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

Meeting held on Wednesday 18th October 2023

Present:

Panel Members:

Professor Eilish Gilvarry (Chair)
Dr Richard J Aspinall
Dr Stephen Morley
Dr Edward Day
Dr Robert Searle
Dr David Fox
Mr James Nutt
Mr Abdul Elghedafi (Lay member)
Miss Sarah Oldham (Lay member)

OBSERVERS:

Professor Denis Cusack	Medical Bureau of Road Safety, Forensic Medicine, Ireland
Dr Colin Graham	Occupational Health Service, Northern Ireland
Dr Ewan Hutchison	Civil Aviation Authority
Dr Sue Stannard	Chief Medical Advisor, Maritime and Coastguard Agency

EX-OFFICIO:

Dr Nick Jenkins	Senior DVLA Doctor
Dr Amanda Edgeworth	DVLA Doctor
Dr Claire Fang	DVLA Doctor
Mrs Rachael Toft	Head of Driver Licensing Policy
Mrs Keya Nicholas	Driver Licensing Policy Lead
Mr Leigh A Bromfield	Driver Licensing Policy
Ms Emma Lewis	Driver Licensing Policy
Mrs Julie Bartlett	Driver Licensing Policy
Mr Richard Davies	Service Management
Mrs Suzanne Richards	Service Management
Miss Danielle Theophilus	Service Management
Mr David Snelling	Policy Team Leader, Road Policing Team, DFT
Mrs Katy Adams	DVLA Panel Coordination Team
Mrs Siân Taylor	DVLA Panel Coordinator/PA to Senior DVLA Doctor

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SECTION A: INTRODUCTION

1. Apologies for Absence

Apologies were received from,

Dr Ed Bebb	Professional Head of Health and Wellbeing Rail Safety and Standards Board
Dr Bhagat Sharma	Consultant Addiction Psychiatrist
Dr Sandeep Gwinnett	DVLA Doctor
Dr Claire McGlinchey	DVLA Doctor

2. CHAIR'S REMARKS

The Chair welcomed panel members.

3. Actions of the previous meeting

i. **Persistent Alcohol Misuse**
Currently ongoing (discussed under agenda item 7).

SECTION B: TOPICS FOR DISCUSSION

4. Department for Transport (DfT) Update

DfT outlined The plan for drivers - GOV.UK (www.gov.uk)recently published by the Government. The detail provided applies to England only. DfT reported that the Government is giving consideration to a call for evidence on motoring offences that will encompass the Road Traffic Act and Road Traffic Offenders Act of 1988.

5. Drug Wipe and Roadside Testing

Professor Cusack provided a presentation detailing statistics and recent developments regarding roadside and confirmatory drug testing in Ireland. This was in the context of road safety and driver licensing provisions common to the United Kingdom and Irish jurisdictions.

Preliminary drug testing (PDT) in Ireland is carried out using the Dräger Drug Test 5000 (2017-2022), and now the Securetec DrugWipe6S (since December 2022). The latter tests for the six classes of drugs: cannabis, cocaine, benzodiazepines, opiates, D-amphetamine, and D-methamphetamine.

The use of the devices and the data results from the testing for 2022-2023 to date were presented in the context of driver health, driver licensing, societal drugs misuse and of drugs and medicines information for drivers.

Panel thanked Prof. Cusack for the presentation.

6. Hepatic Encephalopathy

Dr Aspinall provided a presentation on Hepatic Encephalopathy.

Over the last 40 years, chronic liver disease (including cirrhosis) has become much more common, with age-standardised mortality rates rising by over 400%. The major aetiological factors are alcohol misuse and obesity/diabetes-related metabolic dysfunction (Non-alcoholic fatty liver disease (NAFLD) / Non-alcoholic Steatohepatitis (NASH)). Cirrhosis deaths are generally at a much younger age than other common killers (cardiovascular, cancer, etc) and the peak of liver deaths occur in the 45-60 age group.

Hepatic encephalopathy (HE) is a common complication of decompensated (i.e., advanced) cirrhosis and can also occur where there is "shunting" of blood from the gut avoiding the liver. HE is mainly the result of gut-derived toxins (e.g., ammonia, inflammatory bacterial cell wall products, false neurotransmitters) that would usually be filtered out by the liver but are finding their way into the systemic circulation where they can cross the blood-brain barrier and affect neurological function.

