

29/8/24

Land Transport Drug Driving Amendment Bill Select Committee
Transport and Infrastructure Committee
Parliament Buildings
Wellington

Dear Committee members,

As the lead doctor of New Zealand's largest Medicinal Cannabis clinic, I am writing to express my concerns regarding the potential implications of the proposed Land Transport Drug Driving Amendment Bill on our patients.

Background

I represent the Cannabis Clinic which employs more than 40 doctors and nurses, from a variety of specialities including general practice, psychiatry, anaesthetics, occupational health, urgent care, and many more.

Before this role, I have worked as a doctor on the front line in hospitals, inpatient psychiatric units, emergency departments and several years supporting St John and FENZ as a PRIME clinician in rural General Practice. I have cared for patients dying on the side of the road after road traffic accidents, as well as losing a close friend who was hit by a drunk driver.

I therefore certainly support any effort to deter people driving while drunk, or on medications or illicit drugs that impair their performance.

Unfortunately, the currently proposed roadside oral salivary testing is neither backed by scientific evidence, or as highlighted in the Land Transport (Drug Driving) Amendment Bill 2021 Regulatory Impact Statement (1), proven to deter drugged or dangerous driving.

Medicinal Cannabis Context

Since Medicinal Cannabis was legalised in New Zealand, we have seen more than 35,000 patients who are seeking science-based advice and treatment in this specialist area. We advocate for our patients, who are receiving care in an area of medicine that is in its infancy in New Zealand, and one that is still filled with stigma and opinions not based on science.

Most of our patients have found Medicinal Cannabis improves their medical conditions in ways that conventional medications have not and they are then able to regain control of their lives, rejoin the workplace, complete education, stay active well into retirement and generally, live better lives. They are often able to decrease or stop other medications that cause impairment such as opioids, tricyclic antidepressants, gabapentinoids, benzodiazapines and many others.

Under the guidance of a prescribing doctor, patients are legally able to use CBD oils (containing up to 2% THC by definition), oils with varying ratios of CBD:THC, THC oils with no CBD, and THC flower. See MOH website for a list of available products (2).

To develop a tailored treatment plan, our clinicians ensure they gather a holistic view of the patient, including the conditions they are treating, patients' previous experiences with cannabis and other medications, their background medical and psychosocial context, their ideas and expectations, prior to formulating a science based best practice recommendation in collaboration with the patient.

Harm minimisation is at the heart of what our clinicians do and so part of the advice they get it to use the lowest effective dose of THC, have regular tolerance breaks, use an oil rather than inhaled flower unless there are reasons for using the flower, tobacco cessation, reducing alcohol.

Many of our patients have been using cannabis for years and moving people away from smoking illicit cannabis flower to an oil, or legal vaporised flower, is something that can decrease the potential for harm on many levels. A large part of harm minimisation is providing good advice, keeping our patients away from criminal activity and ensuring their behaviour does not put them or others at harm.

Advice around driving is a standard part of a consultation when prescribing any medication with potential impairing effects. This is particularly important for THC.

Our Advice for those Driving with CBD or THC

CBD is typically prescribed as a daytime medicine as it is non-impairing and is very unlikely to affect the ability to drive or operate heavy machinery when taken within the guidelines of the medicinal prescription. We consider CBD (used within the confines of the prescribed instructions) to be a safe medicine, even when used by people who are driving or working in safety sensitive tasks. (3)

THC can certainly be intoxicating at high doses or by those who are not used to the effects of THC. When we prescribe medicinal cannabis, the dose will typically be much smaller than that obtained through recreational smoking.

Some jurisdictions such as Colorado, where medicinal cannabis is more established, the Department of Transportation recommend that people do not drive, work or operate heavy machinery for at least 6 hours after THC inhalation and 8 after ingestion. (4) The baseline advice here is based on 35mg of inhaled THC or 18mg ingested THC which is a reasonably large dose. Public are advised to wait longer if they take a larger amount or consume other impairing substances.

We currently recommend a (some say conservative) stand down period of 6 hours after inhalation of THC and 10 hours after ingestion of a THC oil. To make this recommendation we have reviewed the latest existing evidence and spoken to a leading authority on THC and impairment from Australia, Dr Thomas Arkell (5).

Potential for Positive Results when Not Impaired and Negative Results when Impaired

The proposed legislation introduces a zero-tolerance approach to THC, utilising salivary testing, which will result in positive results when not impaired and potential for negative results when impaired, despite two tests being performed.

This is in addition to, and separate from, the commonly reported false positives and false negatives that can come from the tests themselves (and vary depending on which test is used)

Negative results when impaired can occur because THC is not excreted in saliva and so someone could take an extremely large, and intoxicating dose of THC via capsule and immediately test negative on roadside testing.

However, by far the most common scenario in our patients will be that they test positive for THC, but are in no way impaired.

