MEETING OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON ALCOHOL, DRUGS AND SUBSTANCE MISUSE AND DRIVING

Held on Wednesday, 15 March 2017

Present:

Professor E Gilvarry	Chair
Professor K Wolff	
Dr J Marshall	
Dr A Brind	
Dr P Rice	
Dr O Bowden-Jones	

Ex-officio:

Dr C Graham	DVLNI
Dr M Prunty	Department of Health
Dr N Dowdall	Civil Aviation Authority
Professor A Forrest	Assistant Coroner, Professor of Law
Dr W Parry	Senior Medical Adviser, DVLA
Dr S Williams	Panel Secretary (Drugs and Alcohol), Medical Adviser, DVLA
Dr M De Britto	Medical Adviser, DVLA
Dr N Jenkins	Medical Adviser, DVLA
Dr K Davies	Medical Adviser, DVLA
Dr J Evans	Medical Adviser, DVLA
Mrs S Charles-Phillips	Business Change and Support, DVLA
Mr R Morgan	Business Change and Support, DVLA
Mrs K Bevan	PA to Head of Drivers Medical Group, DVLA
Mr J Donovan	Head of Driver Licensing Policy, DVLA
Mrs R Toft	Driver Licensing Policy, DVLA
Ms J Kabugu	DfT

1. Apologies for Absence

Apologies were received from Professor D Cusack, Dr Sally Bell, Miss Nadine Davies and Professor C Gerada.

2. Chair's remarks

The Chair wished to thank Mr Martin Ellis from the Department for Transport for all his work and support over the years.

This was also Mr Mark Prunty's last meeting with the Panel as observer for the Department of Health as he is due to retire soon. The Chair expressed thanks and appreciation for his input to the Panel over many years both personally and as a representative of the Department for Health.

3. Minutes of previous meeting of 12 October 2016

The minutes were agreed as accurate.

4. Matters arising

Most will come up as part of the medical standards review later in the meeting. The new GMC confidentiality guidelines have now been published but are not due to be fully launched until April 2017.

5. Update on drug driving: Road User Licensing, DfT

Ms J Kabugu attended the meeting on behalf of the Department of Transport. She informed the Panel that there have been no changes to report since the last meeting.

6. Update on drink driving

Ms Kubugu informed the Panel that there have been no changes to report since the last meeting.

There was a general discussion around the reduction in drink drive alcohol levels in Scotland. Panel support similar reductions to the drink drive limits in the rest of the UK.

7. Update on Panels

DVLA is still considering the recommendations on the review of the governance arrangements for the Medical Panels. It is hoped that this will be discussed at the Panel Chair's meeting to be arranged soon.

The Panel discussed the potential benefits of merging the Psychiatry Panel with the Alcohol and Drugs Panel.

Issues raised were whether the Psychiatry Panel workload could be split so that dementia was then covered by the Neurology Panel.

It was felt that dementia should stay with psychiatry, as diagnosis, treatment and capacity assessments are part of psychiatric work. Dementia is currently a hot topic and likely to increase workload with an aging population.

In summary, no definite decision was made but the above comments should be considered as part of the review of panels.

8. National Criteria Review presentation: Policy

Policy gave a presentation comparing the standards for alcohol and drug misuse/dependency in other countries including North America, Canada, Australia, New Zealand, and 9 EU countries (GB, Czech R, Croatia, Finland, France, Germany, Ireland, Netherlands, Sweden).

EU countries appear to interpret the EU regulations differently and some countries have the same standards for Group 2 and Group 1 drivers. All require evidence of abstinence and rehabilitation.

There is no definitive evidence to link the severity of driving restrictions to road safety. Accident data and medical condition data cannot be easily linked as it is difficult to prove causation. The overall road safety statistics are a result of many factors. From an alcohol/drug driving perspective, the limits chosen, enforcement, criteria for conviction and penalties all make a difference, as well as the medical standards.

9. Orange Guidelines

'Drug Misuse and dependence. UK guidelines on clinical management', also known as the 'Orange Guidelines', have been reviewed by the Department of Health with a view to updating the 2007 version.

These have not yet been published. The final publication should be in line with the new GMC guidelines on confidentiality, as well as DVLA guidelines.

10. Medical Standards Review

The amendments from the previous Panel meeting have now been made to Chapter 5 of the AFTD.

Alcohol related disorders.

The previous meeting agreed that the word 'permanently' should be removed from the standards for Group 2, as the psychiatric standards allow a return to vocational driving after one year in the case of psychosis.

It was pointed out that there can be recovery from hepatic encephalopathy if alcohol use stops. In addition cognitive impairment may improve.

Therefore the addition of 'until recovery is satisfactory' was recommended.

The Group 1 standards require that 'any other relevant medical standards for fitness to drive are satisfied, for example, Chapter 4, psychiatric disorders, page 73.'

It was asked whether this note was superfluous or should be added at the beginning of the chapter as many alcohol and drug related problems encompass other aspects of medical fitness to drive, such as seizures and mental health conditions. A form of words was discussed.

For **alcohol induced psychosis**, operationally we apply the standards for psychosis and for any related alcohol misuse/dependency to these cases.

There is no formal published standard for drug induced psychosis but the same operational standard is applied.

There was debate as to whether alcohol and/or drug induced acute toxic psychosis should be handled in the same way as other psychiatric psychoses.

It was agreed that information regarding the definition of acute toxic psychosis should be sought and further discussion is needed as to whether a separate standard should apply for this condition.

Alcohol - related seizure

In this section it was agreed that the standards for Group 2 should mirror those for Group 1 with regard to control of alcohol misuse and/or dependency. The wording for both should read 'an appropriate period free from persistent alcohol misuse and/or dependence'.

The discussion then considered whether the period of five years off driving vocationally for a solitary alcohol induced seizure was appropriate if this was in the context of alcohol withdrawal. Should these be classed as provoked seizures? In this situation the time off vocational driving would be for a minimum three years to allow them to meet the dependency standards.

The CAA consider that definite alcohol withdrawal or drug induced seizures are provoked.

The concept of reduced seizure threshold was considered relevant, particularly when there was no background of dependency or misuse. The epilepsy regulations refer to epilepsy or solitary seizure, they do not specify a cause for the isolated seizure. Currently the guidelines on provoked seizures state that seizures associated with alcohol or drug misuse are not considered provoked for licensing purposes.

It was considered that a legal opinion may be required. The Panel asked for clarification from the Neurology Panel.

Drug misuse or dependence

In this section it was agreed that the 'Y' after 'methamphetamine drug group' was an error and can be removed.

The sentence should read 'amphetamines (but see methamphetamine drug group below).'

Seizure associate with drug use

In this section the current standards advise that, following a drug related seizure, maintained abstinence from alcohol is required if previously dependent. It was agreed that this should refer to drug misuse/dependence.

The previous discussion surrounding alcohol induced seizures also relates to this section, with a similar request for legal and neurology panel advice.

In relation to the HRO section, there was a discussion about the accuracy required to specify a breath of alcohol level of 87.5g, and it was recognised that this requirement is legislative.

11. CDT Update and guidance for doctors

At the last Panel meeting it was agreed that a letter providing information to drivers' doctors about the significance of the CDT result would be developed, and also that information about CDT could be added to the AFTD.

Currently the CDT result is included in the revocation letters of those drivers with very high CDT values but no information is routinely sent out to customers' doctors with regard to the significance of results.

The Panel advised that the CDT blood test is a marker of liver function rather than damage. If the CDT is abnormal this is most likely due to high alcohol intake. The result is not evidence

of current pathology requiring clinical treatment, (albeit this could exist as well), but could indicate that preventative intervention is required and the information should be used to promote health.

The Panel agreed that an information leaflet/letter should be sent to drivers, giving the test result, explaining the meaning of the result and giving information on suitable self help websites such as NHS Choices, and to seek medical advice if necessary.

The information should be compatible with the Chief Medical Officers Low Risk Drinking Guidelines.

