Expert Panel on Drug Driving – approved minutes of 21 August 2012 meeting, 11:30 – 16:00

Venue: Department for Transport

Attendees:

Dr. Kim Wolff, Chair (King's College London)
Dr. Lily Read (Northampton Healthcare NHS Trust)
Professor Robert Forrest (Sheffield University)
Dr. Judith Morgan (DVLA)
Professor Atholl Johnston (Barts & London School of Medicine, Queen Mary University)
Dr. Roger Brimblecombe (ACMD representative)
Professor David Osselton (Bournemouth University)
Dr. J. Colin Forfar (CHM representative)

Xxxxx Xxxxxxx (DfT)
Xxxxxxx Xxxxxxxxxxx (DfT)
Xxxxxx Xxxxx (DfT)
Xxxxxxx Xxxxxx (DfT)

Mark Prunty (DoH) - Observer

Apologies:

Honorary Professor Eilish Gilvarry (Newcastle University)
Xxxxxx Xxxxxxx (Centre of Applied Science & Technology)
Professor David Taylor (South London and Maudsley NHS Foundation Trust)

1. Approval of Minutes from the previous meeting and matter arising

The draft minutes of the meeting on 23 July 2012 were agreed, subject to amendments to the units of measurements quoted in the tables.

After a brief discussion about units of measurement of drug concentrations it was agreed that mass units (either nanograms (ng), micrograms (ug) or milligrams (mg)) per litre of blood should be used for recommended limits.

[Action: Xxx Xxxxxxxxxxx would try to share data on polysubstance use ahead of publication of the ACMD paper.]

2. Teleconferences with international experts

Two teleconferences were carried out by the panel, with Xxxxxxxx Xxxxx Xxxxx from Xxxxxxxxxx and Xxxxxxxx Xxxxx Xxxxxxxxx from Xxxxxxx. Separate records of these discussions have been produced.

It was noted by the panel that regulatory structure in relation to driving legislation for both the Netherlands and Belgium are fundamentally different

from that in the UK making comparisons between practice in the UK and these two countries difficult.

3. Epidemiological Evidence

A table showing data from the drink drive High Risk Offender (HRO) scheme was discussed. This showed self-reported use of drugs by drivers on the scheme during one random week, indicating use of no drugs, cannabis, cocaine and heroin or other drugs. Cannabis use was most frequently reported by those in the HRO scheme. A correction was raised by Xxxxxx Xxxxxx, changing the sum total for cannabis to 91.

An updated report based on British Crime Survey data for 2009/10 and 2010/11 was presented containing further details as requested during the panel meeting of 23 July 2012. It was noted that data showing a breakdown by age group should be interpreted cautiously due to the low numbers of respondents.

A literature review produced by Clockwork Research for the panel was discussed. This report was found to be useful, especially information reproduced from Elvik 2012 on odds ratios. Panel members agreed that Clockwork should be asked to assemble all available odds ration data from different sources for each of the key drugs in the Panel's Terms of Reference.

Xxxx Xxxxxxx reminded the panel that the agreed methodology was that where there was evidence of a dose response for a drug, a level associated with road traffic risk would be identified and a corresponding limit set. If no odds ratio data was available for a drug, but there was still evidence of a significant behavioural change in those using the drug then it would be appropriate for the panel to recommend a limit related to an analytical cut-off level.

Action: Xxxxxxx to source and circulate the Elvik report
Xxxxxxx and Xxxxx to meet with Clockwork to discuss additional material requirements

Xxxxxxx provided a short summary of the data from a small study of drug prevalence involving voluntary screening of persons in police custody who were being screened as part of the Home Office Drug Intervention Programme (DIP). It was noted that the sample of people tested was not representative of the general population nor of drug drivers. The drugs most commonly detected were cannabis, cocaine and opiates.

The panel then discussed a recent paper by Transport Research Laboratory (TRL) on alcohol and drugs in road fatalities based on 2010 forensic data. This was found to be very useful. The panel requested that the data be broken down to show data for drivers (currently included all types of road users incl. pedestrians and passengers). Panel members asked about the definition and grouping of drugs used in the paper, which needed to be

clarified. Xxxxxxx explained that the paper would be published and shared with Coroners.

Action: Xxxxxxx would ask TRL for the following information: a new version of table 11 showing drivers only; the definition of the category of therapeutic drugs called non-benzodiazepines; clarification and rationale of the split between therapeutic opioid drugs and opioid drugs of abuse.

4. Scientific literature and evidence for specific drugs:
a) benzodiazepines

The panel considered the notes from the meeting with Xxxx Xxxxxxx Xxxxx on 13 August 2012. Xxxx xxxxx had pointed to road safety ratings of medicinal drugs by the International Council on Alcohol, Drugs and Traffic Safety (ICADTS), which had been circulated to the panel. This categorised different benzodiazepines according to their road safety risk. Xxxx Xxxxx had also pointed out that for elderly drivers the road safety risk associated with benzodiazepine use was multiplied. It was noted that according to the ICADTS Diazepam, Oxazepam, Lorazepam, the Z-drugs and indeed all of the drugs in the panel's terms of reference were rated 'III' and considered dangerous to consume when there was an intention to drive.

