Legal medicine, outdated laws:

Updating NSW road rules

unharm

Executive summary

NSW's driving laws treat legal medicinal cannabis as an illicit drug. Meanwhile, law enforcement focuses on detecting residue of prior cannabis use rather than impairment. This has effectively prohibited people prescribed medicinal cannabis from driving regardless of the legality of their cannabis use and their actual driving capability.

Other jurisdictions including the UK, Germany, and Ireland have adopted more proportionate approaches through medical exemptions and guidelines, or by basing offences on behavioural evidence of impairment.

NSW should immediately introduce reforms to reflect the legal status of medicinal cannabis so that people who are prescribed medicinal cannabis can drive when unimpaired and prescribers can provide patients with relevant information about safer driving.

Proposed solution for NSW

Urgent and immediate reform: exemption to S111.1 for people prescribed medicinal cannabis

NSW should move immediately to introduce an exemption to Section 111.1 so that people who are prescribed medicinal cannabis can drive when unimpaired.

This could be achieved by amending the definition of 'prescribed illicit drug' in Section 4 of the Road Transport Act 2013, to exclude THC prescribed by a medical practitioner and taken in accordance with a medical practitioner's prescription. This exemption should be available at the roadside to prevent the undue disruption, stress and cost of court proceedings for legitimate medicinal users.

This medical exemption should be supported by:

Improved guidance for health care providers

Prescriber guidelines and medicinal cannabis packaging should include clearer information about impairment duration and driving risks.

Public education

Public education initiatives should help people understand impairment indicators and avoid driving while impaired.

Legal to use, illegal to drive

Current law and enforcement

Section 111.1 of the NSW Road Transport Act 2013 makes it an offence to drive with any 'prescribed illicit drug' present in oral fluid, saliva, urine or blood. The 2013 Road Transport Act defines 'prescribed illicit drug' as inclusive of delta-9-tetrahydrocannabinol (THC), the main psychoactive substance in cannabis. This definition has not been updated to reflect the legalisation of medicinal cannabis in 2016. This means any detectable presence of THC constitutes an offence, regardless of whether it has been used legally, and in the absence of any suspicion of impairment.

Note a separate section of the act, Section 112, prohibits driving under the influence of 'alcohol or any other drug.'

Australia is the only country with a widespread random mobile program for testing drivers for the presence of THC.[1] NSW has vastly expanded the number of roadside oral fluid tests from around 20,000 in 2008 to 156,000 in 2019, with corresponding growth in charges for drug presence offences.[2]

Disconnection from impairment

Oral fluid testing technology used in enforcement of Section 111.1 can detect THC for extended periods - with median last detection times ranging from six to 30 hours after use.[3] NSW Police Standard Operating Procedures explicitly state that oral fluid testing is not used to determine impairment.[4] Recent research has shown that most driving-related cognitive skills recover within five hours of inhaling 20mg of THC, with almost all recovery occurring within seven hours.[5] Given that oral fluid testing can detect THC for up to 30 hours after use, there is a substantial gap between actual impairment and known detection windows.

Harmful impact on people prescribed medicinal cannabis

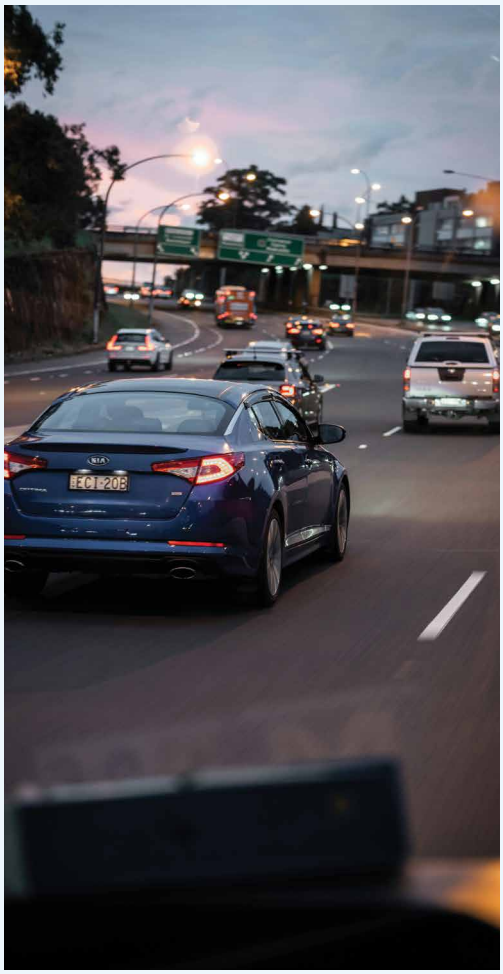
Defining THC as an 'illicit drug' prevents people who are prescribed medicinal cannabis containing THC from driving, with NSW Health advising that "it is illegal for patients taking cannabis medicines which contain delta-9-tetrahydrocannabinol (THC) to drive."[6] This blanket prohibition applies regardless of impairment level or driving capability and is disconnected from actual crash risk. It also effectively prevents prescribing doctors, nurses and pharmacists from providing relevant information about safer driving – as occurs with other medications.

Penalties for THC presence are substantial, including fines of at least $572 and licence suspension of at least three months for a first offence.[7] These punishments can create particular hardship for people on lower incomes and those in regional areas without access to public transport, who face disproportionate impacts from licence loss.