THC can remain detectable in the saliva long after its psychoactive effects have worn off. THC is typically detectable in oral fluid for 4–6 hours after vaporising cannabis and likely longer in those taking a THC containing oil sublingually. In those taking doses of cannabis, THC may be detectable in oral fluid for up to three days following cessation of use. (6, 7)

As mentioned above, CBD is well recognised to not be an impairing cannabinoid and many of our patients use this in the morning. To be classified as a CBD product, it must contain less than 2% THC. CBD oil (like THC oil) is generally taken sublingually, and the oil then sits in the mouth for some time and is absorbed by the mucosa so as to improve its effectiveness.

Despite the quantity of THC in these CBD oils being extremely low, and not at a level that would cause impairment, it certainly could return a positive result on salivary testing.

This highlights the limitations of the oral fluid test. It also highlights the risk of patients, who are taking our advice, are not impaired and are following their doctors advice, being unfairly penalised for a positive THC test.

Impairment in Medicinal Cannabis Patients Lacks Scientific Backing

To date, the degree of impairment in THC positive Medicinal Cannabis patients is unclear.

Studies have demonstrated that those who take THC regularly (such as Medicinal Cannabis patients), experience less impairment than occasional users. (8)

The 2021 paper by Arkell et al, summarised the available research on THC and driving, and stated with regards to epidemiological studies in this field *“that cannabis-positive drivers are approximately 1.1–1.4 times more likely to be involved in a crash than sober drivers and are also more likely to be culpable for a crash. Notably, however, there have also been major recent studies in which no increases in crash or culpability risk were detected, particularly when drivers had low blood THC concentrations (<5 ng/mL). Overall, the increase in crash risk associated with THC is similar to that associated with a low-range blood alcohol concentration (BAC; 0.01–0.05 g/L).”* (9)

The paper goes on to report that on-road experimental studies *“indicate that cannabis-induced increases in SDLP [standard deviation of lateral position] are of a similar magnitude to low-range BACs (approximately 0.05 g/L), 10 mg diazepam or **one night of sleep deprivation.**”* (9)

A more recently released study looked at impairment in simulated driving while Medicinal Cannabis patients used their usual prescribed THC at doses between 1.13–39.18mg and found no impairment in this context, despite some patients having positive salivary tests 6 hours post dose. (10)

Lack of Clear Provisions for Medical Cannabis Patients

The Bill currently lacks a clear framework for how medical cannabis patients can demonstrate compliance with their prescribed treatments. It instead creates a framework by which patients who are likely not impaired, and following their doctor's advice, are forced to have a mandatory 12-hour standdown from driving.

If the roadside testing is rolled out, it is critical that the law provides a clear, fair, and scientifically sound process for medical cannabis patients to prove their compliance (at the roadside) without facing undue embarrassment, penalties or costs associated with loss of earnings, inconvenience etc.

Impact on Patient Compliance and Access to Treatment

This Bill may inadvertently discourage patients from adhering to their prescribed Medicinal Cannabis treatment due to fear of embarrassment; losing their driving privileges causing disruption to work or their life (particularly to those in rural areas or with mobility challenges where the ability to drive is crucial to maintaining their independence and accessing healthcare); or the hassle of proving they should not receive a fine and demerit points.

If the law dissuades patients from using their prescribed medication, it could lead to poorer health outcomes, a reduced quality of life and more impairment in driving than if they continued on their regime.

Many patients find THC greatly improves their sleep or resolves their insomnia when nothing else has helped. As mentioned above, studies have shown that the level of impairment from driving whilst under the influence of THC is the same as a night of sleep deprivation and so implementing this policy could inadvertently lead to driving impairment in these patients.

It could also lead to some patients turning back to other medications that are well recognised to cause impairment, more so than Medicinal Cannabis.

Recommendations for Amendments

I believe New Zealand should only introduce roadside THC testing when a suitable device, that proves impairment and is backed by science, becomes available.

Failing that, provide an exemption or defence for Medicinal Cannabis patients whereby they can provide proof they are following their doctor's advice, and using a valid prescription and so are not impaired at the roadside to avoid unnecessary standdown periods, should they test positive.

There should also be clear guidelines from the Ministry on recommended standdown periods following THC inhalation and ingestion.

Additionally, ensure that both the public and law enforcement are educated on the nuances of medicinal cannabis use to decrease the stigma and judgement that these patients experience.

Conclusion

While the safety of all road users is paramount, it is equally important that the law recognises and protects the rights of patients using medicinal cannabis under the guidance of their healthcare providers. I urge the committee to consider these recommendations to ensure that the proposed legislation does not inadvertently penalise patients who are responsibly managing their health conditions.

Thank you for considering this submission. I am available for further discussion or to provide additional information as required.

Ngā mihi nui,



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