be drafted as a panel of medical and pharmacological experts are assessing which substances would need to be within the scheme.[86] Preliminary documents indicate that THC (the psycho-active ingredient in cannabis), methamphetamine, benzodiazepines (sedatives), MDMA (ecstasy), opiates (e.g. morphine) and cocaine would be oral fluid tested.[87] The key new provisions are within clause 9, which would replace the existing s 57A with new s 57A-D. New s 57A-C contain the offences and s 57D contains the penalties provision. Note also that Subpart 2 amends the Land Transport (Offences and Penalties) Regulations 1999 to set the infringement fees and demerit points for the new infringement offences under new s 57A-57C.

1 New section 57A

New s 57A(1) creates an offence for any person who drives or attempts to drive a motor vehicle if the person's blood contains evidence of the presence of one qualifying drug. If

[86] Land Transport (Drug Driving) Amendment Bill 2020 (317-1) (explanatory note) at 2.

[87] Cabinet Economic Development Committee "Approval for an Proposed Enhanced Drug Driver Testing Regime in New Zealand", above n 5, at 2.

the qualifying drug is listed in Schedule 5, then the proportion of the drug in the person's blood must be equal to or exceed the level specified in the schedule.[88] If it is not a qualifying drug then the blood test could only have been taken following a CIT. An offence would occur if the presence of drugs is found regardless of the level.

New ss 57A(2)-(3) create infringement offences for any person who drives or attempts to drive if their blood shows evidence of the presence of one qualifying drug and it is listed in Schedule 5 but is at less than the specified level of drug. Alternatively, an infringement offence will occur if the results of the two oral fluid tests undergone by the person are positive and indicate the presence of the same qualifying drug, and the person does not elect to have a blood test in accordance with s 71D.

2 New section 57B

This section relates to where a person's blood or oral fluid indicates the use of two or more qualifying drugs. Under new s 57B(1) a person commits an offence if their blood shows evidence of two or more qualifying drugs, and one or more of the qualifying drugs are at a level that is equal to or that exceeds the level specified in Schedule 5. There remains the exception again, that if the blood test was carried out following the CIT, and one or more of the drugs are not listed in Schedule 5 then an offence still occurs, whatever the level of drug in the person's blood.

The new ss 57B(2)-(3) relate to infringement offences occurring if the person's blood or oral fluid indicates that there is the use of 1 or more qualifying drugs but that the blood levels do not exceed the specified limit for the drugs in Schedule 5 or they do not elect to have a blood test.

3 New section 57C

This provision relates to situations in which the driver has a mix of alcohol and a qualifying drug present in their blood, breath, or oral fluid.

[88] Section 57(2)(b).

A person commits a criminal offence if they drive or attempt to drive a motor vehicle and their blood contains both alcohol and evidence of the presence of a qualifying drug. A criminal offence occurs if their blood contains evidence of alcohol over the criminal limit or evidence of a qualifying drug equal to or over the limit in Schedule 5. The Bill states that an offence occurs if "any or all" of these factors apply. This implies that if the person exceeds the alcohol limit, and there is the presence of qualifying drug, an offence regardless of the level of the drug. The converse applies as well; an offence occurs if the presence of a qualifying drug exceeds the limit and there is the presence of alcohol.

Section 57C(2) creates an infringement offence, if the person's blood alcohol and drug level is below the legal limit or specified limit. Section 57C(3) creates an infringement offence if a person's blood alcohol is equal to or less than the legal limit, and following two oral fluid tests, there is an indication of the presence of qualifying drugs in the persons oral fluid, and they do not elect to have a blood test. Section 57C(4) creates an infringement offence if the person's breath alcohol is equal to or less than the criminal limit of 400mg of alcohol per litre of breath, the results of 2 oral fluid tests taken are positive, and the person does not elect to have a blood test.

4 New section 57D - Penalties

For first or second time offences against s 57A(1) the maximum penalty is imprisonment not exceeding 3 months or a fine not exceeding $4,500 and a mandatory order for person to be disqualified for 6 months.

For a first or second offence against s 57B(1) or 57C(1), the maximum penalty is imprisonment not exceeding 6 months or a fine of $4,500. The court also must order the person to be disqualified for 9 months.

If person is convicted of a third or subsequent offence against s 57A(1), 57B(1) or 57C(1), then the maximum penalty increases to a term of imprisonment not exceeding two years or a fine not exceeding $6,000. The court must order the person to be disqualified for more than one year from holding or obtaining a driver licence. The term of more than one year

is important because it means that a person must re-sit a driver's test in order to obtain a driver licence. By contrast, a term less than a year would mean they would only have to reapply for it.[89]

5 Infringement offence penalties – changes to regulations

Subpart 2 amends the Land Transport (Offences and Penalties) Regulations 1999 to set the infringement fees and demerit points for the new infringements offences under ss 57A to 57C. The penalty for driving or attempting to drive a motor vehicle on a road with a specified drug in a person's blood below the criminal limit or for failing two oral fluid tests is a $200 fee, 50 demerit points and a 12-hour suspension from driving.

There are also infringement combination offences. This applies to driving or attempting to drive a motor vehicle on a road with more than one substance in the person's oral fluid or more than one substance in the person's blood below the specified limit. It also applies to the offences where drugs and alcohol are mixed at levels below the limits. The infringement penalty for these offences is set at $400 fee, 75 demerit points and a 12-hour suspension from driving.

6 Process for enforcements procedures for offences involving the use of qualifying drugs

New ss 71A-C create the provisions for the procedure that must be followed by enforcement officers when carrying out oral fluid testing. New s 71A outlines who must undergo the first oral fluid test. It clarifies that any person may be required to undergo an oral fluid test, and that they can require a person to undergo the test regardless of whether or not the person has already undergone a breath screening test. Section 71A(2)(c) states that a person cannot be required to undergo oral fluid testing if they have already been required to under a CIT. Section 71A also gives enforcement officers the power to require the person to remain stopped in order to undergo the first oral fluid test, or to accompany the enforcement officer to a place where it would be practicable to undergo the test if the place where they were stopped was not safe.

[89] Land Transport Act, s 83.

Section 71A(4) states that an enforcement officer must advise a person that refusal to undergo the first or second oral fluid test means they will be required to undergo a blood test instead. The enforcement officer must also advise that the result of that blood test could result in either infringement or criminal offences, and that they that may be liable to pay for the cost of the test. Section 71A(5) gives enforcement officers the power to arrest a person without a warrant if that person does not accompany an enforcement officer when they are required to do so, or remain in that place until the results have been ascertained.

Section 71B defines who must undergo a second oral fluid test. It sets out that this includes a person who has undergone the first oral fluid test, and that test has shown a positive result. The same powers and obligations on enforcement officers apply as they were did under s 71A.

Section 71C concerns situations where there are issues with the first or second oral fluid test. If either test does not produce a result, then the enforcement officer must require the person to undergo a further oral fluid test. If the further test fails to produce a result, then the result of the further oral fluid is deemed to have produced a result that is not positive.

Section 71D provides for a person's right to elect to have a blood test after 2 positive oral fluid tests. A person has 10 minutes to decide to take a blood test after being an advised by an enforcement officer that the second oral fluid test was positive, and that the positive results could be presumptive evidence that the person has committed an infringement offence against this Act if they do not request a blood test (this is stated within s 77A). Furthermore, the enforcement officer must also inform them without delay that, if the person elects to have a blood test, the costs may fall on to them if the test establishes that they committed an offence against ss 57A(1), 57B(1) or 57C(1).

Section 71E gives enforcement officers the power to require people to accompany them to a place where an evidential blood test could be undertaken

7 CIT – retention in the scheme

Section 71F sets out how the CIT process will fit within the new system. It will remain a power limited to specially trained officers, and it will also maintain the good cause to suspect threshold. The provision allows specially trained officers to exercise this power in addition to any breath screening testing. This power may also be exercised in addition to an oral fluid test if the test produces a negative result but the enforcement officer has good cause to suspect the person has consumed a qualifying drug. Lastly, it is able to be used in addition to the first oral fluid test if this test produces a positive result and indicates the use of more than one qualifying drug.

8 Other relevant parts of the Bill

An additional thing to note about the Bill is that its scheme would not warrant grounds for a search or be grounds for other drug offences as stated in s 73A(2).