A paper about benzodiazepines and driving was circulated by Xxxx Xxxxx. It was noted that there good scientific evidence regarding use of benzodiazepines and driving. Five large case control studies indicate BZ use approximately doubles the risk of a RTA (ORs 1.45 to 2.4). In apprehended drivers in Norway (adjusted for all background variables) there was increased risk of Diazepam (OR: 1.61 (n= 411;P< 0.001); Oxazepam OR: 3.65 (n= 73; P < 0.05) and Flunitrazepam (OR: 4.11 (n= 211;(P < 0.05) use.

It was noted that the use of any benzodiazepine in combination with alcohol significantly increased the risk of a RTA. In a study in the UK, Tayside police (19, 386 drivers involved first RTA) the risk of being involved in a RTA was increased 8 times if benzodiazepines were detected alongside alcohol use (OR; 8.15, 2.06-32.34). The Benzodiazepine/driving collaboration group (1993) noted that the responsibility for a RTC was twice as likely if benzodiazepines were detected with alcohol levels between 0.2-0.8g/L (OR: 2.0) and 7 times as likely if benzodiazepines were detected with alcohol level above >0.2g/L (OR: 7.0).

It was additionally noted that the scientific literature reported that flunitrazepam has an increased risk of RTA compared to other BZ (OR: 4.11, P < 0.05) and that the prescription of the short acting antidepressant drug zopiclone significantly increases the risk of a RTA (OR: 4.00, 1.31 – 12.2).

In order to decide which benzodiazepines should be recommended by the panel for inclusion in the new offence data about their prevalence among drivers should be taken into account. Specific limits based on road safety risk

would be set for the most prevalent controlled (by the Misuse of Drugs Act 1972) benzodiazepines.

It should be noted that certain benzodiazepines have common metabolic pathways so that more than one benzodiazepine could be detected in biological fluids following the consumption of one medication.

Polysubstance use was then discussed in the context of benzodiazepines. It was noted that the combination with alcohol significantly increased road safety risk. The panel agreed that the presence of alcohol could usefully be defined as a concentration in excess of the low limit already used for some aviation purposes, i.e.,20 milligrammes of alcohol per 100 millilitres of blood. This could then be combined with a lower limit for the drug (as compared to the limit for the drug on its own). This lower limit might be set to capture any trace of the drug (i.e. minimum limit of detection/ analytical threshold) depending on what the evidence about road safety risk suggests.

b) Opioids – methadone

The panel heard a presentation by Xx Xxxx on the drug methadone in the context of drug driving. There was significant research available. If a patient was stabilised on methadone, i.e. had been on a stable dose for around 3 months, and did not use other drugs or alcohol in combination, there was no evidence of impaired driving.

It was noted that there was no agreement in research about whether a dose-response relationship existed with regard to driving behaviour. There was a lot of evidence available as to the significant additional road safety risk when methadone was combined with alcohol. Odds ratio data was available from the European DRUID project about medicinal opiates and illicit opiates.

Evidence was noted from the previously considered Dutch report (31 March 2010) that noted the relative risks as an odds ratio (OR) for involvement in, responsibility for or injury as the result of a traffic accident when driving under the influence of a drug (as below).

Opiates	OR: 2.35 (95% CI: 0.87-6.32)
	OR: 1.41 (95% CI: 0.7-2.9
-morphine	OR: 32
-morphine □ 20 micrograms/l	OR: 8.2 (95% CI: 2.5-27.3)

Action: Xx Xxxx to provide paper on methadone; Xxxxx Xxxxxxx to provide paper on z drugs.

The UK guidelines on clinical management of drug dependence, or “orange” guidelines, classified opiates and methadone specifically as low to moderate risk in relation to driving when the medication was taken as prescribed. It was noted that newer guidelines were available from the General Medical Council.

The panel agreed that it might want to make a recommendation that the DVLA's guidance (At a glance guide to current medical standard of fitness to drive) in relation to therapeutic drugs needed to be strengthened.
The panel agreed that it might recommend that the drugs covered by the offence should be reviewed periodically, for example five years after the initial regulations.

The panel considered feedback from the representations by NAPP Pharmaceuticals and the British Pain Society was given and a paper summarising the literature. These organisations emphasised that the chronic pain, which opioids are often prescribed to alleviate, can in itself be impairing of a sufferer's capacity to drive. They also claimed that fitness or unfitness to drive for those on opioid pain medication was dependent on a number of factors, such as the time a patient had been on prescribed medication and the length of period of stabilization on the dose.

The panel discussed the literature review and summary paper on opioids and driving submitted by Napp. It was noted that the paper concentrated on the issue of impairment, which was not a core issue for the panel.

The panel concluded that opioid drugs raised some difficult questions, for example the synthetic opioid fentanyl, which is a very powerful short acting drug. It was agreed that certain individual types of opioids might have to be considered separately. Evidence was clear with regard to the use of opioid drugs in combination with alcohol. There was a clear increase in road safety risk when opioids were combined with other drugs or alcohol.

5. Policy update

Xxxxxxx said that there were no policy developments to update on. A number of background papers had been circulated to the panel. This included a paper showing all amendments proposed by members of the House of Lords about the drug driving provisions in the Crime and Courts Bill in detail. This supplemented the oral update on the Lords debate provided at the panel meeting of 23 July.

The published specification for drug screening devices based at police stations had also been circulated for background. This was not discussed in detail.

Finally, the response by the ACMD to questions on drug driving contained in the DfT's 2008 Consultation on Compliance with Road Safety Law had been circulated for information.

6. AOB

Xxxx Xxxxx asked panel members about their availability for an additional meeting in September. The secretariat would e-mail to find and arrange an additional meeting which most members could make.