In addition, Panel felt that any result over 1.6 should be notified to the driver's doctor where there was consent. The GP should be informed of the result and the clinical significance of this, but also that the patient has been sent information about the result and directed to appropriate on line self help services.

It must be made clear that the way the test is administered by the DVLA is for licensing purposes with high cut off levels. It is used as a single test in the context of self declaration, the examination report and, where necessary, additional clinical information from their own doctors.

The wording of the information letters will be considered by a small group of Panel members. Patient review may be helpful as would further discussion with the laboratory.

Discussion took place as to how reliable the CDT test was as a single reading. The test is only requested by the DVLA where the driver is a High Risk Offender or where there is a previous history of, or reason to suspect, alcohol misuse. The high cut-off values used for licensing purposes were set using specificity and sensitivity studies. It is a scientifically and evidence based biomarker and considered to be more robust than previous blood tests used by the DVLA for this purpose.

There are issues with doctors having difficulty recognising that their patients have alcohol problems. Alcohol problems typically present late and a drink driving charge may be the first presentation.

12. Methadone standards

The Panel confirmed that all cases of Group 2 drivers on methadone should be reviewed by the full Panel before issuing a licence, both at first notification and on renewals. Numbers are likely to be small.

It was agreed that an in depth review of the standards was required which cannot be done in the limited time available at the Panel meeting. In addition, changes may be required following the publication of the updated Orange Guidelines. It was suggested that a small subgroup of Panel members look at this topic when the new guidelines are available. Standards should not be added in detail to the AFTD until there has been clarification after the next Panel meeting, and they may need to be reviewed biannually.

Use of anabolic steroids does not need to be considered with regard to methadone use.

13. Multiple substance misuse

Multiple substance misuse is becoming very common, particularly with severe opiate use, and is associated with an increased risk for driving.

It was agreed to defer the discussion to the next meeting.

14. Hair testing as evidence of false positive CDT: Case discussion and reference paper

The Panel considered an HRO case where the individual had a number of raised CDT tests resulting in repeated licence refusal. They had subsequently provided evidence of negative ethyl glucuronide testing in hair.

The panel viewed the paper:

Abstinence Monitoring of Suspected Drinking Drivers: Ethyl Glucuronide in Hair Versus CDT. Bruno Liniger, Ariane Nguyen, Andrea Friedrich-Koch and Michel Yegles. Traffic Injury Prevention, 11:123-126, 2010

In addition, previous Panel discussions on this subject and the European Guidelines for Drug and Alcohol testing in hair were considered.

It was agreed that in this case the hair test result could be accepted and a licence issued.

Hair testing from a reputable laboratory can be accepted as evidence in similar cases, where the information provided is considered reliable. However, it is not yet widely used clinically and it is currently considered to be too expensive to undertake these tests routinely for driving licence investigations.

15. B and D isoforms - guidelines for management of cases

The Panel were asked for advice on managing the few CDT cases where drivers are noted to have B and D isoforms of CDT which can cause falsely low or high results respectively.

The Panel asked for more information regarding the number of cases that this applies to as a percentage of the total CDT tests requested by DVLA. In addition it would be helpful to ask the laboratory to separate the B and D isoforms, as B is less important for our population.

16. Drug urine screens, should the sample be witnessed?

Following the publication of the European Guidelines for work place testing in urine, the Panel were asked for their opinion. The guidelines advise that the dignity of the individual must be respected '*whilst ensuring that the sample is freshly voided and has not been tampered with in any way.'*

'Procedures for collecting urine specimens shall allow individual privacy during urination and no observed collection is appropriate in normal cases….. If there is a strong suspicion of specimen adulteration and/or the previous specimen, collected from the donor, was adulterated the specimen can be collected under the direct observation of the collecting officer. '

Previous advice from the Panel has been that urine samples for DVLA drug screening examinations are witnessed samples and the franchise doctors undertaking these examinations are required to ensure that this is undertaken. However this advice was given 10 years ago. The drivers are advised in the referral letters that the sample will be witnessed when they attend.

It was suggested that we check what the franchise doctors are currently doing. It was considered that you cannot reliably say that any urine sample definitely belongs to the person who provided it unless you have actually seen the sample being given.

Clinically drug screens used to be witnessed but are not usually now, although every effort is made to ensure that the sample is valid.

Proportionality and case law need to be taken into account.

17. Audit of Audit 10

The AUDIT 10 questionnaire was introduced to our HRO and alcohol examinations following the Panel meeting in March 2015. The idea was that this would help with interpreting amber zone CDT results.

The Audit score refers to standard drinks: in the UK this is the Unit of alcohol (8g). The Panel considered an audit of the Audit 10 score in relation to CDT results in the amber zone cases, which was recently undertaken by one of the DVLA medical advisers.

The audit study undertaken questions the usefulness of the score in assessing fitness to drive. There appeared to be no correlation between the Audit score and the CDT result. The Audit scores were mostly less than 7 despite being applied to a high risk population i.e. HRO's. It was considered that the test rarely added anything useful to the case and could be used as evidence against the licensing decision.

The Panel felt that the AUDIT 10 score is an internationally and clinically validated test and did not wish to remove it from the questionnaire purely on the basis that it did not seem to correlate with the CDT results. It covers drinking behaviour over the last 12 months as opposed to the CDT which only covers recent use. Therefore they cannot be directly compared due to time frames.

However, the Audit score is a case identification tool used in primary care as a screening test, and the use of it in a situation where someone's driving licence is at risk may reduce its validity. Therefore if it isn't an accurate or useful addition to the investigation then it should be removed from the form.

It was felt that it would be useful to perform further statistical analysis of the results to see if any particular questions were of more use than others.

The SADQ or SAQ were mentioned as alternatives to the Audit 10.

18. Any Other Business

The Panel were asked, 'When does dependency stop being dependency?

There is an ICD code for alcohol dependence in full remission (ICD 10.202).

If you are dependent you are always suffering from the condition even if it is controlled, as there is an ongoing liability to relapse. The risk reduces with time. If the dependency has been controlled for a long time (a period of 10 years was suggested) then any new alcohol problem could be considered as misuse if no evidence of dependency is present at the time.

The more severe the dependency, the more likely it is that any alcohol use will result in a relapse.

19. Date and time of next meeting

Wednesday, 11 October 2017.

S Williams

DR S WILLIAMS MB ChB
Panel Secretary

9 June 2017

REFERENCES

Previous Panel meeting minutes are available at:
www.gov.uk/government/groups/secretary-of-state-for-transports-honorary-medical-advisory-panel-on-alcohol-drugs-and-substance-misuse-and-driving

Assessing Fitness to Drive - a guide for medical professionals
https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

Abstinence Monitoring of Suspected Drinking Drivers: Ethyl Glucuronide in Hair Versus CDT

Bruno Liniger, Ariane Nguyen, Andrea Friedrich-Koch and Michel Yegles

Traffic Injury Prevention, 11:123-126, 2010

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European Workplace Drug Testing Society.

25-11-01 Version 2

European Guidelines for Workplace Drug and Alcohol Testing in Hair

European Guidelines for Workplace Drug Testing in Urine

http://www.ewdts.org/ewdts-guidelines.html

Chief Medical Officers Low Risk Drinking Guidelines.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs_report.pdf

AUDIT 10

https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf

SADQ
https://www.alcohollearningcentre.org.uk/Topics/Latest/Severity-of-Alcohol-Dependence-Questionnaire-SADQ/

Short alcohol questionnaire

https://www.drinkaware.co.uk/selfassessment

NHS Choices
http://www.nhs.uk/conditions/Alcohol-misuse/Pages/Introduction.aspx

GMCguidelines on confidentiality.

http://www.gmc-uk.org/Patients fitness to drive and reporting concerns to the DVLA or DVA.pdf 69092316.pdf

Orange guidelines
Drug misuse and dependence UK guidelines on clinical management

www.nta.nhs.uk/guidelines-clinical-management.aspx