Driver & Vehicle Licensing Agency

Minutes of the Secretary of State for Transport's Honorary Medical Advisory Panel on Alcohol, Drugs and Substance Misuse and Driving – 3rd April 2019

Attendees:

Professor E Gilvarry	Panel Chair
Professor Kim Wolff	
Dr Alison Brind	
Dr Jane Marshall	
Dr Stephen Morley	
Dr Edward Day	

Lay Member

Mr. Abdul Elghadafi

Observers:

Dr. Stuart Mitchell	Civil Aviation Authority
Professor Robert Forest	Assistant Coroner in Sheffield & Hull
Professor Denis Cusack	Irish Medical Bureau of Road Safety

Ex Officio

Dr Stephanie Williams	Doctor/Panel Secretary DVLA
Dr Anca Birliga	Doctor/Joint Panel Secretary DVLA
Dr Nick Jenkins	Senior Doctor DVLA
Mrs. Rachael Toft	Driver Licensing Policy DVLA
Mrs. Keya Nicholas	Driver Licensing Policy DVLA
Mrs. Sharon Abbott	Business Support Manager DVLA
Mrs. Lorraine Jones	Panel Coordinator DVLA
Mr. David Evans	Drivers Medical Complex Casework
Mr. Glyn Wallis-Jones	Head of road Safety Strategy DFT

Section A: Introduction

1. Apologies for Absence were received from Tim Burton, Sally Bell, Sally Evans, and Claire Rees.

2. Chair's Remarks. Professor Gilvarry will be unable to attend the panel chairs' meeting in June. She thanked Professor Wolff for agreeing to attend in her place.

Professor Gilvarry and Dr Nick Jenkins have recently met with the GMC to discuss their concerns that many clinicians are unaware of fitness to drive standards. They wished to raise awareness and ensure that higher priority is given to fitness to drive in the training curriculum. Ways to increase awareness were discussed by the panel.

3. **Minutes of the previous meeting and actions.** Some grammatical errors were identified. Other than these, the October 2018 minutes were agreed as accurate.

The Agency gave an update on an action from the last panel meeting around drug urine screening. Panel were advised that 80% of DVLA drug urine screens in 2018 were negative for illicit drugs. This was in the context that the participants knew that they were attending for a drug urine screen for the purposes of driver licensing. It was pointed out that the test will only screen for certain drugs.

Section B: Ongoing Topics for Discussion

4. Alcohol dependence

Over the last few years, panel have been asked to review the medical standards surrounding alcohol dependence. A proven period of abstinence is required by EU legislation for relicensing. Panel have confirmed that abstinence means no alcohol, although occasional small amounts of alcohol may be acceptable, one glass or similar. Regular drinking is not abstinence. The 12 months of abstinence required in the standards is evidence based and relates to the increased risk of relapse in the first 12 months. Abstinence should be assessed based upon self-declaration, medical reports, and a single CDT result. A CDT over 1.6% is not consistent with abstinence.

At the October 2018 panel meeting, the panel was asked for advice about when it would be reasonable for someone with dependence to return to drinking regularly.
'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.'

Panel was asked to review their previous advice of applying the abstinence standard for life in recognition of the impact applying this standard had on drivers.

Panel also considered questions from a member of the public about this topic.

It was advised that dependence is an important diagnosis, affecting prognosis and clinical management. It is a chronic relapsing remitting disorder which results in a loss

of control of alcohol use, and increased time spent thinking about and craving alcohol, such that any life stressors can result in a relapse. There does not have to be a physical withdrawal state present for someone to be identified as dependent. Alcohol dependence is a diagnosis which is relevant for life.

Panel discussed the importance of accurate diagnosis. Many forms are completed by doctors who may not be experts in substance misuse. There are many different diagnostic tools that can be used and many different classifications. Panel reviewed the current advice in AFTD, which is a guide for medical professionals rather than the public. It was confirmed that the following guidance is sent out with our medical forms.

'Guide to definition of dependence
There is no single definition to embrace all the variables within alcohol dependence – but the DVLA offers the following:
"A cluster of behavioural, cognitive and physiological phenomena that develop after repeated alcohol use, including:

- a strong desire to take alcohol
- difficulties in controlling its use
- persistent use in spite of harmful consequences
- and with evidence of increased tolerance and sometimes a physical withdrawal state."

Indicators may include any history of withdrawal symptoms, tolerance, detoxification or alcohol-related seizures.

The World Health Organization's classification (ICD-10) code F10.2 is relevant.'

It was agreed that directing doctors to the relevant classification system to enable them to make a clinical decision based upon their own knowledge of the patient was appropriate.

Panel also discussed pragmatic markers used by DVLA to identify those with misuse and dependence, including declared alcohol intake, and CDT levels. It was agreed that these were reasonable in the context that DVLA make licensing decisions on the balance of probability but should not be considered as independent markers in themselves if challenged.

Panel discussed ways to identify those people with milder alcohol dependence who may be able to return to controlled drinking without relapsing. It was noted that DVLA

do see cases of drivers who seem to have managed to control their drinking for a number of years without relapse, others who may manage controlled drinking for a short time and then gradually relapse into heavy drinking and a return to dependence. Others relapse quickly with the first drink. It was pointed out that some people with dependence may lose rational control with any alcohol.

Panel considered various clinical assessment and classification tools, including amongst others SADQ, AUDIT 10, WHO ICD, DSM and NICE guidelines. They also took into account public health issues, the doctor patient relationship and the legal requirement for assessment and proportionality, balancing risk to road safety against individual rights.

SADQ –severity of alcohol dependence questionnaire.
AUDIT 10 – Alcohol use disorders identification test
WHO ICD – World Health Organization International Classification of Diseases
DSM- The Diagnostic and Statistical Manual of Mental Disorders
NICE- The National Institute for Health and Care Excellence (Provides national guidance and advice to improve health and social care**)**

It was agreed that it is difficult for DVLA to assess the severity of an individual's dependence.

Panel confirmed that abstinence is essential for the first 12 months, and this complies with the legislative requirement for a proven period of abstinence.

There was discussion regarding whether we could apply some discretion in drivers who had demonstrated control of their alcohol dependence for some time despite continuing to drink, albeit at low levels. Panel advised that discretion could be applied in group 1 drivers provided they are clearly drinking within healthy limits, their doctors are supportive that their alcohol use has been controlled for several years, and their CDT remains equal to or less than 1.6%. Regular review would be required in these drivers.

Abstinence would be required for the full period of review for group 2 drivers.

DVLA wished to understand what factors should be taken into account to guide the duration of short term review licensing. Panel suggested a review period of 5 years for both group 1 and group 2 drivers, in that if someone has managed 5 years without relapsing then the subsequent prognosis is good. It was agreed that abstinence reduces the risk of subsequent relapse. Any relapse would require a further year of abstinence before licensing.

Following the 5 years, information letters to driver and their doctors should advise that any relapse should be notified to the DVLA

5. CDT – Feedback from the DVLA appointed laboratory regarding glycoprotein syndromes was shared with the panel. A raised CDT should be assumed to be due to alcohol use. **However, if there is a particular high CDT result and concerns are raised about possible glycoprotein syndromes then additional tests can be undertaken.**

Panel reviewed the cut off levels for %CDT agreed at the last panel meeting. It was confirmed that a CDT up to **and including** 1.6% would be acceptable in someone with alcohol dependence as evidence of there being no recent excessive alcohol intake.
A cut off of up to 2.2% is acceptable as evidence of controlled drinking in someone with a previous history of alcohol misuse only. Otherwise the previous amber zones advised for HRO's would apply.

A case was discussed where a possible medical cause for a raised CDT was queried. Panel felt that in this case the raised CDT was likely to be due to increased alcohol intake.

6. Review of drugs misuse standards – This follows on from advice in the last meeting and from a recent teleconference.

Panel was asked to review guidance on what would be considered as persistent misuse for drivers who declared regular drug use but did not have any confirmed medical history of drug problems and had a negative drug urine screen.

The discussion covered the fact that group 2 driving is associated with greater risk due to the size of the vehicle and time spent behind the wheel and therefore a higher standard should be applied. Whilst the legality of drugs should not be an issue as it is the risk to driving that is important, it was recognized that illicit drugs are often impure therefore people do not know exactly what they are taking or how much. Much more is known about the effects of alcohol on driving and also the amount of alcohol in any product is clearly stated. Alcohol and drug driving legislation has acceptable levels for driving for both alcohol and prescribed controlled drugs but zero tolerance for illicit drugs.

For group 1 drivers it was agreed that declared drug use once a month or less would not be considered as persistent misuse in this situation. Weekly use of heroin or cocaine would be considered as persistent misuse. For other drugs, daily use would

be considered as definite persistent misuse. Anything in between these would need individual assessment. Gamma hydroxyl butyrate (GHB) and ketamine should be considered with other drugs as requiring six months' control whether or not misuse or dependence was present.

For group 2 drivers, weekly use of any drug should be considered as persistent misuse. Any drug use less than once every three months would not be considered as persistent misuse.

A positive drug urine screen in the context of driver licensing is evidence of persistent misuse.

It was agreed that daily misuse should continue for at least a month to be defined as persistent misuse.

Multiple substance use, especially when combined with any level of alcohol, is concerning. This includes use of alcohol with psychoactive prescription medicines. A small group will work on a risk chart for different drug and alcohol combinations. The most common combinations used include cannabis, cocaine and alcohol.

7.AFTD review – panel advised that it would be appropriate to remove the reference to separate standards for ketamine misuse and dependence, advising that ketamine misuse should follow the same guidance as for other club drugs.

Standards for methadone have now been included in the AFTD. It was noted that some drug treatment teams probably will be trialing heroin assisted treatment. For now, the panel advice remains that parenteral drug treatments are not acceptable for licensing.

Section C: New Topics for Discussion

8. Provoked seizures – Panel were provided with information and advice from the neurology panel about the impact of alcohol and drug related seizures now being considered as provoked seizures. The previous requirement for a minimum of six months off driving for group 1 and 5 years for group 2 has not changed. For alcohol withdrawal seizures the time off driving would be a minimum of 12 months as the driver would have to meet the alcohol dependence standards requiring 12 months of abstinence. Panel reiterated their opinion that for group 2 drivers with alcohol withdrawal seizure, the time off driving should be reduced to 3 years to meet the standards for dependency. The neurology panel have agreed that if evidence is found that such seizures have a lower than 2% per annum risk of recurrence then the time off driving for group 2 can be reduced. However, it was suggested that having any

seizure due to any cause increases the risk of further seizures, and that this was the basis of the guidance from the neurology panel. There is a further meeting of panel chairs to discuss this topic planned for later in the year.

9. Legalisation of cannabis – Panel discussed the possible impact of the recent changes in legislation allowing wider use of medicinal cannabis on prescription. There are likely to be very few cases and many of these would not be driving due to their underlying condition. **Panel would like to discuss this annually.**

10. Pain control – One case was discussed as part of this section.

11. Older Vulnerable Road users – informing Government's future policy thinking.

Panel was provided with information on the Government's future policy thinking with regards to different groups of drivers and were advised of the Ministerial announcement made in June 2018.

More information can be found at: https://www.gov.uk/government/speeches/road-safety-recent-progress-and-future-work

Panel identified concerns about older drivers with multiple morbidity and multiple prescription drugs and the impact alcohol may have in such instances. Panel advised that there are also more drug users who are on methadone programs who are now surviving to an older age.

Section D: Standard Items

12. Tests – Panel were asked to provide a position statement for alternative tests which can be accepted as evidence of abstinence.

Professor Forest gave a brief presentation on the uses and difficulties with hair testing for drugs and alcohol. Use of hair tests by DVLA could be a useful adjunct to the CDT test in difficult cases such as appeals, and could be used as an adjunct to urine drug screens. However, they are expensive and need to be considered in context and with expert interpretation.

Lab Update- DVLA contracts team requested advice from the panel as to what drugs should be tested for in the specification for a new contract.

13. Research and Literature – The following research and literature items were considered by panel as part of the bundle of documents for discussion.

A systematic review of the next-day effects of heavy alcohol consumption on cognitive performance. Craig Gunn et al. Lancet 2019; 393: 321–29. Published Online December 12, 2018

An evaluation of the effects of lowering blood alcohol concentration limits for drivers on the rates of road traffic accidents and alcohol consumption: a natural experiment. Houra Haghpanahan et al. Lancet vol 393, Issue 10169 p321-329.

Effect of recreational marijuana sales on police-reported crashes in Colorado, Oregon, and Washington. October 2018
Samuel S. Monfort. Insurance Institute for Highway Safety

Ethyl Glucuronide Determination: Head Hair versus Non-Head Hair
Isabelle Kerekes et al. Alcohol & Alcoholism Vol. 44, No. 1, pp. 62–66, 2009 doi: 10.1093/alcalc/agn096. Advance Access publication 28 November 2008

Hair Analysis in Forensic Toxicology: An Updated Review with a Special Focus on Pitfalls.
Pascal Kintz. Current Pharmaceutical Design, 2017, 23, 1-8

14. Horizon Scanning - New buprenorphine implants have been developed.

15. Appeals Data - Just over half of DVLA summons received in the period from October 2018 to January 2019 were related to alcohol and drugs cases. No appeals have been upheld in this period.

16. Declaration of Members Interests - Panel were advised that these have been updated. Panel members were asked to check the information held and to let DVLA know if there are any further updates.

17. AOB- Professor Wolff gave an overview of discussions concerning proposals to implement a High Risk Offenders Scheme for drug driving to mirror that already in place for drink drivers. Professor Wolff is chairing an expert panel providing advice to the Department for Transport with regard to this. Currently they are looking at what criteria would be required for drivers to qualify for the scheme. In the future, panel will be asked for advice as to how DVLA can screen such drivers for ongoing drug misuse.

18. Date and Time of next meeting – 3rd October 2019 (now rescheduled to the 2nd October 2019)

Driver & Vehicle Licensing Agency

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

Date: 16th April 2019

Final Minutes signed off by **Professor Eilish Gilvarry**
Panel Chair
Date: 30th May 2019

The DVLA will consider the advice provided by the panel and no changes to standards will take effect until the impact on individuals and road safety is fully assessed.