DRAFT

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

WEDNESDAY, 21 MARCH 2018

Present:

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

Ex-officio:

Professor Denis Cusack	National Programme Office for Traffic Medicine
Dr Stuart Mitchell	Civil Aviation Authority
Ms Carolina Castillo	Department for Transport
Professor Robert Forrest	Assistant Coroner (Sheffield & Hull)
Dr Sally Bell	Maritime & Coastguard Agency
Dr Stephanie Williams	Panel Secretary
Dr Wyn Parry	Senior DVLA Doctor
Dr Ben Wiles	DVLA Doctor
Dr Elliott King	DVLA Doctor
Dr Karen Davies	DVLA Doctor
Mrs Rachael Toft	Driver Licensing Policy
Mrs Emma Melrose	Head of Drivers Medical Group
Mrs Kay Bevan	PA to Mrs Emma Melrose
Mrs Sue Charles-Phillips	Business Change, DVLA
Mrs Lorraine Jones	Panel Co-ordinator
Mr David Thomas	Contracts Manager
Mrs Sian Taylor	DVLA Doctors Support

Introduction, Chair's remarks and apologies for absence

Apologies have been received from Dr P Rice and Dr Colin Graham

1.Minutes and actions from last meeting.

The previous panel meeting minutes have not yet been signed off as there were some queries which needed to be finalised. Following further discussion Professor Cusack confirmed that in Ireland the Blood Alcohol Concentration (BAC) limit has been reduced to 50mg in non- specified drivers and 20 mg in specified drivers (novice, learner, and professional drivers). The October minutes have been amended to reflect this.

2. Department of Transport update.

Panel welcomed Ms Carolina Castillo who provided the following information.

On 8 February, the Government released provisional figures for 2016 drink driving collisions in Great Britain. These figures are based on a small sample of toxicology reports from coroners and procurators fiscal and also breath tests taken at the scene. The figures should therefore be interpreted with some caution.

In 2016, the number of people killed in road collisions where at least one driver was over the drink-drive limit is provisionally estimated to be between 200 and 280, with a central estimate of 240 deaths. This provisional estimate represents a statistically significant increase from 2015 (200), although compared to the five year drink drive casualty average for the years 2010 to 2014, the provisional figures for 2016 represent a 2% statistically significant reduction.

The total number of collisions where at least one driver was over the alcohol limit rose by 6% to 6,080 in 2016. This increase is statistically significant.

The final drink driving figures for 2016 will be published in August 2018 and will provide an accurate set of results for that full year.

In the 6 months prior to panel there have been 4 drink and drug driving campaigns, the aim of which has been to reinforce social unacceptability and ramifications.

Ms Castillo also confirmed that there are no plans to reduce the drink driving limit in England and Wales. Panel expressed their disappointment at this news.

DfT is undertaking research on drink and drug driving matters in lieu of a consultation mentioned in the previous panel meeting. This has been postponed.

Commencement orders enabling the introduction of section 5A of the Road Traffic Act 1998 for Scotland and Northern Ireland commenced on 1 March 2018.These extend the existing drug driving legislation to Scotland and NI, which means that the specified drugs and limits that apply in England and Wales can also be introduced in Scotland and NI.

Following the DFT update, Professor Kim Wolff gave a summary of the Drug-driving legislation introduced in March 2015 and recommendations from the latest expert panel reviewof alternative biological matrices for use as an evidential sample for drug driving.

Reference RM4825 SB-2988. Kim Wolff et al, 2017;
https://www.gov.uk/government/publications/review-of-oral-fluid-alternative-biological-matrices-for-drug-driving

In the 18 months since the new legislation was introduced, 94% of those arrested on suspicion of drug-driving were male. 73% were white Northern Europeans of which 48% were British, and 7% of the total were Asian. The mean age of arrestees was 29 years for men and 32 years for women.

There were 1718 positive evidential blood tests submitted for analysis, of which 68.4% were over the specified drug-drive limits. LSD, flunitrazepam and clonazepam were not detected.

Cannabis was the most common substance detected (57% of the total positive tests), cocaine and benzoylecgonine combined accounted for 29% of the total positive tests and 32% of these were above the specified limit.

