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EDITORIAL

New guidelines on fitness to drive: what do they mean to psychiatrists and their patients?

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The publication of the new guidelines is a welcome step, bringing more lucidity to the subject and providing useful guidance to clinicians. However, the guidelines pose new and unique responsibilities on mental health services with resulting training needs, resource issues and ethical issues. We propose a collaborative model based on the development of regional specialised teams to perform this task. This may prove to be a more suitable and cost effective option in the long run.

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Introduction

The past decade has seen a dramatic and steady reduction in road related deaths in Ireland with a 48.9% fall in the number of people killed in road accidents between 2000 and 2010 (Central Statistics Office, 2012). This admirable achievement may be attributed to improvement of road conditions, increased public awareness of road safety policies and more rigorous enforcement of road safety policies.

As part of its effort to further reduce road-related accidents, the Road Safety Authority (RSA) launched and circulated the new guidelines on fitness to drive (FTD); Sláinte agus Tiomáint, Medical Fitness to Drive Guidelines (Group 1 Drivers) (RSA, 2012). This document was developed by the National Programme Office for Traffic Medicine (a joint initiative between the Royal College of Physicians of Ireland and the RSA) and was compiled with participation of different professional bodies involved including the College of Psychiatry in Ireland. A generally welcome step, this detailed document comes relatively late when compared with other jurisdictions like Australia and New Zealand, United Kingdom, Canada and the United States where clear guidelines on FTD had been adopted more than a decade ago. The general principles underpinning guidelines on FTD from different jurisdictions include the recognition of the delicate balance between patients' autonomy and quality of life in one hand and patients' and public safety on the other. There is also a uniform recognition of the differences between different medical conditions and the durations of stability needed before resuming driving. The issue of medications – including psychotropic medications – and road safety is another area different guideline attempted to address.

In Ireland and before the publication of the RSA guidelines, the issue of FTD appeared both in statutory Acts and RSA publications but to far less degree of detail. The Road Traffic Act (1961) and its subsequent amendments and statutory instruments refer to the concept of 'disqualification on grounds of physical or mental health'. Additionally, the RSA published a guide document on assessment of FTD in 2010 but with only a small section on mental health (RSA, 2010). Previous research findings into general practitioners' utilisation of the RSA previous guidance documents have been inconsistent and contradictory. A survey of general practitioners in 2007 revealed that two-third of general practitioners refer to the RSA guidance and a lesser number refer to the UK [Drivers and Vehicle Licensing Authority (DVLA)] or other guidelines (Whelan & Cashman, 2007). A more recent and larger survey on general practitioners reveals only one-third often used the RSA 2010 guide and a further 14% were unaware of its existence (Omer *et al.* 2013).

Psychiatric disorders and FTD

It is becoming increasingly difficult to ignore the impact of psychiatric disorders and psychotropic medications on road safety. In a study of a diagnostically mixed sample of psychiatric outpatient new attendants, 90% of patients failed to achieve scores needed for driving licence renewal and around 70% failed the tests 6 weeks after pharmacological therapy (De Las Cuevas *et al.* 2010). A large retrospective study on road fatalities in Finland reported that 20% of all drivers fatalities had

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psychiatric disorders (Rainio *et al.* 2007). Another well designed study on patients treated of major depression, 60% performed at a 'questionable level' of FTD and 16% were found to be unfit to drive (Brunnauer *et al.* 2006). A two-fold increase in the risk of traffic accidents was suggested in patients with dementia (Carr & Ott, 2010); and as one may expect, patients with substance use disorders have been identified as a high risk group (Rio *et al.* 2001).

Overview of the guidelines

Our new guidelines are largely based on the DVLA guidelines in UK (DVLA, 2013). In fact, with some minor differences, the two documents are identical. The first part on general information is broadly identical to that on the Australian and New Zealand Road Transport and Traffic Authorities (AUSTROADS) guidelines (AUSTROADS, 2012).

The document comprises two parts: an initial section on general information on compilation of the new guidelines, clarification of roles and responsibilities of different parties and general guidance on conditions and medications commonly affecting driving skills. The first section also addresses some of the medico-legal and ethical issues that may arise by applying the guidance like reporting and confidentiality, effects on patients–doctors relationship and risk of hostility to health professionals. The second part of the document addresses individual disease categories including two chapters on psychiatric disorders and substance use disorders.

Review of conditions related the psychiatric disorders and patients

In terms of operational recommendations, the document retains the role of general practitioners as vanguard for FTD assessments in most cases. Specialist consultant opinion is saved for cases 'were doubt exists about a patient's FTD or if the patient's particular condition or circumstances are not covered specifically by the standards'.