THC presence also has substantial impacts for unimpaired drivers involved in a motor accident. Under the Motor Injuries Act 2017 Section 3.37, no statutory benefits are payable to an injured person who commits an offence against Section 111 of the Road Transport Act 2013. In addition, some comprehensive car insurance policies exclude coverage for 'damage, loss, cost or legal liability that is caused by or arises from or involves' an incident where the insured vehicle's driver has more than the legal limit for drugs.[8] Together, this means that a person prescribed medical cannabis and who is not impaired but is involved in a motor accident and tests positive for the presence of THC would not receive statutory benefits if injured, and damage to their vehicle may not be covered by its comprehensive insurance policy. In addition, any damage to third party property may not be covered, which creates a financial risk for the broader community.

Risk of perverse outcomes

The focus on identifying the residual presence of THC rather than impairment creates counterproductive incentives. If drivers face identical penalties regardless of their impairment level, there is reduced incentive to wait until genuinely safe to drive. Furthermore, oral fluid testing can produce false-negative results, where some people who have consumed THC recently are not detected with any THC present.[9] Saliva testing measures THC present in the oral cavity, so consumption of cannabis preparations like capsules, suppositories or patches which bypass the oral cavity are particularly unlikely to be detected by a saliva test.[10] This combination of perverse incentive and over-reliance on a testing method with significantly limited capabilities is counter to the policy's safety objectives.



Resource misallocation

The focus on THC residue testing diverts resources from proven road safety interventions that can have a much larger impact like random breath testing for alcohol, speed management, and infrastructure improvements.[11]

Road safety context

NSW has achieved remarkable long-term success in reducing road fatalities. The 2021 annual road toll of 270 deaths was the lowest since 1923 - representing more than 1,000 fewer lives lost compared to 1978 when 1,384 people died on NSW roads.[12]

Systematic reviews demonstrate that proven interventions include random breath testing (reducing alcohol-related crashes), sobriety checkpoints (17% crash reduction), road safety campaigns (9% crash reduction), roundabouts (30-50% injury crash reduction), and electronic stability control (49% reduction in single-vehicle crashes).[13] Speed management remains the most critical factor, as speeding is the main cause of crashes and speed reduction interventions are highly effective in preventing fatalities and serious injuries.[14]

Since 2001, the proportion of recent drug users in Australia who self-reported driving under the influence of an illicit substance in the previous 12 months has declined from about 25% in 2001, to 14% in the most recent wave of the National Drug Strategy Household Survey.[15] This downward trend started prior to the commencement of the roadside drug testing program, and fell more slowly in the years following NSW's expansion of the program from 2015 to 2023.[16]

Internationally, 'cannabis impaired driving as a whole is estimated to have a minor impact on the total number of crashes.'[17] Furthermore, medicinal cannabis legalisation has been associated with reductions in crash fatalities, occurring in jurisdictions without random roadside saliva testing for THC presence.[18]

Driving safely with medicinal THC: what the evidence says

Research has shown that the mere presence of THC makes little or no contribution to crash risk.[19] Among all cannabis users there appears to be a small number of 'high-dose drivers with more substantially raised risks,'[20] with recent meta-analysis indicating that a THC blood concentration of 5.0 ng/ml is associated with an approximately doubled risk of causing a crash.[21] This doubled risk of causing a crash is comparable to the risk from being aged over 75,[22] or sleeping fewer than six hours the previous night.[23] However people choosing to drive while acutely intoxicated by cannabis tend to be a small minority of high-risk drivers with higher crash risk independent of use.[24]

Current laws effectively prevent prescribers from providing people prescribed medical cannabis with relevant information about safer driving. Nevertheless, recent Australian research has shown that people using prescribed medicinal cannabis tend to be more careful about their consumption than recreational users, less impaired by their cannabis use and more cautious when driving.[25]

International approaches

Other jurisdictions have adopted approaches that better balance safety with proportionality:

Medical exemptions: The UK, Germany, Ireland, Israel, and Norway have introduced specific protections for people prescribed medicinal cannabis. These range from statutory medical defences (UK) to complete exemptions for patients who comply with rules about wait times after consuming medicinal cannabis (Germany, Ireland, Israel, Norway). In Australia, Tasmanian road laws include a legal defence to the 'presence' law for people prescribed medical cannabis.

Impairment-based testing: New Zealand historically relied on Compulsory Impairment Tests, focusing on actual driving capability rather than presence. Some US states maintain impairment-only standards without fixed THC limits.

Threshold approaches: Canada (2ng/ml, 5 ng/ml), Germany (3.5 ng/ml), and the Netherlands (3 ng/ml) set low but non-zero thresholds for THC, and testing is only conducted after suspicion of impairment. The thresholds themselves however lack validity as indicators of impairment.[26]

Education: Most jurisdictions emphasise education about impairment rather than blanket prohibitions, helping people make informed decisions about when it's safe to drive.

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This brief has been developed in consultation with legal, medicinal cannabis and road safety experts including Clinical Professor and Dean of Law David Heilpern, Professor Nick Lintzeris, Michael White, Dr Matthew Albrecht, Dr Danielle McCartney, Professor Iain McGregor, Professor Luke McNamara and Professor Julia Quilter.

The proposal for reform in this brief has been endorsed by all the organisations whose logos are included above. These include the University of Sydney's Lambert Initiative for Cannabinoid Therapeutics which has been at the forefront of medicinal cannabis research in Australia for a decade; community legal service providers and law reform advocacy organisations the Australian Lawyers Alliance, the NSW Aboriginal Legal Service and Redfern Legal Service; law reform advocates the NSW Council for Civil Liberties; social service provider and advocacy organisation Uniting; and the NSW Nurses and Midwives Association, the union representing the nurses and midwives workforce of NSW. We also acknowledge the work by the Drive Change campaign who have been leading the advocacy to amend the drug driving laws for patients on prescribed medicinal cannabis for over five years.

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