The report recommended adding amphetamine type drugs and ketamine to the current roadside screening panel of THC, cocaine and benzoylecgonine to reflect the growing use of these compounds in the driving population.

The conclusion was that oral fluid would only be useful for evidential testing for illicit drugs when the lowest limit of quantification (LLOQ) or limit of detection (LOD) was used reflecting a zero tolerance approach.

With regards to medicinal substances, levels are designed to reflect impairment, the so called Per Se limits. Whole blood is the best matrix to use for this.

However the science of oral fluid is currently not good enough to quantify levels consistent with impairment, so can be used for zero tolerance testing only. Oral fluid has the potential to be quantifiable in the future.

Sweat testing, dried spot blood test or latent finger print can also be used for screening but are not yet quantifiable.

Hair testing cannot be used to relate drug use directly to road traffic incidents as it takes 7 days for a drug to be incorporated into hair. However it could be used for medical assessment prior to relicensing and is currently used in many EU states.

The report also highlighted that poly substance misuse is common but confirmatory testing results tend to be below the threshold levels. Some countries use additive limits for drug classes.

The panel recommended looking at penalties for alcohol combined with other drugs. Alcohol and cannabis use together is a particular problem when driving. There is also evidence of driving impairment from the use of Z drugs (zopiclone). In addition it was highlighted that there has been a large increase in prescriptions of sedating drugs such as pregabalin which can be abused.

Panel chair thanked Professor Wolff for providing such a comprehensive overview of her report.

3. Medical standards review including AFTD.

Definition of controlled drinking for persistent misuse of alcohol

The published standards require 'controlled drinking' where there is a diagnosis of persistent misuse, but do not specify what this means.

Panel were asked for a definition and suggested:

Drinking within government recommended health guidelines which are currently 14 units per week.

Wording for alcohol dependence standards

At the last meeting it was discussed whether we should remove the word 'usually' from the wording. Further discussion took place and it was agreed that it should be removed as the definition of abstinence had already been discussed at the previous meeting.

4. CDT update.

Panel were asked whether repeating the %CDT blood test in the 'amber zone' High Risk Offender cases would increase the sensitivity and specificity of the test. The sensitivity and specificity figures provided relate to the test itself so these figures would not change. However repeating the test could be helpful.

It was confirmed that a CDT% of 1.6% or over is definitely not consistent with abstinence.

5. CDT information letters.

The wording and format of the CDT information letters/leaflets has been amended following suggestions at the last panel meeting. Further amendments were suggested.

6. Methadone standards.

Prior to this panel meeting a telephone conference took place to review the existing standards. The panel chair highlighted the benefit of this approach as it enabled panel members time to focus and allowed a more in depth debate. The relevant standards follow and are highlighted in bold text.

The treatment programme is supervised by a consultant or specialist GP

Policy confirmed a report can be completed by a Heath care practitioner or nurse but has to be countersigned by a doctor.

The treatment is for management of opiate dependence (whether illicit, prescribed or over the counter)

Oral treatment only, not parenteral, but naltrexone implants may be considered. There has been compliance with the programme. (Adherence to prescription and appointments, and toxicology testing with sustained stability)

Panel advised that full compliance is rare. There was some discussion around instances where discretion could be applied. DVLA would need guidance from the panel on what this means to ensure consistency. Panel wish to consider example cases before providing further guidance. Panel secretary agreed to present cases for discussion at the next meeting.

No non prescribed psychoactive drug use during the programme or extra use of prescribed drugs such as methadone, buprenorphine, benzodiazepines

There is no toxicological evidence of drug misuse

It can be difficult for DVLA to obtain results of random drug urine tests. The driver's GP may not have sight of or access to the test results and DVLA cannot always get a report from the drug treatment clinic. In this situation it was considered that the driver could obtain the results themselves and provide to DVLA.

It was discussed that many of the tests are not confirmatory. Often point of contact testing is used which is not quantitative and is not usually sent to the laboratory for a full screen.

There is no adverse effect from treatment likely to affect safe driving

There is no alcohol misuse or dependence

There are no other relevant medical conditions e.g. mental health issues

There should be no other disqualifying conditions

Panel advised that the above should include seizures and cardiac problems e.g. long QT syndrome due to medications.