Clinically, the guidelines provide both general rules and more specific criteria to certain mental disorders and medications. For psychotic disorders, mood disorders and anxiety disorders, the authors used a model based on diagnostic categorisation, severity specifiers and duration of stability as determinants of FTD. Further conditions related to medications side effects, insight and adherence were attached. Less well-defined criteria were used on dealing with dementia and mild cognitive impairment (MCI).

During acute psychotic episodes and hypomanic/manic episodes, the document advises cessation of driving regardless of severity. A minimum 3 months of stability is needed before resuming driving (6 months in the case of rapidly cycling bipolar disorder). For chronic psychoses, driving is allowed on meeting certain stability duration (minimum 3 months) and engagement requirements. For patients who suffered from psychotic disorders, hypomania or mania, adherence to medications is required before resuming driving. Depression and anxiety were generally considered non-notifiable and FTD was conditioned with the absence of severity specifiers: memory or concentration impairment, agitation, behavioural disturbances or suicidal thoughts.

Dementia and MCI with objective impairment were both considered notifiable condition to the licensing authority. An assessment of FTD based on severity cognitive, rate of progression and medical report and possibly an on-road testing is recommended.

A minimum 6 months of abstinence will be required before patients with substance abuse/dependence (including alcohol) are to be certified as fit to drive. Normalisation of blood parameters for alcohol and negative blood levels for those abusing benzodiazepines are also required. Drivers who are established on and compliant with methadone or buprenorphine maintenance programmes are allowed to drive but annual reviews are recommended.

Potential impact of guidelines mental health teams

This new document articulates a more comprehensive set of guidelines which by their profile visibility will impact more significantly on the practice of psychiatrists and mental health teams than previously (Table 1). They also bring about clarity and formality on best practice in the area of FTD. Nonetheless, this set of new responsibilities will create new training needs, resource requirements and of course increase in workload of secondary level mental health services.

While the guidelines provide greater lucidity on the subject, the process of assessment of FTD remains a complex task. It would be reasonable to hypothesise that most psychiatric teams lack the expertise and resources required for this task. Furthermore, there is a genuine concern of damage to the patient–doctor relationship as a result of recommendations to stop driving or reporting of unfit drivers to the authorities. In their timely survey of general practitioners, Omer *et al.* (2013) concluded that 76% of respondents felt mandatory reporting of unsafe drivers has negative impacts on doctors–patients relationship. The guidelines advise self-disqualification by the health professional and transfer of patient's care to another professional in such a situation. In a strict catchment area-based Irish mental health system; arranging such transfers is likely to prove unrealistic.

The possibly mandatory reporting of unfit drivers who will not or cannot stop driving raises a number of

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Table 1. *Summary of responsibilities of drivers and health professionals under the new guidelines*

Responsibilities of driver patients

1. Notification to the DLA of any long-term illness that may affect their abilities to drive safely
2. Notification of insurance provider of any such illness
3. To respond truthfully to questions from health professionals regarding their health status
4. Adherence to medications and monitoring procedures related to their conditions
5. To comply with requirements of their licence including periodic medical review

Responsibilities of health professionals

1. Assessment of FTD: a review by a specialised consultant may be warranted in certain conditions. The general practitioner should refer the patient to secondary care such a case
2. Interim Advice: Health professionals are required to decide and advice on the patient's on driving abilities in the interim while waiting for more information or investigations
3. To recommend restrictions on driving or ongoing monitoring as required
4. To advise patients on impact of their conditions on their ability to drive
5. To advise patients of their responsibility to report their condition to the DLA
6. To treat, monitor and manage the person's condition with ongoing consideration of their FTD
7. Documentation of assessment results, communication with the patient and DLA
8. To report to the DLA in writing if there is a risk to the public or in the case an unfit driving patient cannot or will not stop driving

FTD, fitness to drive; DLA, Driving Licensing Authority.

ethical and practical issues. In other jurisdictions, where reporting to authorities is mandatory or recommended, a number of ethical concerns were voiced. Niveau and Kelley-Puskas (2001) found that physicians tend to report male patients, patients with poor educational background and patients with severe mental illness and questioned the ethicality of reporting in the absence of objective assessments and some authors called for objective measures of FTD beyond mere subjective judgement (Goldman & Jacob, 1989).

The development of specialised regional FTD assessment teams who perform the assessments in collaboration with primary care and secondary care teams would be of a great help in addressing most of the concerns discussed above. Incorporating this model within the existing system of assessment of FTD, these teams should be able to provide more accurate and fairer decisions on FTD and may also prove to be more cost effective in the long run.

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