An expert science panel has been appointed to create Schedule 5. As part of that, this panel will set the criminal limit for each qualifying drug, which will be the equivalent to 80mg/100ml BAC.[90] Furthermore, the panel will also be set low level tolerance limits, although these are not specified within the Bill.[91]

A medical defence will be available for drivers who have taken prescription drugs in accordance with their prescription, any instructions from a health practitioner, or from the manufacturer of the qualifying drug.[92] This is simply an extension of the existing medical defence in s 64 of the Land Transport Act, and the Bill amends it to ensure that it is available for people who elect to have the blood test following the failure of the two oral fluid tests.

The regime also proposes a harm minimisation approach to drug driving, requiring compulsory referrals to drug education or rehabilitation programmes for second criminal offences in some situations and all third and subsequent criminal offence. The implications

[90] Explanatory Note, above n 86, at 2.

[91] Explanatory Note, above n 86, at 1.

[92] Explanatory Note, above n 86, at 4.

of this approach will be explored further in this dissertation with reference to Māori and the disproportionate affect this Bill will have on them.

D Discussion on the proposed schemes - including comparisons to drink driving

The Bill clearly indicates that the government's approach is to essentially create a system which fits within the existing drink driving provisions. This Bill is thus a continuation of the current status quo, and avoids creating an entirely new legal approach to driving under the influence of drugs.

1 The offences and penalties – how they compare to drink driving

There are a significant number of issues with the offence and penalty provisions within the proposed Bill. This is particularly true, when compared to the existing drink driving regime. Specifically, there are inconsistencies in the treatment of offences.

Notably, the mandatory nine month disqualification from driving if a person is found to have committed an offence against s 57B(1) or 57C(1) does not currently exist within the Land Transport Act. Although disqualifications for 3, 6, and 12 months appear at various points within the Land Transport Act, the Bill introduces the first nine month disqualification period. Both of those provisions relate to a mixing of drugs, or alcohol and drugs.

Furthermore, if blood testing does not occur in those circumstances, a person will still commit an infringement offence, and receive 75 demerit points. If this Bill is passed, this would be the harshest demerit penalty within the Act. The demerit system works through licence holders receiving demerit points for a range of different infringement offences. If a driver accumulates 100 or more demerit points in a two year period then they lose their licence for a three month period.[93] Therefore, receiving 75 demerit points could have very serious consequences; because if a person has 25 demerit points already then they will

[93]Land Transport Act, s 90.

immediately be disqualified from driving for 3 months.[94] The rationale for this appears to be that the mixing of different types of drugs or drugs and alcohol increases the harm potential that a person may commit. While this may be true, the potential for harm also depends on the type of drugs that people have consumed.[95]

Under the current Bill, a person driving under the influence of methamphetamine would receive a lower fine and only 50 demerit points. By contrast, a person who drives under the influence of both alcohol and cannabis at an infringement level would receive a higher fine and 75 demerit points. Although research does show that the mix of alcohol and drugs increases crash risk by 5-30 times, methamphetamine alone also increases crash risk also by 5-30 times.[96]

This concern is further exacerbated by the treatment of all qualifying drugs as completely the same under the Bill. Even if an oral fluid test returns a positive result from a person with low levels of cannabis in their system, that person could suffer the same penalties as someone who has methamphetamine below the specified limit. This is problematic as the potential risk for both of these drugs are being entirely different. The Bill's presence-based approach reflects a lack of consideration for the different levels of harm different drugs can cause. This raises issues of fairness. The real risk of a person losing their licence for mixing alcohol and cannabis at low levels seems disproportionate to the less serious consequence when a person driving on methamphetamine would face.

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[94] Land Transport (Offences and Penalties) Regulations 1999, sch 2 provides the scale of demerit points. The scale of demerits varies and the range includes 10 demerit points for speeding below 10km/h over the speed limit, 25 points for failing to give way at give-way sign on a one way section of road, 35 demerit points for unsafe passing, and 50 demerit points for drink driving with a blood alcohol limit exceeding 50mg but not exceeding 80mg.

[95] WJ Firth *Risks of driving when affected by cannabis, MDMA (ecstasy) and methamphetamine and the deterrence of such behaviour: a literature review* (NZ Transport Agency research report 644, May 2020) at 15 highlights that systematic reviews of literature have shown that the extent of risk is greatly variable based on the drug; some individual drugs pose a higher risk than combination of drugs or drugs and alcohol.

[96] Schulze and others, above n 30, at 25.

The choice to have a blood test is another significant loophole within the Bill. A blood test is the only way to indicate the level of drug in a person's system while driving. This provides a loophole that does not exist within the drink driving regime – where although people do have a choice to elect a blood test the evidential breath test has already indicated the amount of alcohol in the person's system.[97] The Bill's oral fluid test would not be able to determine the quantity of drug in a person's system, whereas the alcohol breath screening test indicates, in general terms, the level of alcohol. If the alcohol breath screening test returns a result above the legal level, either an evidential breath test or a blood test confirms the level of alcohol a person was driving under. However, because the oral fluid test does not show the level of drug in a person's system they could choose to not have a blood test. This choice would mean that they only an infringement offence even if they were driving with significant levels of a drug in their system, which will not actually reflect the severity of the offending that has occurred, unless the CIT process is switched to.

It appears that the Bill is wanting to take quite a practical approach; blood testing can take an additional 30 minutes, which is a significant amount of time and resource for the police. Perhaps then it is justifiable that a more blanket approach is taken, and people have the opportunity to have a blood test if they want to. However, there is scope for the Bill to take a more nuanced approach. It may be more justifiable to require persons who test positive for more than one qualifying drug to automatically have a blood test, in order to assess the level of drug in their system. Another option would be if the oral fluid shows a Class A drug within the person's system then they automatically need to have a blood test. If these type of measures are not implemented, the system that the Bill proposes creates a wide loophole; people who would have met the threshold can easily escape criminal penalties by simply choosing not to elect to have a blood test.

Furthermore, there is a concern that police may be frustrated by this loophole and try to circumvent it by using the CIT process. If a person fails to satisfactorily complete the CIT, then the current approach would apply, which requires the person to have a blood test. The

[97] Land Transport Act, s 70A provides the right to elect a blood test.

police, after a positive return of an oral fluid test for a mix of drugs or drug and alcohol can still choose to then switch to the CIT process. This may be appealing to the police because that would circumvent the person's right to elect a blood test or not. Requiring the person to have a blood test widens the scope for potential penalties. It could be argued that this flexibility means that the system would create more fairness. For example, a person who has mixed methamphetamine and MDMA, would then be switched to the CIT process. However, there still exists an inconsistency within the Bill that should be remedied. If the government wishes to have a system where blood testing will occur in practice, then the proposed legislation should create clearer powers for this. It is important to note that the CIT process still requires specially trained officers, who may not always be available meaning it would not always be possible to switch to the CIT system in these circumstances.

2 Medical defence and blood testing process

The medical defence available within the Bill reflects what already exist within s 64 of the Land Transport Act. There are concerns, however, that a person must get a blood test for a medical defence. This has risks of delay and costs associated with it. It is also of particular concern given the fact that, if a person fails the oral fluid tests, there is mandatory disqualification from driving for 12-hours. A person who wishes to use the medical defence will still have this 12-hour ban applied to them, despite the fact it may transpire they could legally drive.

Furthermore, there are practical issues as to how the blood testing process and 10 minute window given to elect to a blood test will be carried out. Within the current drink driving system, because of the testing process a person is already at the police station when they are given their 10 minutes to elect to have a blood test. However in the proposed scheme, at the time when a person is being asked if they want a blood test, it is most likely that they would still be roadside. Although there are powers for the police to require people to accompany them, it would be quite an extreme use of this power to require every single person who fails two oral fluid tests to accompany the enforcement officer to the station to ensure they have a full 10 minutes to decide whether they want to have a blood test. The

police may need to create new policies on this procedure to ensure they fulfil their duties without being unnecessarily onerous on people's obligation to accompany them. Furthermore, it would be preferable to state this procedure clearly in the legislation rather than relying on police or the courts to create a procedure to ensure proper process is followed.