7. Discussion.

It was highlighted that DVLA should continue to review drivers for the first year after the treatment programme has finished as the risk of relapse is high initially. Weaning off programmes can be very slow. If a quick detoxification is undertaken or the driver is just starting treatment then they should not be driving.

Panel were asked if there could be any flexibility in the requirement for 12 months stability on the programme. Panel advised that each case can be considered individually if necessary

but it was pointed out that the NTORS study demonstrated positive changes in behaviour after 12 months.

Panel also advised that misuse of over the counter drugs such as codeine should be considered under the same standards if opioid substitution therapy is required.

Panel were asked about use of Fentanyl patches prescribed for pain in people with a past history of opioid dependence. Panel advised these should be considered as per any other prescription for pain. However it is a drug of abuse and should be used with caution.

Professor Wolff provided a summary of her pharmacy study mentioned in previous minutes. The study looked at 30 community based pharmacies in greater London. Methadone patients and pharmacists were interviewed with regards to their knowledge of drug driving and legislation. Of those collecting a prescription for methadone 30-50% were driving to collect their medication, more than had been previously thought.

8. AUDIT 10 audit -at the request of the Panel following the October 2017 meeting.

Dr Wiles provided further data and statistical analysis of his audit of AUDIT 10 scores versus %CDT results. The AUDIT 10 is useful in a clinical setting to screen for and identify people in a high risk group for alcohol intake. However, our cases are already in a high risk group.

It was recognised the %CDT and AUDIT 10 scores have different contexts and time frames.

However there were a number of people with very low or zero AUDIT 10 scores despite having amber zone %CDT results.

It was concluded that there was no statistical correlation between the two results.

It was also noted that splitting the questions into groups did not affect the result.

9. CASES for discussion.

4 cases were discussed, two related to opioid drug treatment programmes in group 2 drivers. One related to prescribed benzodiazepines over recommended limits and one to multiple drug use and psychosis.

Panel would like to discuss the standards for poly drug use further at the next panel meeting.

Standards currently do not specify what is meant by multiple substance misuse. Currently these cases require one year of control before a licence can be issued.

10.Laboratory Data.

The laboratory has provided a written update about changes to our current screening panel of drugs. Drugs added include pregabalin, gabapentin, mirtazapine, quetiapine, promethazine, clonazepam and other benzodiazepines and fentanyl. Some are prescription

drugs which are becoming drugs of abuse due to misdirection. We do not currently have driving standards for misuse of these drugs. Panel advice was that they should be considered in the same way as similar illicit drugs within the same category such as stimulants, benzodiazepines, opioids.

11.Research and literature review.

There were no additional papers considered other than those mentioned below.

12. Recruitment Update.

Current panel members confirmed that they have been asked to extend their time on the panel for several years. Recruitment is ongoing.

The psychiatry panel is to continue as a separate panel.

13. Any other business.

Policy advised that they had contacted EU countries regarding their driving standards for misuse of anabolic steroids. Five responses had been obtained. Four have no specific provision. One country, Sweden, consider anabolic steroids as having the same driving risks as other illegal drugs and apply the same standards.

This topic is to be discussed again at the next meeting.

With regard to capturing ethnicity data on medical questionnaires to help with identifying B and D isoforms of CDT, policy advised that we need to explore if this data can be found elsewhere. If this was not possible, there would need to be a clear clinical basis for requesting the information.

Date of next meeting Wednesday 17th October 2018. Dates for March 2019 to be considered.

References:

Reference RM4825 SB-2988. Kim Wolff et al, 2017;
https://www.gov.uk/government/publications/review-of-oral-fluid-alternative-biological-matrices-for-drug-driving

http://www.ntors.org.uk/
https://www.gov.uk/government/publications/summary-of-key-findings-from-the-drug-treatment-outcomes-research-study-dtors

Original Draft prepared by: Dr Stephanie Williams
Panel Secretary

Date: 16th April 2018

Final Minutes signed off by: Professor Eilish Gilvarry

Chair:
Date: 23rd May 2018

Dr Stephanie Williams
Panel Secretary: