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

Held on Wednesday, 11 October 2017 11.00 am

Present:

Professor Eilish Gilvarry	Chair
Professor Kim Wolff	
Dr Alison Brind	
Dr Jane Marshall	

Ex-officio:

Professor D Cusack	National Programme Office for Traffic Medicine, Dublin
Mr Jai Nathan	Head of Drink Driving, DfT
Dr Sally Evans	Civil Aviation Authority
Dr Sally Bell	Chief Medical Officer Maritime & Coastguard Agency
Professor Robert Forrest	Assistant Coroner Sheffield & Hull
Dr Stephanie Williams	Panel Secretary, DVLA
Dr W Parry	Senior Medical Doctor, DVLA
Dr Anca Birliga	Medical Doctor, DVLA
Dr Cathy Armstrong	Medical Doctor, DVLA
Mrs R Toft	Driver Licensing Policy, DVLA
Miss N Davies	Head of Drivers Medical Group, DVLA
Mrs S Charles-Phillips	Business Change and Support, DVLA
Mr David P Thomas	Contracts Manager, DVLA
Mr Paul Davies	Service Management, DVLA
Mrs K Bevan	PA to Nadine Davies, Head of Group
Mrs S Taylor	Assistant PA to the Head of Drivers Medical Group, DVLA

1. Apologies for Absence

Apologies have been received from Dr P Rice and Dr C Gerada

2. Chair's remarks

Dr Gerada has withdrawn from the panel, and Professor Gilvarry has sent her a 'Thank you' letter for all her work.

Professor Gilvarry informed the panel about the recent Chairs meeting held at the DVLA in Swansea. Five of the six panel chairs were able to attend. The meeting included a tour of DVLA. Professor Gilvarry extended her thanks to the team involved for their warm welcome.

The future of panels was discussed including terms of reference. The potential merger with the Psychiatry Panel needs further consideration.

Nadine Davies, Head of Drivers Medical, tendered an open invitation to all panel members to come and visit DVLA.

3. Minutes of previous meeting

Corrections were made as below.

Page 2, paragraph 2 - should read Dr Mark Prunty as opposed to Mr Mark Prunty.

Page 6, paragraph 2 - take out 'of' between 'breath' and 'alcohol'.

AUDIT 10 should be in capital letters as it is an acronym and stands for Alcohol Use Disorders Identification Test. This information should be included in the narrative.

Otherwise the minutes were considered accurate.

4. Matters arising

These were considered as part of the general agenda.

5. Update on drink driving

Panel welcomed Jai Nathan, the new Head of Drink and Drug driving at DfT, who provided the following update: Enforcement and penalties in relation to drink driving are important and this remains the view for now, as they are delivering reductions in casualties. However there are public calls to lower limits for alcohol in England and Wales following the reduction in Scotland and Northern Ireland. A recent report from Parliamentary Advisory Council on Transport Safety (PACTS) highlighted the need to review drink driving as a whole.

The minister needs a full understanding of the background before moving forward, and is fully open to representation from key stakeholders.

Panel have been recommending the reduction of the drink drive limit for many years and the current expert panel members confirmed that they remain unanimous in this advice, whilst recognising the importance of enforcement and penalties. Reducing the limit is likely to have an effect on drinking behaviour.

Professor Cusack provided information on the situation in Ireland where the Blood Alcohol Concentration (BAC) limit has been reduced to 50mg in non-specified drivers and 20mg in specified drivers (novice, learner, and professional drivers).

6. Update on drink driving

Two Government commissioned drug driving reports were issued in August 2017 and are available on GOV.UK. The links can be found below.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/609852/drug-driving-evaluation-report.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/624915/expert-panel-report.pdf

The first evaluates the effectiveness of the new drug driving offence from March 2015, looking at the first year. It looks at operation and enforcement, public action and awareness, conviction and road collision data. Overall the new drug driving offence does seem to be effective and positive effects have been seen. There has been a high rate of prosecutions and conviction rates with police reporting a disruption in criminal behaviour.

The second report was chaired by Professor Kim Wolff and involved an Expert Panel review of alternative evidential samples. Blood is considered the gold standard. The report identified a future aim to look at oral fluids and hair testing.

The report considered the standardisation of collection methods, storage, and transportation. It recommended the use of oral fluid testing for illicit substances.