3 Presumptions

Section 77A(1) of the Bill includes presumptions related to blood analysis, stating that whatever level of drug the blood analysis shows is the level presumed at the time of the offence. This presumption exists within the drink driving regime as well and is contained within s 77 of the Land Transport Act. Commentary on this presumption suggests its purpose of it is to both reflect the time lag that exists within testing, but also to stop 'post-consumption' defences.[98] There are a number of drink driving cases where the defendant argued that they had consumed alcohol post driving. However this presumption and the wording of the offence, which includes 'attempts', means that the courts do not accept these arguments.[99] This is interesting given the fact that drug culture, especially cannabis culture, does often involves people driving to scenic locations to consume the drug. If the defendant tried to argue that they were not going to drive afterwards, and instead use alternative transport like an Uber or bus to get home, the court would not have to accept this argument because of this presumption. However, given the likelihood that most consumers would attempt to drive after drug consumption it seems sensible to maintain this presumption.[100]

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[98] Andrew Becroft and Geoff Hall (ed) *Becroft and Hall's Transport Law (NZ)* (online looseleaf ed, LexisNexis) at [LTA77.3].

[99] See generally *Ministry of Transport v Martis* [1993] 1 NZLR 307 (CA) explained that the presumption creates a legal fiction to "prevent a drinking driver from escaping conviction by drinking after the accident or apprehension and before being tested". In *Siegel v Ministry of Transport* (1989) 4 CRNZ 183 the police found the defendant at his home less than an hour after he had been involved in a car accident, and the victim reported their suspicion that the driver had been drinking. The police undertook testing, and despite the claiming to consume significant amounts of wine after the accident the judge still held that it was appropriate for the police to do so and that this was the purpose of presumption.

[100] Interview with anonymous drug user, Dunedin (the author, Dunedin, 5 August 2020).

4 Implication from 12-hour mandatory disqualification

There are also problems with the mandatory 12-hour mandatory disqualification. The 12-hour mandatory disqualification penalty indicates that the Bill has relied too much on the existing drink driving provisions. Most people would be below the legal alcohol limit 12-hours after consuming alcohol, provided of course that they had not consumed more alcohol in that 12 hour window. However, that is not true for all drugs; pharmacokinetic research shows that some drugs will remain in the system for longer than 12-hours.[101]

The Bill, in making its 12-hour disqualification window, creates two key interrelated issues. Firstly, it can be construed that a person is safe to drive after 12 hours, even though they may still have a presence of drugs within their system. This leads to the second issue. It arises when a person with a 12-hour disqualification follows the rules by refraining from driving 12-hours and has no more drugs within that time period, but then proceeds to drive, and is once again pulled over, and fails two oral fluid tests. They could still be in breach of s 57A despite following the rules. It is unclear if there would be a defence for being in breach despite following the rules. In other words they could they argue in court a defence that they followed the rules, and are being excessively punished for the same incident multiple times, however the court may simply say that they still had the option to not drive. This will be considered further in Chapter 3, where the approaches taken in overseas jurisdictions will be discussed.

[101] This will depend on the drug, how it was taken, what bodily sample is taken and what molecular marker the test is looking at and individual person factor such as drug experience as explained with reference to THC in Wolff and others, above n 48, at 63-64.

III Chapter Three – New Zealand Bill of Rights and Discrimination

A Zero Tolerance Based Approach

The proposed scheme is a zero tolerance, presence-based approach to drug driving. This is significant because it means a person will commit a drug driving offence even if their driving is not affected by any impairment. The risk that drugs pose to road safety is their capacity to impair people's abilities to drive well by interfering with their reaction times, increasing risk taking and decreasing coordination, among other things.[102] However, the regime as it stands goes further than impairment, and punishes people for the mere presence of drugs in their system. This is a departure from the approach taken currently to drink driving. A presence-based approach does stop impaired people from driving because they are captured by a zero tolerance threshold, however it also punishes people purely for the presence of a drug, even if their driving is not known to be affected by this presence. Therefore, the scheme as it stands will punish people for consuming an illicit substance rather than the actual risk they pose to others on the road. Although prescription medications are included within the proposed scheme, they are treated differently to illicit substances, because there will be a medical defence available for people who test positive for the presence of prescription medication but who follow the directions as to use. The defence essentially allows for an impairment based argument to be raised, because by taking their prescription in accordance with the medical professionals' advice, they would not be driving in an illegally impaired state, even if the drug was still present within their system. This illustrates that the presence-based approach is more concerned with the illegality of the substance rather than how much it impairs the person who is driving.

B New Zealand Bill of Rights Implications

The proposed scheme has a number of New Zealand Bill of Rights 1990 (NZBORA) implications given that it involves the taking of bodily fluid, a detention, and includes strict

[102] See discussion in Chapter 1 at 8-10 and Firth, above n 95, at 6.

liability offences. Some of these implications existed for the NZBORA assessment that occurred for drink driving where it was determined that breaches of these rights were justifiable. However, there are significant differences between the two schemes and the Attorney-General's s 7 report on the Bill found that it breached ss 21, 22, and 25(c) of the NZBORA, and that none of these breaches were justifiable

1 Section 21

Section 21 of NZBORA affirms people's right to be free from unreasonable search and seizure. The key touchstone for this is the reasonable expectation of privacy.[103] The Supreme Court has also held that the right is such that it cannot be justified through s 5 of the Act. Instead, there must be a sufficiently compelling public interest for the search to take place.[104] The search must also be proportionate to this public interest, and there must be safeguards to ensure that the power is not abused. In this assessment it must firstly be ascertained whether a search has taken place and then, if it has, whether that search was reasonable. The taking of bodily fluids is clearly a search and seizure for the purposes of NZBORA.[105]

The question then turns to whether there is a sufficiently compelling public interest for the search to take place. Once again, the Attorney-General assessed that there was a compelling public interest, due to the death toll for drug related crashes, and the lack of deterrence that seems to contribute to this, and thus that there was a strong public policy objective.[106] However, the Attorney-General identified issues with whether the intrusion was proportionate to the public interest. This is complicated by the fact that driving is a heavily regulated activity and drivers have a lower expectation of privacy.[107] However, this is

[103] *R v Hamed* [2011] NZSC 27, [2011] 3 NZLR 725 at [161].

[104] *R v Hamed*, above n 103, at [162]

[105] *R v Hamed*, above n 103, at [161] held that if it invades a person's privacy then it is a search, the taking of a person's bodily fluid while they are roadside clearly does invade a person's privacy. In the drink driving jurisdiction courts have held that the taking of blood is a seizure, although in most of those cases it was a justifiable one see *R v Faasipa* (1995) 2 HRNZ 50 (CA).

[106] David Parker *Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the Land Transport (Drug Driving) Amendment* (2020) at 5.

[107] *R v Jefferies* [1994] 1 NZLR 290 (CA) at 324.

weighed against the fact that any search of the body will always have a greater expectation of privacy, and the greater the intrusion of the procedure the more expectation there is of privacy.[108] On this basis the Attorney-General reasoned that taking of oral fluid is less intrusive than taking blood but more intrusive than a breath test. Ultimately, they concluded that because the proposed scheme actually goes beyond the scope of its purpose, the intrusion would not be proportionate.[109]

This reflects the concerns that the author raised above in relation to the fact that a person may be liable for an offence through the presence of a qualifying drug alone, not on the basis of impairment. The Attorney-General's main concern is that the Bill equates presence with impairment, and instead of having an infringement level and criminal level, there will only be one specified limit, meaning there is no ability to challenge the offence on impairment grounds.[110] Rather than suggesting the premise of the scheme is actually wrong, and that it needs to be reconceived, their report suggests that it is poorly worded, and is thus that is not fulfilling its policy objective of reducing the number of people driving while impaired by drugs. However, Cabinet has been exceptionally clear that the scheme is presence-based, and that they are adopting a zero tolerance basis for drug driving.[111] Therefore, the conclusion that the Bill's scheme would be justifiable under s 22 of NZBORA if there was a specified infringement level is questionable, given the fact that Bill's primary purpose is to punish those who are consuming an illicit substance and driving. The policy objective is an important one, roads need to be safe, but that objective should not be in tension with people's rights. If an impairment approach were to be taken, the policy would be a justifiable breach, because the impingement is clearly and directly linked to a quantifiable harm, and furthermore, would be challengeable.

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[108] *R v Williams* [2007] NZCA 52, [2007] 3 NZLR 207 at [23].

[109] Parker, above n 106, at 6.

[110] Parker, above n 106, at 6.

[111] Cabinet Economic Development Committee "Approval for an Proposed Enhanced Drug Driver Testing Regime in New Zealand", above n 5, at 1.

2 Section 22 and Section 23

Section 22 of NZBORA states that every person has the right to not be arbitrarily detained. The Court of Appeal has held that a person may be arbitrarily detained if the detention is "capricious, unreasoned, without reasonable cause: if it is made without reference to an adequate determining principle or without following proper procedures".[112] The alcohol regime has been held by the courts to amount to a detention.[113]

The proposed scheme allows an enforcement officer to require a person to stop, and remain in that place until the test has been undertaken and results received.[114] If a person fails to comply with these requirements, the enforcement officer has the power to arrest them without a warrant and then require them to undergo a blood test.[115] An oral fluid test would likely amount to a detention as it places a statutory restraint on a person's movement in order to undergo the test, and if they do not comply they will suffer penalties. Furthermore, if alcohol breath testing has been held to be a detention, despite requiring a significantly shorter period of time it is very likely that the courts would view this as a detention. The question then turns to whether it is an arbitrary detention. The Attorney-General found that the detention for testing would be arbitrary because of the risk that a driver who is not impaired but has the presence of drugs in their system will be issued an infringement notice. He concludes that because this goes beyond the objective of the Act the detention would amount to an arbitrary one, which seems correct given the wording of the Bill as it stands.[116]

Although the Attorney-General does not consider the implications of the Bill on s 23 of NZBORA, the rights affirmed in that provision are relevant to the rights assessment of the Bill. Section 23 of NZBORA affirms the right to consult a lawyer without delay. This has also been an issue within the drink driving regime. In the drink driving regime, the right to consult a lawyer comes into force following the positive breath screening test because it is

[112] *Neilsen v AG* [2001] 3 NZLR 433 at 34.

[113] Most notably it was held to be arbitrary detention by the Court of Appeal in *Temese v Police* (1992) 9 CRNZ 425 (CA).

[114] Section 71A of the Bill.

[115] Section 71A(5) of the Bill.

[116] At 8.

at this point that a person is detained for the purposes of NZBORA.[117] The courts in the drink driving jurisdiction have made it clear that there is to be a "limited but reasonable" opportunity to access legal counsel.[118] Within the proposed scheme it could be after the failure of the first oral fluid test that the right to consult a lawyer becomes relevant. It is at this point that another failed test will result an offence occurring and thus it may be the point at which a person is detained for the purposes of the Act. The need for a lawyer, however, would become particularly relevant if a person fails a second oral fluid test, at which point they have ten minutes to determine if they will elect to have a blood test. The drink driving regime has created a clear obligation on the police to assist in the facilitation of this right, including allowing them to call multiple lawyers.[119] The issue under the proposed Bill is that most of this would occur on the roadside rather than at the police station. At the point where detention occurs in the drink driving regime, the person will already be going to the police station, however this is unlikely to be the case in the proposed Bill. A person would likely only accompany the enforcement officer to the police station if they elect to have the blood test, but at this point it is important for the detained person to receive legal counsel before they make this decision. Therefore, it may become harder for the police to facilitate this right as there is less availability of resources like the list of duty lawyers. That said, these are all fixable issues, as it may be as simple as requiring the police to have this information available via cell phones or other devices. However, it will remain absolutely necessary for the executive to ensure that this right is still facilitated. *Kerr v Police* held that the obligation to facilitate this right is imposed on the executive, so it is not enough for the police officer involved to say they had done all they could, because this obligation rests on the broader executive power.[120] Therefore, the onus is not just on the police to provide a cell phone or have a link to a list of lawyers, it falls upon the executive to ensure that the scheme can be carried out in a way that facilitates this right, and policies must be in place do so or it will be failing in its duty.

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[117] Becroft and Hall, above n 98, at [BOR23.1].

[118] *Ministry of Transport v Noort* [1992] 3 NZLR 260 at 274.

[119] Discussed in *Ministry of Transport v Noort,* above n 118, at 274, and summarised in *Brosnahan v Police* [2009] NZCA 146, [2009] 2 NZLR 777 at [16].

[120] *Kerr v Police* [2020] NZCA 245 at [70].

3 Section 25(c)

Section 25(c) provides for the right to be presumed innocent until proven guilty. Part of this right is also that the burden of proof is on the prosecution. However, the Bill proposes strict liability offences, through the infringement notices, which shifts the burden of proof on to the drivers, requiring them to prove their innocence, rather than the prosecution having to disprove any potentially available defence. Strict liability offences automatically raise issues of inconsistency with s 25(c) of NZBORA.[121] However, an assessment must then occur using s 5 of NZBORA, to decide whether this limitation on the right is demonstrably justifiable in a free and democratic society. The Supreme Court held that it must first be determined if the objective serves a purpose sufficiently important to justify some limitation, and if it does then it must be assessed whether the limit is rationally connected to the objective.[122] Furthermore, it is necessary to ascertain that the offence does not impair the right more than is reasonably necessary to achieve the objective, and that the limit is in proportion to the objective.[123]

As has been noted at various points, the policy objective of reducing drug driving, and in turn reducing the amount of drug related crashes on New Zealand's roads is a significant objective, and one that the Attorney-General thought may warrant the reversed burden of proof.[124] However, the Attorney-General found that there was no rational connection between the limit of the presumption of innocence and the policy objective, because of the fact that the Bill equates recent use with impairment.[125] Furthermore, the Attorney-General found that the Bill does impair this right more than necessary because of available alternatives, including introducing an infringement level of impairment in the Bill. This would link to the objective, but also create an effective safeguard because the blood test function could be used as a way to show lack of impairment.[126] Ultimately, he concluded

[121] *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [38]-[39] per Elias CJ, [202] per McGrath J, [269] per Anderson J.

[122] *R v Hansen*, above 121, at [92] per Tipping J.

[123] *R v Hansen*, above 121, at [92] per Tipping J.

[124] At 9.

[125] At 9.

[126] At 10.

that the limitation was not proportionate because the policy objectives would be fulfilled with an infringement level being set, which would allow any false positives, or the fact that the driver was not actually impaired, to be challenged.[127]

4 Problems with the Attorney-General's s 7 report

The s 7 report is useful in that it provides an analysis of the ways in which the Bill as it stands breaches NZBORA, and also provides mechanisms for the proposed scheme to be more rights consistent.

The issue with the report however is that there is a lack of discussion on the difference in the treatment of different qualifying drugs. The report explicitly states that the scheme would be consistent, or breach with NZBORA less if an infringement level, which is what the testing devices would be set at, was introduced to the Bill. Although this in theory does sound good, it becomes more difficult to reconcile this approach when there is no recognition that the different qualifying drugs have different levels of harm.[128] Although this can be justified, the Attorney-General should have considered this more in his analysis. The Attorney-General seems to pin the issue of the Bill as being that there is not an infringement level, and while this is an issue, the more significant issue is really that there is a lack of consideration of impairment and the different harm levels that different substances have.

C The disproportionate harm for Māori

A significant issue within the New Zealand Police force and criminal justice system as a whole is the unconscious bias that exists within the system.[129] Recent reports,[130] and even the Deputy Police Commissioner, have acknowledged that racism within the police force exists, and that more needs to be done to remedy it.[131] Studies show that Māori are 2.2

[127] At 11.

[128] Firth, above n 95, at 15.

[129] JustSpeak *A Justice System for Everyone* (February 2020) at 1.

[130] See generally JustSpeak, above n 129.

[131] Interview with Wally Haumaha, Police Deputy Commissioner (Meriana Johnsen, Midday Report, RNZ, 13 July 2020).

times as likely to use cannabis compared to non-Māori in the population, and are 1.2 times as likely to have driven under the influence of cannabis in the last 12 months compared to non-Māori.[132] Furthermore, drug prohibition particularly hurts Māori, who made up 44 per cent of those convicted of a low-level drug charge in 2018, 41 per cent of which were cannabis offences, despite changes to the Misuse of Drugs Act 1975 which gave police greater levels of discretion.[133] Therefore, any policy that relates to drugs and significant amounts of power being given to police is always going to have the potential to disproportionately harm Māori.