The condition leads to a range of neuropsychiatric impairments which could potentially affect driving skills including disrupted sleep (with reversed daily sleep-wake cycle), impaired psychomotor coordination, delayed reaction times, drowsiness, disorientation, and confusion. HE usually runs a relapsing/remitting course, and it can be successfully treated with medications that reduce frequency of episodes. However, there can be overlaps with other common causes of mild cognitive impairment such as vascular disease, medications, chronic fatigue, or alcohol-related brain injury.

In addition to overt (i.e., clinically obvious) HE, it is also recognised that approximately 60% of people with cirrhosis have a subclinical form known as Minimal Hepatic Encephalopathy (MHE) which is only detectable on formal psychometric testing. However, there is no standardised definition of MHE and there is disagreement on the optimum diagnostic tests, which are not routinely available in general clinical practice.

It is well established that overt HE impairs driving and current DVLA guidance is that such patients should inform the DVLA. The guidance appears in Assessing Fitness to Drive, under the section on alcohol-related illness where it is stated people with "chronic hepatic encephalopathy" must not drive and must notify the DVLA.

During the presentation panel discussed recent literature linking MHE to impaired driving skills as assessed by simulator performance, supervised driving tests, driving diaries and history of road traffic accidents. However, these studies were relatively small (only one had >100 patients), their methods were heterogeneous preventing meta-analysis (different tests used to diagnose MHE, different driving assessments, different aetiologies of liver disease) and there have been no published studies from the United Kingdom (most studies are from North America with a few from Spain, Italy, and India).

Panel also discussed a recent global survey of clinical academics with a research interest in HE that looked at current practice in terms of screening for MHE, assessing driving risk and knowledge of local driving laws. The survey (conducted by ISHEN, the International Society for Hepatic Encephalopathy & Nitrogen Metabolism) found that, whilst most experts agreed HE can impair driving, there was uncertainty as to how best to define, screen for, diagnose and manage MHE.

Panel discussed a letter received by DVLA, enquiring as to the DVLA's current position on HE. Given the growth in liver diseases due to factors other than alcohol (e.g., obesity-related fatty liver disease) panel advised that the current placement of HE guidance (currently under the alcohol-related section of Assessing Fitness to Drive) be considered to recognise other aetiologies.

The Panel also discussed the current gap in evidence regarding MHE and driving performance, particularly the heterogenous nature of previous studies, and recognised the absence of comparable studies in UK populations.

The Chair suggested an approach could be made to the UK professional societies responsible for managing people with liver disease (British Society of Gastroenterology; British Association for the Study of the Liver) regarding building a clinical consensus given the uncertainties in the literature. Panel also discussed a potential approach to the commissioners of UK clinical research (e.g., NIHR, the National Institute for Health & Care Research) highlighting the evidence gap and encouraging further studies in the UK.

DVLA thanked panel for their advice.

7. Alcohol Dependence

Dr Amanda Edgeworth provided an update on the proposed changes to the wording of the Assessing Fitness to Drive (AFTD) for persistent misuse and alcohol dependence.

DVLA advised panel information provided by clinicians showed variation in clarity and distinction between persistent alcohol misuse and dependence. And this along with the recommendation of ongoing abstinence for continued licensing were causing challenges for the agency when managing cases.

It was agreed high risk features will be used to identify individuals who are likely to have a physiological dependence on alcohol and therefore likely to have a more severe condition with an increased risk of relapse. The individuals with a high-risk feature(s) will be required to observe one year of abstinence from alcohol before Group 1 licensing can be considered and abstinence will need to be continued for three years for ongoing licensing. For Group 2 licensing abstinence will be required for three years before licensing can be considered and will need to continue for five years for ongoing licensing.

The features to be considered high risk were discussed. The use of the Severity of Alcohol Dependence Questionnaire (SADQ) score as a high-risk feature was suggested. Panel advised this should not be included because it is not widely used and there is variability in scoring. Panel confirmed alcohol withdrawal seizures should be included as a high-risk feature. Medication assisted alcohol withdrawal was discussed and panel advised the wording should make it clear the use of medication was required to safely withdraw someone from alcohol. Panel concluded the high-risk features should be,

- Requiring medication assisted alcohol withdrawal.
- Alcohol withdrawal seizure(s).