Jai advised that it was important that drug driving legislation be kept open to add new substances that are found to be dangerous to driving. An evidence based approach is needed. Consideration also needs to be given to how to manage alcohol and drug driving combined. For example, to apply a lower alcohol limit if drugs have also been taken, and /or higher penalties. Multiple substance misuse is not unusual. There is a huge increased risk when cannabis and alcohol are used together. A consultation is planned on this topic.

There has been a pilot of combined drink/drug driving rehabilitation courses which were well received by trainers and participants. The early report produced by the Driver and Vehicle Standards Agency (DVSA) is under review by DfT. To roll it out nationally would require changes to primary legislation.

Professor Cusack provided an update into the current situation in the Republic of Ireland. The legislation came into being in April 2017. Up to now the level of appeals for drug driving offences in Ireland has been lower than expected.

Ireland test for Cannabis (THC and THC acid), Cocaine/ Benzoylecgonine, and Heroin. They use oral fluid testing and are able to test at the roadside and in police stations. Mean Cannabis levels are around 4-7 micrograms per litre of blood (mcg/l) based upon early data.[1]

The legal cut off level of THC of 2 mcg/l is lower than the level at which impairment would be expected, at about 5mcg/l or above. By putting levels in legislation we are unlinking impairment from level and looking at 'risk' rather than impairment.

[1]In England and Wales the drug driving limits set in legislation are set at a level where a road safety risk is likely. Levels for prescription medications are above normal therapeutic ranges, while levels for illegal drugs such as THC are based on a 'zero tolerance approach' and limits are set above levels of accidental exposure.

7. Update on Panels

DVLA advised that the recruitment to the medical panels has always looked to follow the spirit of the Code of Practice for Scientific Advisory Panels (COPSAC) guidance. However, moving forward we intend to more closely apply the principles set out in the Governance Code on Public Appointments. This will provide increased assurance and confidence in the robustness and validity of the panels' advice. Draft proposals were discussed at the recent panel chair's meeting; changes were made and submitted to the minister for approval.

Changes to recruitment and the amount of time served by panel members have been considered. Panel chairs were asked to consider the current composition of their panels and to identify where additional expertise maybe needed. It was also recognised that some panel members were coming to the end of their membership and in order to ensure continuity they would be invited to extend their membership for a certain period of time.

The Alcohol Panel would like expertise in primary care, addiction psychiatry, hepatology/gastroenterology, neurology and a toxicology/legal expert/coroner. It would be preferable to have lay members who are involved in road safety in some way, ideally someone with expertise so they can be fully involved in panel discussions.

Panel discussed the future of the Psychiatry Panel and it was recognised that the standards have been relatively stable and membership has fallen off. There is an increasing focus around older drivers with our aging population, many of whom wish to remain mobile. Older drivers often have multiple medications and morbidity which spans all the panels. Frailty is now a diagnosis and early identification of cognitive issues is also important. There is clearly an identifiable need for guidance. This would need contributions from medicine for the elderly, neuropsychiatry and old age psychiatry.

8. Medical Standards Review

- **Alcohol Dependence**

Panel were asked to review the current standards for alcohol dependence. Panel confirmed that a one year period of abstinence was required for Group 1 and a three year period of abstinence for Group 2.

The twelve months period of abstinence required is based upon clinical data, comparing international driving guidelines, and judgment from clinical samples of the very high relapse rate in moderate to severe dependence. No one piece of research is available to quote as evidence. If someone can manage to abstain for a year, there is much less risk of relapse; therefore the longer term prognosis is good. In milder forms of dependence people usually do well.

The current published Group 2 standards say that the driver must be free from dependence. Based on the discussions, Panel agreed that the comment '**Abstinence is usually required, with normalised blood parameters if relevant,'** should refer to both Group 1 and Group 2.

Panel were asked for a view on how to determine a 'proven period of abstinence'. There is a wide variation in different countries on the interpretation of this. Hair testing and other tests can give the suggestion of abstinence or excessive consumption, but there is no clinical test that can prove abstinence.

It was recognised that you cannot say the person is not drinking unless you do serial tests. There is currently no requirement for specific monitoring of drivers' alcohol intake in between licensing investigations. However, there is a requirement on all drivers to notify the DVLA of any alcohol related problems.

Panel agreed that drinking regularly is not abstinence. Abstinence would be determined from self-declaration and from the medical reports. Where appropriate it was also recognised that CDT testing should continue to be used in the absence of regular testing.

The standard liver function tests used clinically may not be relevant for screening for alcohol misuse. Someone with alcohol problems may be abstinent at times, so they could have normal LFT's (liver function tests), or liver scans.