This Bill would disproportionately affect Māori given that they use cannabis at higher rates than the rest of the population. This means that the harsh penalties of the Bill, like the large amount of demerit points and long disqualification periods in certain situations, would disproportionately be applied to Māori. This runs counter to efforts being made to honour Te Tiriti o Waitangi and to address the overrepresentation of Māori within the criminal justice system.[134] The evidence of Māori drug conviction rates show that Māori are being charged at disproportionate rates by the police for drug related crimes.[135] It follows then that police may specifically target Māori due to unconscious bias, but also due to societal factors that mean they are using drugs more frequently. Māori, in recent hui on their overrepresentation in the criminal justice system, have discussed the impact that colonisation, neo-colonial practices, and racism have had on their everyday experiences, which can result in substance abuse.[136]

Currently, police use an intervention based approach to alcohol and drug driving that relies on targeting their policing activities to localities, communities, routes and times of greatest

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[132] Ministry of Health *Cannabis Use 2012/2013: New Zealand Health Survey* (May 2015) at 2.

[133] New Zealand Drug Foundation *State of the Nation 2019: A stocktake of how New Zealand is dealing with the issue of drugs* (November 2019) at 4.

[134] See generally Department of Corrections *Hōkai Rangi Ara Poutama Aotearoa Strategy 2019-2024* (2019), and the New Zealand Police *Turning of the Tide: A Whānau Ora Crime and Crash Prevention Strategy* (December 2012).

[135] Drug Foundation, above n 133, at 4.

[136] Te Uepū Hāpai i te Ora – the Safe and Effective Justice Advisory Group *He Waka Roimata Transforming Our Criminal Justice System* (June 2019) at 24.

risk.[137] In practice, this policy means that they will put more random drink and drug driving stops in poorer communities, which often have an overrepresentation of Māori. For example, for police in Auckland following this logic, random stops would be placed in Manukau rather than Remuera. This in turn creates a confirmation bias, as Māori communities will be targeted more, creating higher rates of drug driving for Māori, and thus confirming that Māori are drug driving more. Furthermore, this assumption will create even worse outcomes for Māori because there are more serious consequences for repeat offending.[138]

The lack of recognition within the Bill for this impact was noted in the Regulatory Impact Statement, but was justified by the fact that police would undergo unconscious bias training, and also through the fact that the scheme is only at the infringement level.[139] However, this justification fundamentally disregards the fact that unconscious bias training has existed for years, yet Māori are still drastically overrepresented in the criminal justice system.[140] Furthermore, to justify the disproportionate effect because most penalties occur at the infringement level fundamentally ignores the hardships that Māori face within society. Receiving 50 demerit points could mean they lose their licence, which could have implications for employment and remaining socially connected. Te Puni Kōkiri also recognised the financial implication that infringement level offences have, and suggested that the fine be tied to income levels, but this has not been established in the Bill.[141] If people are unable to pay their fine, that can lead to further interface with the criminal justice system.

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[137] New Zealand Transport Agency *2015-2018 Road Policing Programme* (New Zealand Police and Ministry of Transport, 2015), at 14.

[138] Section 57D of the Bill.

[139] Ministry of Transport *Updated Regulatory Impact Statement: Enhanced drug driver testing* (July 2020) at 34.

[140] See Te Uepū Hāpai i te Ora – the Safe and Effective Justice Advisory Group, above n 136, at 6, Māori make up 16 per cent of the general population but 51per cent of the prison population at 6.

[141] Ministry of Transport *Updated Regulatory Impact Statement: Enhanced drug driver testing,* above n 139, at 19.

Submissions on the Discussion Document showed that Māori health organisations were concerned by this, and that they wanted a harm minimisation approach to be taken.[142] Health advocates strongly felt that a health-based, non-punitive approach to drug driving offences should be taken, and submitters favoured an impairment based approach to drug driving over the presence-based regime. [143] Although the Bill does acknowledge harm minimisation as part of the approach taken, it is not until third time offending, or in limited situations second time offending, that drug counselling is required.[144] Another important issue that submitters recognised was the societal factors that influence higher rates of Māori drug use like income, housing, employment, and education.[145] The Ministry of Transport's approach has not followed this advice from Māori health professionals, and shows a lack of consideration of Treaty obligations.

The scheme as it stands will mean that Māori are going to face greater punishment despite the absence of any actual evidence that they are causing the majority of crashes, or that they are even impaired to drive to a greater extent than any other group in society. New Zealand roads need to be safe, but that should not be at the expense of a disenfranchised group, to whom the government owes specific obligations. Māori, and ultimately all people of colour, deserve to have a scheme that acknowledges and mitigates the disproportionate harm they will face. This could be achieved, as submitters noted, through a greater focus on a health based, non-punitive approach. Māori have more substance addiction issues because the key drivers of addiction are things like lack of quality education, adequate income and housing.[146] The approach taken in the Bill is at odds with the work being done to transform the criminal justice system, with a particular focus on transforming it for Māori, which includes the transferring of power to Māori agencies.[147] The Bill could

[142] Ministry of Transport *Summary of Submissions Enhanced Drug-Impaired Driver Testing* (December 2019) at p 8.
[143] Ministry of Transport *Summary of Submissions,* above 142, at page 5.
[144] Explanatory Note, above n 86, at 4
[145] Ministry of Transport *Summary of Submissions,* above 142, at page 9.
[146] Te Uepū Hāpai i te Ora – the Safe and Effective Justice Advisory Group, above n 136, 14.
[147] Te Uepū Hāpai i te Ora – the Safe and Effective Justice Advisory Group *Turuki! Turuki!* (December 2019) at 25.

achieve its aim of reducing impaired driving on the road by taking a health based approach instead of a punishment based one, and could include Māori organisations in this approach.

D Conclusion

Deterrence is the theoretical basis for the Bill, and there is significant evidence to support its efficacy in improving road safety because it has worked for drink driving. However, the deterrence based stance has resulted in people's rights and freedoms being sacrificed. The government has taken a zero tolerance approach to illicit drug driving because deterrence underpins the policy. This zero tolerance approach has been found to impinge on the rights affirmed under ss 21, 22, 23 and 25(c) of NZBORA, and the Attorney-General found that these infringements were not justifiable. Moreover, this strict approach will also have a disproportionate effect on Māori, which is also not justifiable when the government owes additional obligations to them because of Te Tiriti o Waitangi. Although road safety is important and it is necessary to have a scheme that effectively deters people from drug driving, the proposed approach is not justifiable from a rights and discrimination perspective because there are alternative ways to fulfil this purpose which would infringe on people's rights to a lesser extent.[148]

[148] See discussion in Chapter 4 at 43 on what overseas jurisdictions do.

IV Chapter Four – Lessons from Overseas Jurisdictions

A Lessons from Australia

Australia has had a random roadside drug driving oral fluid testing regime since 2004 when it was first introduced into the state of Victoria.[149] It is evident that the New Zealand based scheme has been heavily influenced by the approach taken by Australia. Although there is variation between the different states, there is a consistent approach to drug driving that relies on a presence-based oral fluid testing regime. In the majority of states, two oral fluid tests are taken, and if the presence of drugs is shown in both of these tests, then the sample is sent to a laboratory to confirm the results.[150] The policy basis for this presence-based system is heavily reliant upon deterrence theory.[151] Notably, the majority of Australian states only test for illicit substances, and use a different regime for prescription medication.

Legal scholars in Australia have identified three main critiques of the regime, that broadly reflect concern that it does not fit with the impairment road safety risk equation that has traditionally underpinned drink and drug driving laws.[152]

The first issue is the presence-based scheme, where an offence occurs if there is the presence of any detectable quantity of drug in a person's oral fluid. Despite suggestions to the contrary by some politicians, the system functions upon the presence of any amount of a drug in oral fluid rather than the presence of active drugs.[153]

The second problem with the scheme is that the regime is based on 'oral fluid testing' both for the preliminary random test and the final oral test. In most states an initial test is taken using a drug wipe stick which usually involves the driver wiping their tongue along the

[149] National Drug Driving Working Group *Australia's second generational approach to roadside drug testing* (October 2018) at 23.

[150] National Drug Driving Working Group, above n 149, at 12.

[151] National Drug Driving Working Group, above n 149, at 14.

[152] Quilter and McNamara, above n 36, at 52

[153] Quilter and McNamara, above n 36, at 55, note comments made by the then Tasmanian Minister for Police and Public Safety, David Llewellyn who stated that scientific evidence shows direct correlation between the presence of certain drugs in blood and presence in oral fluid.

testing stick. If the test is positive, it is followed by a saliva sample taken in a roadside testing bus/van (or at a police station).[154] This sample is then usually sent for analysis to confirm the presence of drugs, and the confirmation of this is admissible evidence for charges to be laid against the driver.

Legal scholars in Australia have queried the use of oral fluid as the standard for prosecution because evidence indicates it is not the best standard for assessing a person's drug impairment.[155] This is particularly true for THC, as the devices can detect residual deposits of THC in the mouth despite the drug no longer being present in the driver's bloodstream, and thus not having an adverse effect on driving.[156] The issues with THC detection were of particular concern for critics, because it is the most widely used drug in Australia.[157]

Finally, there was concern about the fact the majority of states focus on three illicit drugs only (THC, MDMA and methamphetamine), because this approach does not fit well within the road safety/impairment paradigm. While there is acknowledgement by state officials that other drugs impair driving, they worry that the similarity between some illicit and licit drugs would result in people being punished for prescription drugs through the wrong system.[158] Tasmania is different from other states however, because it tests for eighteen drugs, and also requires a blood test after the initial oral fluid screening.[159]

The Australian scheme also has a lot of variation in the ways in the approaches to the 'no drive' directive following a positive test. New South Wales,[160] Queensland[161] and the Northern Territory all have a 24 hour stand down period.[162] Australian Capital Territory

[154] Quilter and McNamara, above n 36, at 52.

[155] Quilter and McNamara, above n 36, at 55, and see discussion on problems with oral fluid as the standard of impairment in Chapter 1

[156] See discussion in Chapter 1 at 10 and Quilter and McNamara, above n 36, at 55.

[157] Quilter and McNamara, above n 36, at 55.

[158] Quilter and McNamara, above n 36, at 56.

[159] Road Safety (Alcohol and Drugs) Regulations 2009 (Tas), cl 16 and Road Safety (Alcohol and Drugs) Act 1970 (Tas), s 6A.

[160] Road Transport Act 2013 (NSW), s 148G.

[161] Transport Operations (Road Use Management) Act 1995 (Qld), ss 80(22)(ab) and 80(22)(b).

[162] Traffic Act 1987 (NT), s 29AAM.

allows for the police to give a 12 hour no drive directive if they have "reasonable cause to suspect" that a person's ability to drive is impaired by a drug.[163] Victoria and South Australia have more general prohibitions. In Victoria, if a police officer is of the opinion on reasonable grounds that the person is incapable of having proper control of the motor vehicle, they can require them not to drive while incapable and to give up their keys. South Australia is similar, but requires that a person must not drive "until permitted to do so by the police officer".[164] Western Australia and Tasmania do not have express statutory powers on a stand down period, however both states either by common practice or police policy that indicate a stand period should be followed.[165]

Despite the variation in these directions, essentially all of the states have systems which deem people to be incapable of driving on the basis of testing positive for the presence of drugs. By implication once that period of time has passed, unless more drugs have been consumed, the drug will no longer be present in the person's body. However, the District Court in New South Wales has already considered issues with after defendants have argued that a positive oral fluid test resulted after drugs had been consumed days before, or as a result of passive smoking.

It was accepted in *R v Delbridge* that the defendant had an honest and reasonable belief they were not in breach of drug driving legislation when they tested positive with an oral fluid test after being in the presence of others smoking cannabis.[166] In another District Court level decision, a judge reversed a conviction because the defendant drove several days after consuming cannabis. The judge held that it was not common knowledge that

[163] See s 47B Road Transport (Alcohol and Drugs) Act 1977 (ACT).

[164] See s 62 Road Safety Act 1986 (Vic) and s 40K(4) Road Traffic Act 1961 (SA).

[165] See JE Woolley and MRJ Baldock *Review of Western Australian Drug Driving Laws* (May 2009) at 4 which states that "the driver is advised not to drive for 24 hours" and the Department of Policy and Emergency Mangement *Tasmania Police Manual – Orders, Instructions and Operational Guidace for Members of Tasmania Police* (2010) at 14.8.5(1)(k).

[166] *R v Delbridge* [2019] NSWDC 450 at [58], [59] and [64].

testing could return positive results many days after consuming the drug.[167] It is important to note that these are low level court decisions, and have yet to be contested at a higher level.

It is noteworthy that Australia does not use legally defined 'cut off' thresholds.[168] This is similar to the approach being proposed for the New Zealand scheme, with no cut off threshold being contained in the Bill. But there is acknowledgement that devices will be set to a low cut off level, although the level will not publicly available.[169]

It is unclear how a New Zealand court would respond to defences raised by the defendant on the grounds of passive smoking or an honest and reasonable mistake of fact if they have followed the 12 hour disqualification advice but there is still a presence of drugs in their system. Given the proposal is for a strict liability offence in New Zealand, the burden of proof would be on the defendant to raise the defence, with no burden on the prosecution to prove mens rea. Access to justice issues may thus arise because a defendant may be unwilling to risk liability for the costs of having a blood test without knowing if their defence would be accepted.

The problems raised above all relate to the lack of consistent and clear scientific data on how long testing devices can detect a drug in a person's saliva.[170] Furthermore, recent research in Australia has also brought into question how accurately the testing devices can actually test for drugs, particularly for THC. A 2019 study found that 5 per cent of

[167] *Bugden v R* [2015] NSWDC 346 at [14]. It has also been accepted as a defence in lower court decisions like *Police v Carrall* (unreported, Lismore Local Court, 1 Feb 2016) (NSW) where a Magistrate a charge of 'drug (cannabis) driving' when the accused gave evidence that he had consumed cannabis nine days before the time at which he was subjected to a roadside test.

[168] National Drug Driving Working Group, above n 149, at 12.

[169] Explanatory Note, above n 86, at 1.

[170] See discussion on problems with oral fluid testing in Chapter 1 at 10-12.

Securetec DrugWipe test results were false positives, and 16 per cent were false negatives.[171]

The cost-benefit report prepared for the New Zealand proposal noted that the two most common devices include the Securetec DrugWipe and the Drager DrugCheck. It references the that these devices falsely detect drugs 0-10 per cent of the time, but notably did not consider false negative results because they were not considered to have follow on cost implications.[172] The report concluded that the possibility of false positives was mitigated by the fact that two oral fluid tests will be carried out. However, while this reduces the likelihood of a false positive, it does not entirely eradicate it.[173]

The problems with drug testing devices are also relevant to the potential disproportionate affect this could have for chronic drug users. There is once again a heightened concern with respect to cannabis, because THC releases from tissues slowly and is detectable within the blood of chronic users for prolonged periods of time.[174] Studies indicate that individuals who use cannabis products daily or multiple times throughout the day may have detectable THC blood concentrations despite having had a period of cessation for hours or possibly days.[175] For the purposes of the proposed scheme this arguably is irrelevant, because of the zero tolerance approach.

Aspects of the New Zealand scheme have responded to some of the concerns raised about the Australian system. There has been legislative recognition that it would make for a better system to have requirements for cut off thresholds that devices will be set to, however the

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[171] Arkell and others, "Detection of Δ^9-THC in oral fluid following vaporized cannabis with varied cannabidiol (CBD) content: An evaluation of two point-of-collection testing devices" (2019) 11 Drug Test Anal 1486 at 1495.

[172] Ministry of Transport *Enhanced testing regime for drug-impaired driving: Cost-Benefit Analysis* (April 2020) at 26.

[173] Ministry of Transport *Enhanced testing regime for drug-impaired driving: Cost-Benefit Analysis*, above n 173, at 27.

[174] Wallage and others, *Report on Drug Per Se Limits* (Canadian Society of Forensice Sciences Drugs and Driving Committee, September 2017) at 15.

[175] Wallage and others, above n 174, at 16.

legislation would be clearer, and more justifiable if an infringement level was set in the Bill.[176]

The New Zealand approach goes further by applying the proposed scheme to a variety of illicit and licit drug classes, which recognises that both may have significant impairments on people's driving abilities. However, it appears that New Zealand still needs to consider more fully the accuracy of the devices used, access to justice issues in raising a defence, and how long the stand down period should be from driving.

B The Canadian Approach

Canada, being a Commonwealth common law jurisdiction, often provides insights into approaches that New Zealand could take, and has recently updated its law on impaired driving.

Canada has introduced a hybrid impairment-presence-based approach to drug driving. The main driver for this mixed approach is the legalisation of cannabis in 2018.[177] They have maintained a good cause to suspect threshold.[178] The usual grounds for oral fluid testing include factors such as red eyes, muscle tremors, agitation, and abnormal speech patterns. If a police officer observes any of these signs, they may conduct an oral fluid test, and if that returns a positive result then a blood test may be carried out.[179] There is also a Standard Field Sobriety test or a Drug Recognition Expert Evaluation test, which are similar to the CIT in New Zealand, and can be carried out by a police officer.[180] Canada also has a per se limit for THC. If a person has over 2ng of THC in their blood but under 5ng/ml THC in blood within two hours of driving, then they receive a fine of $1,000.[181] If they have 5ng/ml or more of THC in their blood within two hours of driving, a first time offender will face a

[176] See discussion in Chapter 3 on the NZBORA implications that a non-specific infringement level has.
[177] Updated through Bill C-45 "The Cannabis Act".
[178] Criminal Code RSC 1985, s 320.28(2)
[179] Criminal Code RSC 1985, Section 320.27(1)
[180] Section 320.27(1) Criminal Code RSC 1985 and see discussion on these in Chapter 1 at 12.
[181] Drug concentration level specified in Blood Drug Concentration Levels Criminal Code RSC 1985 SOR/2018-148 and penalties specified in s 320.19(1) Criminal Code RSC 1985.

minimum penalty of a $1000 fine up to a maximum penalty of 10 years imprisonment,[182] with penalties increasing for second and third time offences.[183]

Other drugs are treated in a more of a presence-based way, with any "detectable levels" of LSD, psilocybin, psilocin ("magic mushrooms"), ketamine, PCP, cocaine, methamphetamine or 6-mam (a metabolite of heroin) in the blood within two hours of driving being prohibited. The penalties for these drugs are the same as those for 5ng or more of THC.[184] There are also harsher penalties for combinations of THC and alcohol, depending on the amount present.[185]

Historically, there are some key differences between the New Zealand and Canadian approach to impaired driving. Canada did not have a randomised breath testing regime for alcohol until 2017, when it was introduced along with changes to the drug-driving regime.[186] Moreover, the introduction of per se limits coincided with the legalisation of cannabis. These are important distinctions which show a fundamentally different approach to impaired driving in Canada.

New Zealanders have long accepted testing for alcohol impairment as a public safety measure, so it is likely that the introduction of the proposed scheme will feel like less of an erosion of their rights. Possibly the retention of the "good cause to suspect" requirement before an oral fluid test is taken in Canada is a response to the relatively recent introduction of an impaired driving regime. Canada's scheme does not allow for completely random roadside oral fluid testing. Furthermore, the per se limits are justifiable when the substance is no longer illicit. From that perspective it is clear why the Canadian approach differs from the proposed approach in New Zealand, and also the approach in Australia. The existence

[182] Criminal Code RSC 1985, s 320.19(1).
[183] Criminal Code RSC 1985, s 320.19(1).
[184] Criminal Code RSC 1985, s 320.19(1).
[185] Criminal Code RSC 1985, s 320.19(1).
[186] Solomon and others, "Random Breath Testing: A Canadian Perspective" 12 Traffic Injury Prevention 111 at 112.

of per se limits does however provide useful insight into how the potential legalisation of cannabis in New Zealand may affect the proposed scheme.

1 The implications of the Canadian approach for the potential legalisation of cannabis in New Zealand following the 2020 election

On October 3 2020, New Zealand voters will be asked to decide whether or not cannabis should be legalised for recreational use.[187] If the decision of the referendum results in the legalisation of cannabis for recreational use, there will be a number of impacts on society, some foreseen and no doubt others yet to be determined. One of these will be the impact on drug driving laws.

As discussed in Chapter 2, the proposed scheme treats illicit drugs more harshly than prescriptions drugs, through the use of the medical defence.[188] However, if cannabis is legalised, the way THC is currently treated under the scheme would be inconsistent as it would no longer be illicit, and would be analogous to the most widely used recreational drug, alcohol.

The Bill has not yet gone through the Select Committee and parliamentary process, so what the final regime looks like may be significantly different from its current form.[189] If the referendum is successful then it could be particularly important for the Select Committee to consider specified per se limits for THC, and the limits set by Canada provide a particularly good foundation for this. In setting per se limits for THC it is necessary to select a limit that addresses public safety concerns while not prosecuting a number of people who are not impaired. The Canadian Society of Forensic Sciences Drugs and Driving Committee considered the various scientific research that existed on the relevant drugs and then based on this recommended to the Canadian legislature the per se limits,

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[187] New Zealand Government "Cannabis legalization and control referendum: your guide to the 2020 referendum" < https://www.referendums.govt.nz/cannabis/index.html>.

[188] See discussion at 29.

[189] New Zealand Parliament "Land Transport (Drug Driving) Amendment Bill" (2020) <https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_99686/land-transport-drug-driving-amendment-bill>.

which were largely accepted.[190] The Committee considered a range of factors when recommending THC per se limits. Although increased crash risk for THC is contested in the literature, this committee concluded that THC does increase crash risk to a small extent.[191] They considered that a per se limit for THC of 2ng/ml of blood and 5ng/ml of blood would be appropriate. Although the Committee viewed 5ng/ml of THC in blood to be the more appropriate level of impairment, there were concerns raised with the time it would take for procedural requirements to be fulfilled.[192] These requirements would mean that by the time blood was collected a person's blood concentration may have dropped significantly and be below the limit.[193] The limit of between 2ng and 5ng/ml of THC in blood reflects this concern and insures people who were impaired while driving still face penalties. Following the legalisation of cannabis, and the introduction of these laws, surveys suggest that there was not an increase in users driving within two hours of using cannabis.[194]

The approach taken in Canada reflects a science based jurisprudence for driving under the influence that American scholar Andrea Roth has advocated for.[195] Andrea Roth examined the approach taken to drugged driving in the United States, following the legalisation of cannabis in a number of states. She also considered the previous prohibition based jurisprudence for drug driving and then compares it to the jurisprudence of dangerousness. Roth questions whether it is justifiable to take an approach to drug driving that is not based on science when that is the approach taken for alcohol.[196] Using the logic of Roth, it would seem that Canada has taken a science based approach to drug driving, and New Zealand's proposed approach would still function on prohibition based jurisprudence. Given the

[190] Department of Justice Canada "Drug Impaired Driving Laws" (2019) < https://www.justice.gc.ca/eng/cj-jp/sidl-rlcfa/>.

[191] Chapter 1 at 10 and note CSFS DCD Report p 11.

[192] Wallage and others, above n 174, p 14.

[193] See discussion in Chapter 1, at 10-11, on THC's quick metabolism which means drug concentration in blood can drop quickly.

[194] Michelle Rotermann, *What has changes since cannabis was legalized?* (Statistics Canada, February 2020) at 14.

[195] Roth, above n 35, at 845.

[196] Roth, above n 35, at 873.

approach taken to alcohol is firmly based on science in New Zealand, and it would be consistent to take this approach for drug driving as well, and especially if cannabis is legalised.

C The approach in the United Kingdom

It is, as always, useful to consider the approach taken in the United Kingdom to ascertain if this would have any guidance for New Zealand. The United Kingdom takes what they describe as a presence-based approach to drug driving, however it does fall within an impairment paradigm as there are specified limits below which detected drug amounts are deemed passive or inadvertent exposure. The zero tolerance approach is not actually a "zero" limit but instead the United Kingdom has chosen to have the limits at the lowest possible level at which a valid and reliable result can be obtained.

In March 2015 amendments were made to the Road Traffic Act 1988, that made it an offence for a person to drive or attempt to drive a motor vehicle if the proportion of a drug in the person's blood or urine was over the specified limit.[197] This new law also introduced the use of oral fluid roadside testing while maintaining the existing impairment test.[198] Following a failed test the police have the power to arrest without a warrant a person they reasonably suspect has a proportion of drug over the specified limit, and a blood test will then be carried out.[199] If the blood test also shows a result above the specified limit then charges may be laid.

These limits were based on the recommendations of an expert panel of scientists. This report, undertaken in 2013, was one of the first of the time to do such an extensive review into the literature and research on impairment levels of various drugs. The panel's role was to determine if they could establish with sufficient evidence from the literature a relationship between the use of psychoactive drugs and an effect on driving performance

[197] Road Traffic Act 1988 (UK), s 5A.
[198] Road Traffic Act 1988 (UK), ss 6B and 6C.
[199] Road Traffic Act 1988 (UK), s 6D

in average members of the public.[200] Based on this research the report made recommendations that a the threshold for THC should be set at 5mg/L of blood[201], a threshold for cocaine to be at 80mg/L[202], a threshold for MDMA set at 300mg/L[203] and a threshold limit for methamphetamine of 200mg/L.[204] The report also made a number of recommendations for prescription drugs.[205] However, these limits were not followed completely when introduced, illustrating the tension between taking a science based approach, and the politicisation of impaired driving. A 'zero' based approach was adopted with threshold limits for eight illicit drugs and eight prescription drugs.

A year after these changes were introduced an evaluation of the successfulness of the regime was produced.[206] It drew on a number of different indicators to determine if the changes had been successful in reducing the amount of impaired driving in the UK.[207] These indicators included the number of proceedings brought and number of convictions, awareness and attitudes shifts, prevalence and frequency of drug driving and number of crashes involving drug driving.[208] The report found that police successfully implemented the regime, and that there was increase in prosecutions under the section 5A of the Road Traffic Act, as well as similar levels of prosecutions under the remaining s 4 Road Traffic Act.[209] The majority of the preliminary drug screening tests were also carried out successfully by using the new roadside oral fluid tests, and this linked to higher conviction rates for drug driving prosecutions.[210] The report did however state that it was too early to tell if the regime was working effectively as a deterrent to drug driving, and whether it had

[200] Wolff and others, above n 48, at 16.
[201] At 72.
[202] At 86.
[203] At 109.
[204] At 175.
[205] At 175-176.
[206] RiskSolutions *Evaluation of the new drug driving legislation, one year after its introduction* (A report for the Department for Transport, April 2017).
[207] At 1.
[208] At 1-2.
[209] At 7.
[210] At 7.

reduced crash rates although a decrease to previous years had been noted.[211] Ongoing monitoring was recommended by the report to see if a fuller picture could be determined once more data was available.[212]

Although the findings on this report were not fully conclusive there were indications that the system worked effectively and was an efficient use of police time. Furthermore, there was a clear increase in public awareness of the new offence.[213] These findings are important because they show that the New Zealand approach could maintain a "zero" tolerance basis but still be based on a scientific approach, with legislated threshold limits for drugs and provides another example of the way different jurisdictions have implemented roadside oral fluid testing.

D Conclusion

There is not one simple approach used overseas that provides a clear path for New Zealand to follow. While the Australian system has been used for a number of years, there are a number of concerns with the system relating to accuracy. The Canadian and United Kingdom approaches both provide fresher examples of a drug driving scheme, taking into account the most up to date science on how drugs impair driving. The United Kingdom particularly shows how a 'zero tolerance' approach can be taken but with a clear scientific basis, while the Canadian approach illustrates the advantages of a mixed approach that still ensures roads are safe.

[211] At 66.
[212] At 76.
[213] At 76.

V Conclusion

As discussed in this dissertation, there are alternative approaches that New Zealand could take to drug driving, that would better mitigate against some of the issues that have been raised. It is important then to explore what an alternative regime, which could be more effective and would also better protect civil liberties.

A Recommendations on changes to the Bill

The most significant suggested change to the Bill would be to take an impairment based approach to drug driving. The presence-based approach is unjustifiable from a rights perspective, from a science perspective, and in comparison to what some overseas jurisdictions are doing.[214] An impairment based scheme would be more justifiable and more effective.[215] New Zealand has the capacity to create an effective system which would reduce the number of people that drive drugged, and punish who pose an unjustifiable risk to the public.

The scheme could be improved in four specific ways:

1. An impairment based approach should be adopted by using a combination of the schemes in Canada and the United Kingdom. The Bill should adopt different levels for THC aligned with the levels used in Canada. This would make THC levels between 2ng/ml in blood and 5ng/ml in blood an infringement level offence, and 5ng/ml in blood or above being a criminal offence. This change would be important if cannabis is successfully legalised following the referendum. It should, however, go ahead regardless of the outcome, because THC poses a comparatively low relative crash risk, there are significant issues with the accuracy of testing for THC, and there is the greatest body of scientific research on what levels are appropriate

[214] See discussion in Chapter 1 at 10-12 and in Chapter 4.

[215] See discussion in Chapters 1 and 3.

for impairment.[216] Given it is the most consumed drug in New Zealand it would be appropriate to introduce these limits. In relation to other drugs, there should be clearly specified cut off limits which would be legislated for, and the limits provided for in the United Kingdom legislation would be useful starting points. Then there should also be legally specified criminal limits for impairment, which also exists within the scheme currently. Although the Bill states the devices will have low level these will be a policy decision based on the devices used. The proposed changed would make legally legislated cut off threshold which creates more clarity and consistency in law. It is important that these levels are considered and set by the expert science panel to ensure that they reflect the most recent scientific research.

2. Blood testing should be compulsory following two positive (failed) oral fluid tests. This is necessary given that different limits are being adopted for criminal and infringement offences, and also because for many drugs oral fluid is not sufficiently accurate to determine impairment levels.[217] Although this would create a more expensive regime and longer detainment times the trade-off, given the significant amounts of power being given to police, is a more robust system. This is of particular importance when there are significant NZBORA implications and issues with the disproportionate impact this regime will have for Māori. There are concerns that blood testing would slow down the process to the extent that roadside testing could not be carried out at the level required for deterrence to be effective. However, it would still act as a more effective deterrent compared to the current CIT process because the scheme still provides for random roadside testing, which still increases the likelihood of apprehension. Furthermore, the current approach allows severely impaired drivers to face no criminal penalties, even if they would be above the criminal limit, because they have a choice on whether to undertake a blood test.[218] From a deterrence perspective this creates the impression that there

[216] See discussion in Chapter 1 at 10.

[217] See discussion in Chapter 1 at 12-13.

[218] See discussion on the loophole in the Bill at 28.

are not harsh penalties for breaching the law, meaning they may be more likely to drive while under the influence again. Compulsory blood testing would ensure that their punishment truly reflects the extent of their behaviour. Overseas jurisdictions like Canada and the United Kingdom have recognised that as an essential part of the process, and given their schemes reflect current scientific evidence New Zealand should follow this approach as well. [219]

3. Harsher penalties for mixing drugs or drugs and alcohol in the current proposal should remain, because the evidence is clear that this significantly increases relative crash risk, and the scheme should punish more severely the serious level of offending that this involves.[220]

4. A health based approach should be more clearly provided for in the Bill, which could include drug counselling for first time offending. This should be developed with assistance of Māori health professionals and advocates. This approach would help to address the concerns raised about the disproportionate affect this would have on Māori.[221]

These changes would also address the concerns raised within this dissertation regarding access to justice and stand down periods. The current proposal poses access to justice issues because the presence-based approach means that people could feel unable to challenge drug tests if they have consumed drugs previously but not within a recent enough period to remain impaired. If a false positive oral fluid test was returned for a person, and they have previously consumed drugs but not recently enough to warrant a positive test, they may feel unable to challenge it through a blood test because that test would show drug use. This is of particular concern in relation to THC which can remain in blood for a long period of time. Under this system, justice cannot be fully accessed, and people will have to bear

[219] See discussion on deterrence theory at 12.

[220] See section 57D of the Bill.

[221] See discussion in Chapter 3 from 38.

unjust demerit points and fines. An impairment based approach with clearly legislated and evidence-based levels for infringement and criminal offences would address this concern.

Lastly, the approach proposed above would enable more clarity around stand down periods, because clearly legislated threshold limits would mean that people could not as easily raise defences on the grounds of following the twelve hour stand down period. The government and expert science panel should also research this area more to ensure that appropriate cut off thresholds are set, to ensure that people will not be driving impaired but also feel confident about when they can drive without facing penalties.

The Bill as it stands is not justifiable and the executive has an obligation to ensure that any changes to drug driving laws do not unnecessarily infringe upon people's rights. The executive has an obligation to ensure people are safe on the roads however that does not need to come at the expense of arbitrary punishment. At the point where police are being given significant coercive powers of the state to randomly stop and undertake a search of a person, then they should only face punishment for actually posing a risk to other road users. The goal of having of zero road deaths is lofty aim, and one our legislators should be striving for, but the law must still be clear, consistent and fair law.

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