Panel confirmed these features would indicate an individual has a physiological dependence on alcohol and would be at increased risk of relapse into dependent drinking, panel confirmed the published literature supports this position. The more severe cases of dependence experience a 60-70% relapse within the first year after treatment. The achievement and maintenance of abstinence will be beneficial to an individual's recovery and long-term prognosis and panel confirmed a three-year follow-up period from when abstinence is achieved for Group 1 licensing. Panel confirmed after five years the rate of relapse returns to the rate of the normal population and this is therefore an acceptable time to monitor those with Group 2 licences. Panel advised engagement with support is a good prognostic factor.

Panel confirmed evidence in the literature was supportive that some individuals with a history of alcohol dependence can return to controlled drinking in the longer term.

In those with a physiological dependence on alcohol, which will be identified by the presence of high-risk features, there is an increased risk of relapse into dependent drinking. Panel have advised abstinence should be achieved for 12 months before Group 1 licensing, three years for Group 2

licensing, and abstinence should be maintained for three years in Group 1 driving, five years in Group 2. If after three years for Group 1 licensing (5 years for Group 2) there is a return to controlled drinking, and control is confirmed by their clinician, then an individual can continue to be licensed. Panel confirmed that if the condition is controlled for three years the risk to return to dependent drinking is reduced to a level which is acceptable for Group 1 licensing and after five years for Group 2.

In terms of how long the high-risk features indicate an increased risk, panel agreed that the advice provided in 2017 remains relevant. If ten or more years had passed since the high-risk features were present and there had been no relapse, then a new alcohol disorder could be considered as a new episode and the previous features would not impact the medical standard which is applied.

Both the DSM 5 and ICD-11 criteria for alcohol dependence and alcohol use disorders were discussed in relation to the medical standards of fitness to drive and the merits of each system. Panel concluded the inclusion of objective markers in the medical standards would be beneficial for the DVLA and provide clarity to customers and clinicians.

If there are alcohol withdrawal seizure(s) and DVLA are advised by a customer's clinician this did not occur in the context of alcohol dependency these cases could be considered individually.

8. Prescribed Cannabis

DVLA requested clarification from panel and asked whether toxicological testing can distinguish between prescribed and non-prescribed cannabis products.

The Panel advised this would not currently be feasible using the testing procedures commissioned by DVLA.

9. Nitrous Oxide

DVLA asked Panel to consider the implications for driver licensing associated with the recent reclassification of nitrous oxide.

Panel advised that currently no laboratories were testing for nitrous oxide. Further, the substance leaves the body quickly.

The discussion emphasised the delineation between the role of DVLA regarding establishing medical fitness to drive and the role of other professionals in determining the presence or absence of drug-induced impairment whilst driving.

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SECTION C: ONGOING AGENDA ITEMS

10. Case Discussion

A case was discussed regarding the use of nitrous oxide and subsequent medical enquiry.

11. Appeals Data

Between 1st October 2022 to 15th September 2023 the number of appeals received was 448. 304 cases were Alcohol and Drug related.

Out of the 304 cases alcohol = 267, Drugs related = 37. There were four cases upheld.

12. Tests, Horizon Scanning, Research and Literature

DVLA reminded all panel members as part of the Terms and Conditions and of their obligation to update panel about any information/tests/research that could impact on standards or existing processes.

13. AOB

Call for Evidence (CFE)

Driver Licensing Policy provided an update and figures on the call for evidence. Policy advised a link will be sent to panel members for them to participate.

The CFE launched on the 31st July and closes on 22nd October 2023. Evidence will be gathered from experts across organisations. Responses to the call for evidence will be analysed to assist with reviewing the existing legislative framework. Responses will be used to identify areas where policy or legislative changes may be able to improve outcomes for drivers and other road users. Essentially the CFE will explore if there are opportunities to change the legislative framework on which the medical driver licensing process is based.

Thanks were given to the panel members attending and to the outgoing Chair for all the work, time and attention given during her tenure.

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14. Time and Date of next meeting

Wednesday 20th March 2024

Original draft minutes prepared by:	**Sian Taylor** **Note Taker** **Date: 18/10/23**
Final minutes signed off by:	**Professor E Gilvarry** **Panel Chair** **Date: 30/10/23**

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.