

**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, 17 OCTOBER 2018

Present:

Professor E Gilvarry	Chair
Professor K Wolff	
Dr J Marshall	
Dr E Day	

Lay members:

Mr A Elghedafi

DVLA:

Dr S Williams	Panel Secretary
Dr N Jenkins	Interim Senior DVLA Doctor
Dr C Maginnis	DVLA Doctor
Mrs S Charles Phillips	Business Change & Support
Mrs R Toft	Medical Licensing Policy
Mrs L Jones	Panel Co-ordinator
Mr D Thomas	Contracts Manager
Mr I McTaggart	Service Management

Ex-officio:

Dr S Bell	Chief Medical Officer, Maritime and Coastguard Agency
Claire Rees	Head of Road Safety Strategy, DfT
Phillip Vine	Road Safety Strategy, DfT
Professor R Forrest	Assistant Coroner in Sheffield and Hull
Dr S Mitchell	Civil Aviation Authority
Professor D Cusack	National Programme Office for Traffic Medicine, Dublin

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1. Apologies for absence

Apologies were received from Dr A Brind, Mr K Rees (Head of DMG, DVLA), Dr A Birliga, Keya Lianne Nicholas.

2. Chair's remarks

Professor Gilvarry wanted to express huge thanks to Dr Wyn Parry who has retired as Senior DVLA Doctor for his kindness, wisdom and guidance to the Panel over the years. She also welcomed Dr Nick Jenkins who is the Interim Senior DVLA Doctor. Professor Kim Wolff attended the Panel Chair's meeting on behalf of Professor Gilvarry. Professor Wolff advised that the meeting looked at composition of Panels and the communication between different Panels as well as the Panel Chair reports. Recruitment and Terms and Conditions were also discussed. In addition, there was a confidentiality reminder that the minutes remain confidential until published.

3. Minutes of previous meeting and actions

The minutes of the previous meeting were agreed as correct. Professor Wolff confirmed that there are plans to publish the Pharmacy Study in the future. The study showed that 30-50% of people collecting Methadone scripts were driving to do so. It is important for drug treatment clinics to be aware of this in order to provide appropriate advice about driving.

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Section B – Ongoing topics for discussion

4. DfT Update

Claire Rees gave a short update on Mobile Evidential Breath Testing Instruments (MEBTI). The competition to develop these devices was launched by Theresa May in June 2018. The competition is now closed to entries and bids are being assessed. They are hoping the chosen device will be ready by mid 2020, however type approval will take 9 months and the devices will need testing by the police first. It was confirmed that the devices are for England and Wales only, as Scotland have their own equipment.

It was questioned whether the devices would be able to be re-calibrated should the drink-drive limit be reduced as recommended by the Panel.

Road safety statistics have been published recently which show that drink and drug driving are still prevalent. A High Risk Offender scheme for drugs is still being considered.

There was an update from the Civil Aviation Authority. In July 2018 new EU regulations were published requiring mandatory testing of air crew. This will involve testing on the ramps, and airline companies are to have organised programmes for testing.

The Maritime Agency require that drug or alcohol problems be controlled for a full 3 years before seamen can drive a vessel. However, testing is done by the individual companies rather than the Maritime Agency.

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5. Policy update

Driver licensing Policy provided an update into the responses to a questionnaire sent to other European countries with regard to their alcohol and drug policies.

The following questions were asked:

How long does a driver with a history of alcohol misuse or dependence need to be abstinent before a licence is issued? Once a licence has been issued do you require the driver to remain abstinent? If so, for how long? Is any form of monitoring undertaken once the licence has been issued?

Some countries advised that abstinence needed to be proven by the specialist or doctor in charge of the driver's treatment. The information is evaluated by the licensing authority to determine if a licence can be issued. In some instances, cases are referred to a medical board. Other countries send the driver for hair, blood and urine tests on reapplication. One country carried out consecutive tests over a given period of time.

The period a driver has to remain abstinent ranges from 2 months to indefinitely. Some countries carry out periodic reviews and tests to ensure the driver remains abstinent.

We also asked whether drug urine tests needed to be witnessed by the collector.

Some countries advised that they do require them to be witnessed or conducted under supervision, with the majority checking the temperature and creatinine levels. One country followed the EU guidelines on Workplace testing.

6 Persistent alcohol misuse/binge drinking.

The purpose of this discussion was to review existing standards for dealing with persistent alcohol misuse and binge drinking. The current standards refer to persistent alcohol misuse confirmed by medical enquiry and/or otherwise unexplained blood markers. DVLA asked for clarification around the relevance of binge drinking in the context of driving.

The AUDIT 10 questionnaire asks about episodes of drinking over 6 units for women and 8 units for men and this is referring to the medical/ research definition of binge drinking. This definition relates to increased risk of violence and accidents at this level of alcohol intake.

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Panel advised binge drinking should be taken into account when considering cases. The pattern of binge drinking must be put into context with any known history of alcohol misuse or dependence and consider whether it is possible to link binge drinking episodes to patterns of driving. A licensing decision should not be made purely on the basis of a history of binge drinking.

Persistent binge drinking at times when the person is likely to be driving is concerning as they may still be over the limit the next day. Even low levels impair the ability to drive.

People relapsing from alcohol dependence may binge drink intermittently in between periods of abstinence. They may then increase the number of days they drink rather than the amount. Islands of binge drinking then merge. Many heavy drinkers may lose control, not realising they have a problem.

In the presence of known liver disease it is harmful to take any alcohol, therefore if a driver continued to drink alcohol, in the context of driver licensing this is indicative of a lack of control.

With regard to 'otherwise unexplained blood markers' panel were asked to clarify the situation with respect to percentage CDT. Where there is a clear history of alcohol problems and the percentage CDT blood level is raised then this is likely to be due to alcohol.

It was confirmed that a percentage CDT over 3 is definitely an unexplained abnormal blood marker.

As 1.6 is the clinical cut off, suggesting evidence of increased alcohol intake, then a level between 1.6 and 2.9 should be considered as potentially abnormal depending upon the context.

Panel confirmed that controlled drinking means drinking within government recommended health guidelines which are currently set at 14 units per week. It was recognised that when making decisions on fitness to drive, pattern and context needs to be taken in to consideration.

If alcohol use is combined with cannabis or other drugs, then the risk to driving increases.

7 Alcohol dependence.

Panel were asked:

When is it reasonable for someone with dependence to return to drinking regularly?

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It was confirmed that abstinence is required for relicensing as in EU legislation.

Panel advised that where there is a clear history of dependence then the risk of relapse remains high for life, therefore the standards for dependence could be applied indefinitely i.e. licensing in the future requires continued abstinence.

The majority of people with alcohol dependence associated with physical withdrawal symptoms will not be able to return to drinking regularly, without relapsing, especially if they have a long history of dependence.

8 CDT update

Panel were asked for advice as to whether a CDT value over 10 should be considered more likely to be due to rare glycoprotein syndromes rather than alcohol misuse. Panel advised that values above 10 are still more likely to be alcohol related. The levels obtained in glycoprotein syndromes are likely to be much higher than this. These conditions are usually evident in childhood, and are less likely to present in adulthood with a CDT exam.

If a variant is present, the results are likely to remain high. Advice sought from the Laboratory supported this view.

Panel confirmed a percentage CDT over 1.6 is not consistent with abstinence. Percentage CDT itself is not a measure of abstinence however a level below the 1.6 range suggests no biochemical evidence of alcohol misuse in the previous two weeks.

A percentage CDT of 2.3 or above is not consistent with controlled drinking.

For screening purposes panel were happy that DVLA continued to use the red, amber and green zones for CDT as previously recommended, as these represent a high risk in a driving context with fewer false positives.

Panel have asked for an overview of cases going forward using the cut off's as recommended above to be presented at the next panel meeting.

9. Persistent drug misuse

The legislation advises that the persistent misuse of drugs, whether or not this amounts to dependence, is a prescribed disability but does not define persistent misuse. Therefore, DVLA have to rely upon panel advice.

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Panel have to balance the legal requirements for medical licensing, which needs identification of a medical condition or relevant disability, with the drug driving legislation which has a zero tolerance approach to 8 different drugs when driving, and the drug legislation which would indicate that any use of illicit drugs is misuse.

Panel were asked to provide clearer guidance as to what is and what isn't persistent drug misuse particularly with regard to the cases where drivers admit to regular drug misuse but there is no medical history available of drug problems and the drug urine screen is negative.

Panel felt that the legality or not of drug use should not influence the guidance they provide. As an interim measure they have suggested that, in general, any single drug used monthly or less in the context noted above would not be considered as persistent misuse. Daily use would always be considered persistent. Anything in between would need individual risk assessment.

Cannabis use was discussed which is due to be legalised for medical purposes. It is still unclear what this will mean in practice and how it will affect public perception and/or the drug driving legislation. This will need to be considered at the next panel meeting.

Generally, at DVLA we accept that cannabis use four or more times a week is persistent misuse medically and for licensing purposes. Anything below this may be considered as recreational use, but it would depend on the context of the use.

Studies suggest cannabis can cause impairment for up to 24 hours after use in occasional users. However, research has shown less obvious impairment in regular users, who will have steadier state levels in the blood, reduced peaks and trough values. Regular users may also have faster metabolism allowing them to clear the drug quicker.

The zero tolerance values used for drug driving are based upon risk rather than levels of impairment as the latter is difficult to quantify.

The use of cannabis up to 4 times weekly could mean drivers are likely to be over the legal drug drive cut off limits as cannabis remains in the blood for a long time. Impairment from cannabis is significantly worsened if combined with even low levels of alcohol.

Panel felt that a full review of the medical standards for drug use is needed to assess the risk.

10 Polydrug use

Panel agreed that there is a greater risk when driving with multiple drug use and/or substance misuse combined with alcohol and therefore stricter standards are required.

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Very few countries have driving offences related to multiple substance use, therefore it is hard to get statistics related to this topic.

It was confirmed that a period of one year off driving and free from further drug misuse was required for group 1 driving in the presence of multiple substance misuse. However, panel wished to consider this further in the context of group 2 driving.

Poly-substance misuse should be considered in the same context as persistent misuse, in that occasional use of different illicit substances not associated with driving would not usually be concerning.

11 Methadone Standards

Panel agreed that the standards for Methadone can now be published in AFTD.

12 Pain control in the context of driving

DVLA has to consider cases whose method of pain control is unusual. Often these people are attending a consultant led pain clinic for management of chronic and severe pain. The DVLA approach has usually been that, if the pain relief is prescribed and taken as directed then they can continue to drive as long as they are not impaired by either the treatment or underlying condition. However, panel have previously advised that Opioid substitution treatment which is injected is not acceptable due to varying blood levels.

Drug treatment clinics are now seeing more and more cases of people referred by their doctors for treatment of addiction to prescribed medications, with increasing public awareness of this problem. Sometimes these people have genuine pain problems and need to continue on the treatment. Others may have developed an addiction problem, and some are both physically and psychologically addicted, often with complex treatment regimes with multiple potentially impairing medications.

Studies have shown that the risk of accident is increased 4-8 times in Opioid users.

Clearly this needs to be addressed and will be considered as part of the next panel meeting. DVLA are hoping to recruit a pain management expert to the panel for advice.

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13. New cases for discussion

There were 7 cases discussed.

14. Laboratory Update

There was no laboratory update at this meeting.

15. Tests

The purpose of this agenda item was to identify potential alternatives to CDT testing when the driver disputes the CDT result.

Hair testing was discussed as this has been raised in several Independent Complaints Assessor (ICA) cases recently.

There is a lack of clarity as to what is acceptable as alternative evidence of possible false positive CDT results. However, it was confirmed that it is the responsibility of the driver to provide evidence that they are not drinking.

The discussion by the panel was concerned with the issue of the validity of the percentage CDT test. It was noted that true false positives, those for which the result is true and a reason other than alcohol consumption can be attributed to the percentage CDT concentration are very rare. The main causes of this have already been identified as certain types of liver disease (which we ask about on our questionnaires), rare genetic glycoprotein syndromes that are usually diagnosed in childhood (which would produce extremely high percentage CDT results) and B and D isoforms (which are identified on the lab report).

Alternative explanations such as alcohol in medicines and food, or gut fermentation syndrome are unlikely to produce raised CDT results.

Secondly, it was noted that hair testing is not as reliable as percentage CDT in identifying alcohol use that is unsafe for driving. In particular, when long strands of hair are used the marker of alcohol use (Ethyl glucuronide, EtG) is averaged out over the time period that the hair length represents. As hair grows at about 1cm per month, this would be an average value over a 6 month period. The overall result may appear to be lower than the laboratory cut off despite ongoing alcohol intake.

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Therefore, hair test results have to be considered in context and greater weight should be given to the CDT result.

Panel confirmed that if hair testing is presented it should be segmental in nature. The sample should be taken by an individual trained in the technique, full chain of custody must be followed and the specimen should be analysed by a reputable laboratory. A CDT test should be taken at the same time. The result should then be considered in context of the clinical information and individual case.

Similar guidelines should be followed for any other tests used.

16. Research and literature

There was no additional research or literature discussed other than that mentioned previously in the minutes. Panel are encouraged to bring any relevant research or literature to the panel for discussion.

17. Review of AFTD

The advice in the various sections of Chapter 5 was discussed as part of the previous discussions. Panel were provided with a brief summary of the advice from the Neurology Panel with regard to alcohol and drug related seizures which will be detailed in the Neurology Panel minutes.

The Alcohol and Drugs Panel would like more information with regard to the evidence-base for the Neurology Panel advice to be sent to them to consider at the next Panel meeting.

18. Horizon scanning

Panel were asked to advise DVLA of advances in medical science and knowledge which may impact upon the advice that they have provided. Future topics for discussion were identified

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including the legalisation of Cannabis (as the Panel noted Cannabis has recently been legalised in Canada), hair testing, multiple drug use and pain relief.

19. Appeals data

Panel were provided with appeals data which again showed that just under half of the DVLA medical appeals were alcohol or drug related.

20. Declaration of Members Interests

Panel were advised that these will be published on the internet and should be updated at regular intervals.

21. Date and time of next meeting

3 April 19

Dr S Williams MB ChB

Panel Secretary

23 October 2018

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