It was suggested that the time off driving should restart from the date of any relapse, unless it is specified that the relapse is just one glass or similar. If repeat detoxification is required for the relapse then the period of abstinence starts from the date of the most recent detoxification.

Medically assisted withdrawal means detoxification. Panel confirmed that this should be taken as evidence of dependence in the absence of CIWA scores to prove there were no symptoms of withdrawal. (The **Clinical Institute Withdrawal Assessment for Alcohol**, commonly abbreviated as **CIWA** or **CIWA-Ar** (revised version), is a ten item scale used in the assessment and management of alcohol withdrawal).

- **Persistent Misuse of alcohol**

Panel agreed our current triggers for investigation of alcohol problems.

- **Persistent misuse of drugs**.

The panel reviewed the guidance on persistent misuse of drugs and advised that if there is a recent history of persistent misuse then the driver should stop using all drugs before we can licence them as the risk is increased. If the history is a long time ago then occasional use may be considered acceptable.

It was recognised that it is worth asking for amounts of drugs used despite different strengths as well as frequency. Often a more detailed and narrative history is required to make a licensing decision. Cocaine is often used with alcohol. If medical or other support is required to stop using Cocaine then this suggests dependency.

Panel agreed that the current standards for misuse should remain unchanged.

- **Drug and alcohol induced seizures**

This was discussed at the March meeting and advice from the Neurology Panel was requested regarding alcohol withdrawal seizures. It was confirmed by the Neurology Chair that these are not classed as provoked, and therefore for a solitary seizure six months off driving was required for ODL and five years for VOC in line with current legislation. For more than one seizure then the full seizure standards are applied.

It was noted that for alcohol withdrawal seizures, a one year period of control would be required for the associated alcohol dependency, extended to three years for Group 2. It was felt that the period of five years off for a seizure that was clearly due to alcohol withdrawal (e.g. during detoxification treatment where inadequate benzodiazepines had been prescribed) was too long and further discussion was needed with the Neurology Panel to see if this could be reduced to three years.

It was pointed out that alcohol withdrawal seizures are different from alcohol or drug induced seizures where there is no dependency involved or withdrawal effects. The issue is whether the latter cases have an underlying liability to ongoing seizures which would put them into the legal category of solitary seizure requiring twelve months off driving. It is the intention to seek advice from the Neurology Panel.

There was a discussion around drug and alcohol induced seizures which occur during sleep, and without any background of persistent drug or alcohol misuse. The law has a concession for drivers who have a pattern of sleep seizures only.

It was pointed out that alcohol and drug induced seizures do not usually occur during sleep, and that sleep seizures are a particular type of seizure with an increased risk of death.

It was suggested that it would be helpful to have a neurologist as a panel member to provide advice on these issues.

9. CDT Update

Information given to drivers and doctors

This was discussed at the last panel meeting. Following the identification that High Risk Offender (HRO) drivers were contacting DVLA for the results of their %CDT test and asking for advice as to what it meant. DVLA wished to provide this information to the drivers, who could then be told to see their own GP to get advice on the meaning of the results. The BMA were concerned that this would put more pressure on GP's.

Following the panel discussion a response was drafted to the BMA to advise that we would provide a leaflet to the driver containing information about the meaning and interpretation of the test.

The aim is to increase transparency of testing for HRO and other drivers. Self help information would be provided which would help to explain why their %CDT level doesn't comply with licensing.

Panel confirmed their previous advice that the person should be provided with this information. This is considered to be a public health issue, identifying people with probably a significant alcohol problem. They felt it was also right to send a copy to the GP telling them the patient has been given this information, what it means, and that they have been advised of self help websites.

The GMC view is that we should not withhold relevant information from a driver's doctor.

The discussion stressed the importance of having someone with primary care expertise on the panel. An opinion was expressed that the %CDT result does place some responsibility on the patient's doctor as it is a clinical issue. It was felt that it was not our remit to give clinical advice.

The wording of the current draft letter/leaflet was considered by the panel and panel advised that the %CDT relates to alcohol intake over the last month.

- **Guidelines for interpreting B and D isoforms**

At the March meeting panel were asked for advice on managing cases where drivers had the B or D variants of CDT which can cause falsely low or high values. Further information from the laboratory was requested.

The laboratory cannot currently separate the isoforms. 1.6% of the total results were B and D isoforms, which amounted to 1700 plus cases in total since we started using %CDT.

An audit of isoform cases from March 2017 showed that in the majority of cases the %CDT was less than 1.6. Panel discussed the requirement to know what variant the driver has as it may affect the licensing decision and as it can have an impact on patient management.

Demographics of the drivers are not known currently. This information would be useful. Panel asked if it is legally or politically possible to ask for ethnicity on the forms. Knowing the driver's ethnicity would help to reduce inequalities in managing cases and would help to make the licensing decision. Especially as in 10% of Africans the D isoform is present.

The following research paper was considered as part of the discussion;

Association of Alcohol Consumption with Specific Biomarkers: A Cross-sectional Study in South Africa. Pedro T. Pisa, Hester H. Vorster, Annamarie Kruger, Barrie Margetts, Du T. Loots.J HEALTH POPUL NUTR 2015 Mar;33(1):146-156

The paper was considered interesting and supports the use of ethnic questions on our questionnaires. However, the study used different alcohol use criteria, and very old references.

Panel were asked whether we could have a different amber zone for these cases. It was felt that it would be better if we were able to identify what the variant was, either if we had ethnic data or the lab could separate the isoforms.

10. CDT Specification

The panel were asked to review the current CDT contract specification.

Panel agreed the technical sections for CDT specification.

The panel were advised that it is the intention to hold a supplier day before publishing the tender for a new contract.

Panel confirmed that %CDT measurement will be useful and will be used for the foreseeable future at least. It is currently used by regulatory boards. Potential new markers were discussed include PEth (Phosphatidylethanol) testing. These could be used as complementary investigations to an abnormal %CDT on the sample already taken.

11. AUDIT 10 Audit (AUDIT - Alcohol use disorders identification test)

Dr Wiles, DVLA Doctor, has undertaken an audit of the AUDIT 10 scores obtained at the DR3 medical examination versus the %CDT results. This was originally presented at the March 2017 panel meeting.

Further data and statistical analysis have been undertaken which again showed no correlation between the results of the two tests. The AUDIT score is considered to be a very useful, gold standard for screening for alcohol problems in the clinical setting.

However it was recognised that there can be discrepancies between the AUDIT score and the CDT result. This is because the AUDIT score covers a much longer period, whereas the %CDT is more recent, or it could be due to inaccuracies in the information provided by the driver. The study would be affected by the small number of cases studied or biased data. The use of different statistical tests was suggested.

The panel has requested a narrative or executive summary of the data, with formal feedback from Dr Wiles at the next panel meeting.

12. Drug Urine Screens

At the last panel meeting the panel were asked whether or not DVLA drug urine screen samples should be witnessed, following the publication of the European Guidelines for work place testing in urine in 2015 which suggested that the dignity of the individual should be respected '*whilst ensuring that the sample is freshly voided and has not been tampered with in any way.'* A link to the guidelines can be found below:

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

Panel advice at the time was that a legal opinion should be sought and that we should find out what the individual franchise doctors are doing to see if a change in practice is needed.

DVLA confirmed that we should follow the EU guidelines.

Current practice amongst Franchise Doctors is as follows:

Individuals have no access to any water source i.e. basin.

There is dye in the toilet bowl.

No soaps, disinfectants or cleaning products are provided.

No bags/coats etc to be taken into the collection area.

A check is made to ensure nothing is concealed in the patient's clothing/pockets.

Samples are witnessed with the collector being in the direct vicinity, either with or without the use of a screen to provide privacy for the patient.

Samples are witnessed by direct observation by the collector.

The importance of ensuring tests are conducted correctly was discussed, recognising the road safety implications. Family services often ask for supervision of their drug screens as the courts do not like non-supervised testing. Some who undertake screening are careful to make sure that the sample has not been tampered with, others are not as careful. There is enormous variability in methods. The only way to prove that a urine sample is truly valid is to watch it being passed.

Panel advice was that DVLA should aim to reduce the variability in the methods used to confirm reliability of the specimen, and try to standardise this.

The point was raised that Pilots may be asked to undergo three monthly hair testing plus urine testing.

It was considered that if random testing for pilots is introduced, then the DVLA may need to consider this for large truck drivers. Train drivers already undergo random drug tests.

However, routine screens do not test for novel psychoactive drugs, Gabapentinoids, Fentanyl type drugs. This is a good reason for not having a fixed standard battery of drugs tested.

Oral testing and fingerprint (sweat) drug testing were discussed and were considered to be quicker and easier but they do have a shorter window of positivity.

13. Orange Guidelines

The new guidelines were published in July 2017. A working party is planned to consider these with regard to the driving standards.

14. Methadone Standards

Panel were provided with data relating to numbers and licensing decisions for drivers on methadone or buprenorphine programmes. It was agreed that it was necessary to look at the standards and questionnaires with a separate teleconference to discuss these following the release of the Orange Guidelines.

It was confirmed that intravenous, intramuscular and subcutaneous use of Diamorphine is not acceptable for licensing purposes if used as part of a drug treatment programme. We may change the wording to say that parenteral use is not acceptable.

15. Toxicology Contract Specifications

This was reviewed by panel. Lysergic acid diethylamide (LSD) has been removed from our current list of drugs tested. The type of drugs of abuse used keep changing. In particular many newer drugs are not on our list. Novel psychoactive substances such as cathinones, synthetic opioids, synthetic cannabinoids, and benzodiazepines may not be picked up by standard immunochemical screens. Bigger labs are moving to liquid chromatography with mass spectrometry (LCMS) screening.

16. Anabolic Steroids and Novel Psychoactive Substances

This topic has been reviewed by the panel on a number of occasions in the past and they were presented with previous panel minutes regarding these discussions.

Anabolic steroids are now class C drugs. Panel were asked for advice on when we should class use of these drugs as misuse/dependency for licensing purposes. The question was asked as to whether there has to be evidence of harmful use.

Panel felt that the C classification was probably based upon the metabolic and organ affects rather than concerns likely to affect driving. Users may develop cardiovascular and neurological problems down the line.

If individuals were prescribed anabolic steroids they should be considered in the same way as any other prescribed drugs.

In general for licensing purposes we do not require evidence of harm to diagnose persistent misuse of illicit drugs. Therefore, regular use would count as persistent misuse, but evidence that this would affect driving is weak. There is an association of anabolic steroid use with other drug misuse. Panel asked for a review of other EU guidelines and research before deciding whether a driving standard was needed for these drugs.

Anabolic steroids are not considered with regard to driving in Ireland.

Panel advised that novel psychoactive substances should be classified for driving purposes in the same way as the parent compound they are meant to mimic. For example, cannabinoids, stimulants, opioids and benzodiazepines. However it was recognised that there is difficulty in proving such use.

17. Cases

Five cases were discussed in full by the panel.

Two related to drug treatment programs, two cases were discussed as part of the section on alcohol dependence and one case was discussed with regard to driving while taking part in new drug trials.

18. Appeals data

At the Panel Chairs' meeting information on appeals was requested by the chairs so that any issues raised by these appeals can be brought back to the panel for lessons learnt.

Drug and alcohol related cases make up about half of all DVLA medical licensing appeals.

Four appeals have been upheld in the 2016/2017 timeframe. One of these related to alcohol use and %CDT measurement. Two were related to processes rather than medical condition per se.

It was recognised that there is a tremendous amount of work involved in preparing for these appeals.

19. Research and Literature

Two papers were considered, these were:

FIRST OBJECTIVE ASSOCIATION BETWEEN ELEVATED CARBOHYDRATE-DEFICIENT TRANSFERRIN CONCENTRATIONS AND ALCOHOL-RELATED TRAFFIC ACCIDENTS.

Bortolotti F, Micciolo R[2], Canal L[2], Tagliaro F[1].

Alcohol Clin Exp Res. 2015 Nov;39(11):2108-14. doi: 10.1111/acer.12879.

and:

Association of Alcohol Consumption with Specific Biomarkers: A Cross-sectional Study in South Africa.
Pedro T. Pisa, Hester H. Vorster, Annamarie Kruger, Barrie Margetts, Du T. Loots.

J HEALTH POPUL NUTR 2015 Mar;33(1):146-156
ISSN 1606-0997

Important: These advisory notes represent the balanced judgement of the Secretary of State's Honorary Medical Advisory Panel as a whole. If they are quoted, they should be reproduced as such and not as the views of individual Panel members.

20. References and Web Links

http://www.pacts.org.uk/

http://www.pacts.org.uk/wp-content/uploads/sites/2/129256_PACTS_50YearsBreathalyser_V5.pdf

21. Any other business

Biographies of panel members were requested for reference. These could be made available on line to illustrate the expertise of the panel.

22. Date of next meeting

Wednesday 21st March 2018

Original Draft Minutes prepared by: **Dr Stephanie Williams**
Panel Secretary

Date: 25th November 2017

Final Minutes signed off by: **Professor Eilish Gilvary**
Chair

Date: 3rd April 2018.

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