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which 58 young people in 10 prisons participated in focus groups that included their experiences of being in prison (Lyon *et al*, 2000). The thematic report by the Chief Inspector of Prisons also identified similar concerns as those reported by the young prisoners in this study (HM Chief Inspector of Prisons, 1997).

Four officers have now been suspended in relation to identical allegations of mistreatment in the YOI named by the two boys in this study (*Guardian*, 5 August 2000).

While it is important to point out that this study was carried out in a YOI that is now recognised to have been in severe crisis, the conditions described are not unique and the themes, in less extreme form, are prevalent throughout the young offender estate. It is clear that subjecting children to these conditions is detrimental to both their development and mental health.

The factors that lead to this unacceptable situation are complex. They include: the incarceration of children in a prison system primarily designed to hold adults; gross lack of resources both in terms of capital and the appropriate training and support of prison staff; and the challenges posed by the children themselves. The prison service has begun to address these problems by setting down new and appropriate standards of care for young prisoners (Prison Service, 1999).

Children in prison constitute one of the most socially and psychologically deprived and needy young populations in society. It is the responsibility of the prison service, Youth Justice Board and ultimately of the Home Secretary and society that the improved living conditions set out in the new prison standards are implemented in full. However, psychiatric services also have a very significant contribution to make. The report of the joint working party (Prison Service & NHS Executive Working Group, 1999) requires the NHS to work in partnership with the prison service to provide mental health care in prison.

To date, child and adolescent mental health services have been notable by their absence from institutions holding prisoners under the age of 18 years. Child psychiatrists working in prison can contribute to the health and welfare of young people and give direction and support to prison staff. In conjunction with this, the development of health participation in local authority youth offender teams provides an opportunity for locally based mental health professionals to facilitate links by working with boys and girls remanded in prison custody and afterwards back home.

References

AMBROSINI, P. J. (2000) Historical development and present studies of the schedule for affective disorders and schizophrenia for school-age children (K–SADS). *Journal of the American Academy of Child and Adolescent Psychiatry*, **39**, 49–58.

GLASER, B. G. & STRAUSS, A. L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine.

HM CHIEF INSPECTOR OF PRISONS (1997) *Young Prisoners: A Thematic Review.* London: Home Office.

HOME OFFICE RESEARCH & STATISTICS DIRECTORATE (2000) *Prison Statistics England and Wales 1999.* London: Stationery Office.

LYON, J., DENNISON, C. & WILSON, A. (2000) *Home Office research study 201 'People in Custody. Tell Them So they listen': Messages from Young People in Custody.* London: Prison Service.

PRISON SERVICE (1999) Order no. 4950. *Regimes for Prisoners Under 18 Years Old.* London: Prison Service.

—& NATIONAL HEALTH SERVICE EXECUTIVE WORKING GROUP (1999) *The Future Organisation of Prison Health Care.* London: Department of Health.

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M. E. JAN WISE AND JAMES P. WATSON

Postal survey of psychiatrists' knowledge and attitudes towards driving and mental illness

AIMS AND METHOD

We assessed psychiatrists' knowledge and attitudes towards the Driver and Vehicle Licensing Agency (DVLA) regulations concerning mental illness. A postal survey of all consultant and trainee psychiatrists (228) on the South Thames (East) regional psychiatry rotation was carried out.

RESULTS

For category 1 (private car and motorcycles) licenses, 40.0% of psychiatrists could correctly advise patients with a bipolar affective disorder; this figure was 0% for schizophreniform disorders. For category 2 (heavy goods vehicles) licenses the corresponding figures were 13.2% and 11.8%, respectively. For alcohol misuse, alcohol dependency and alcohol related disorders, the scores were 26.0%, 29.1% and 19.7%.

CLINICAL IMPLICATIONS

Psychiatrists fail to know or apply existing DVLA regulations, for a number of reasons. Failure to inform patients of the restrictions and to record this may result in medico-legal liability for practitioners.

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It has been estimated that 25% of drivers involved in accidents have impaired driving owing to alcohol, drugs or illness (Cremona, 1986). Elwood (1998) found that 13% of patients with mental illness were unfit to drive, and that 49% were prescribed medication that could affect their driving. Barbone *et al* (1998) reported an increased risk of accidents in users of anxiolytic benzodiazepines and zopiclone. Brown (1993) commented on the reluctance of psychiatrists to enter this potentially explosive arena because it might infringe upon patients' ability to drive, obtain insurance and perhaps earn a livelihood. An up-to-date understanding of the regulations applicable to driving and mental illness is important. For reference, current (1999) rules are summarised in Table 1.

There have been several surveys of psychiatrists' knowledge of the regulations applied by the Driver and Vehicle Licensing Agency (DVLA) to patients with mental illness. Thompson and Nelson (1996) studied levels of knowledge about private vehicles (category 1) and Humphreys and Roy (1995) assessed awareness of the regulations as applied to heavy goods vehicles and large passenger vehicles (category 2). These surveys found that psychiatrists had poor levels of knowledge, scoring at best 6% (category 1) and 36% (category 2) correct, and that too few patients were advised that they should not drive (46%).

The DVLA has since issued revised guidelines regarding illness and fitness to drive (Drivers Medical Unit, 1999), covering both physical and mental illness/disability. The Royal College of Psychiatrists (1996) has issued comprehensive guidelines on the role of a psychiatrist in advising a patient in his or her care on fitness to drive. The General Medical Council (GMC, 1998), in their pamphlet *Duties of a Doctor*, emphasised doctors' responsibilities towards protecting the public. The GMC is clear that for several conditions it is incumbent upon doctors not only to advise their patients of unwelcome news but also to take steps to ensure that the relevant statutory authorities are informed of breaches of the regulations.

Method

We undertook a survey of the current level of knowledge among all consultants and trainees in the South Thames (East) Regional Psychiatry Rotation. We also attempted to discern whether views about the doctor–patient relationship or the role of doctors in society might influence whether a patient would be informed correctly about the legality of their driving.

The target population was identified as all the trainers and trainees on the local psychiatry rotation. This encompassed one-quarter of London and all of Kent. The studies by Thompson and Nelson (1996) and Humphries and Roy (1995) were perused to enable meaningful comparison. Although the questions followed their form, they were updated to the existing DVLA guidelines. The questions were verbatim extracts with accompanying text to facilitate similarity in format and style. Once the initial questionnaire was composed, it was piloted to test for comprehensibility. Changes were made to grammar, layout and style.

For as much of the questionnaire as possible a true/false/do not know format was used. There were five questions (a 'set') for each of psychosis (schizoaffective, acute psychosis and schizophrenia) and manic depressive psychosis categories for both category 1 and 2 licences, which gives a total of 20 questions. A question set included whether there were requirements for insight, compliance, lack of side-effects, lack of symptoms and what was the recommended driving-free period. To be able to give a patient the correct advice, the doctor had to answer all five parts accurately. There were five questions on alcohol problems. For the attitudinal questions (seven in total), Likert scales were used. The questionnaires were distributed with an addressed self-sealing envelope. At two 2-week intervals, non-respondents were sent a second pack. Subjects who left the rotation before the first reminder were excluded from the sample population.

The data were analysed using the Statistical Package for Social Sciences V.7.5.2 for Windows 95 (SPSS Inc., Chicago, USA). Continuous data were analysed using independent *T*-test and categorical data using the Mann–Whitney *U*-test and analysis of variance (ANOVA). Where appropriate, Levene's test for equality of variance was used. For the calculation of time periods, absent or do not know answers were excluded.

Results

At the start of the study there were 228 senior house officers (SHOs)/specialist registrars (SpRs) and consultants in the rotation studied. During the course of the study 10 left and became untraceable. Of the remaining 218 subjects, 127 responded (58.3%). This response rate compared with the 42% reported by Elwood (1998) and the 54% by Thompson and Nelson (1996). There were 82 men (69.5%) and 36 women (30.5%); nine failed to indicate their gender (7.1%). The modal age range was 30–34 years and the average was 35.7 years. There were 45 SHOs/registrars (35.4%), 20 SpRs/senior registrars (15.7%), 65 total trainees (54.2%) and 58 consultants (45.8%). The average time spent practising psychiatry was 12.2 years and 113 (94.2%) had a driving license: 23 (18.1%) were pre-Part 1 MRCPsych, 20 (15.7%) were pre-Part 2 MRCPsych, 60 (47.2%) were MRCPsych and 14 (11.0%) were FRCPsych.

In questions that required an answer in terms of 'period not allowed to drive for', the highest correct score was 40.0% for category 1 licenses and restrictions owing to 'manic depression'; for schizophreniform disorders, this score decreased to 0% (Table 2). For category 2 licenses, scores were 13.4% and 11.8%, respectively. For alcohol misuse, dependency and related disorders ('severe hepatic cirrhosis, Wernicke's encephalopathy and Korsakoff's psychosis') the scores were, respectively, 26.0%, 29.1% and 19.7%. Of those who gave a period of restriction, 61% would allow a patient with Wernicke's encephalopathy or Korsakoff's psychosis

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Table 1. The Driver and Vehicle Licensing Agency (DVLA) regulation restrictions for mental illness (1999)

Psychiatric disorder	Category 1 restrictions	Category 2 restrictions
Severe anxiety or depression (significant memory or concentration problems, agitation, behavioural disturbances or suicidal thoughts)	The DVLA must be notified and the licence revoked pending outcome of medical enquiry (Restriction 1, R1)	(R1). Cease driving until serious acute illness is over. When symptom-free for 6 months, may drive. Any psychotropic medication must be of a low dosage and not interfere with alertness or concentration or in any way impair driving (R2)
Psychosis (excluding chronic schizophrenia)	(R1). Restored once symptom-free and demonstrating insight and compliant with medication for up to 12/12 (R2)	(R1). 36/12 of (R2). Consultant examination required confirming no residual impairment, insight present and that patient would recognise relapse. No significant likelihood of relapse
Alcohol misuse	Where confirmed by medical enquiry, and by evidence of otherwise unexplained abnormal blood markers, 6/12 revocation during which time controlled drinking or abstinence should be achieved with normalisation of blood markers (R5)	At least 12/12 of (R5)
Alcohol dependency	Including detoxification or alcohol-related fits, 12/12 of (R5). If there has been an alcohol-related fit/s the Epilepsy Regulations apply (R6)	Licence will not be granted where there is a history of alcohol dependency within 36/12. (R6)
Alcohol-related disorders (e.g. Wernicke's encephalopathy, Korsakoff's psychosis, severe hepatic cirrhosis, *et al*)	Licence revoked permanently	Licence revoked permanently
Drug misuse and dependency (cannabis, ecstasy and other 'recreational' psychoactive substances, including LSD and hallucinogens)	Regular use of these substances, confirmed by medical enquiry, leads to revocation for 6/12 (R7). Independent medical assessment and urine screen may be necessary (R8)	12/12 of (R7), (R8)
Drug misuse and dependency (amphetamines, heroin, morphine, methadone[1], cocaine and benzodiazepines)	Minimum of 12/12 (R7), (R8). Favourable consultant or specialist report will be required (R9)	36/12 of (R7). (R8). (R9)

1. Drivers on consultant-supervised oral methadone withdrawal programme may be licensed, subject to annual review and favourable assessment.

Table 2. Doctors' responses concerning category 1 and category 2 driving license regulations

Type of driving license	Patient diagnosis (requiring hospital admission)	Correct advice given %	*n*
Category 1 (not passenger or HGV)	Acute psychosis (schizoaffective, acute psychosis, schizophrenia)	0.0	0
	Acute manic depressive psychosis	40.0	51
Category 2 (passenger or HGV)	Acute psychosis (schizoaffective, acute psychosis, schizophrenia)	13.4	17
	Acute manic depressive psychosis	11.8	15
Category 1 (not passenger or HGV)	Alcohol misuse	26.0	33
	Alcohol dependence	29.1	37
	Alcohol-related disorders	19.7	25
	Drugs: cannabis, etc.	31.5	40
	amphetamines, etc.	26.0	33

to drive after a year. (The legal requirement is permanent revocation of the driving license.)

There were no statistically significant differences between groups in terms of knowledge when gender, position, license holding, qualifications or years of practice were compared. Likewise, there were no statistically significant differences in attitudes about doctors' relationships with their patients or concerning the appropriateness of restrictions on driving in relation to substance misuse.

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Table 3. Doctors' responses concerning implementation of the Driver and Vehicle Licensing Agency guidelines

Question	Category	Agree/strongly agree (%)	Neutral (%)	Disagree/strongly disagree (%)
I would be reluctant to tell patients they are unfit to drive because:	Driving was important for their employment	48.7	19.1	31.2
	It would affect compliance with medication	42.6	24.3	33.1
	It would reduce chances of reattendance	29.5	27.0	42.5
	It would damage the therapeutic relationship	23.5	26.1	49.4
	This role is inappropriate for doctors	17.4	19.1	64.5
Advising a patient places too great a burden on the doctor for:	Alcohol	20.7	21.6	57.7
	Benzodiazepines	18.0	25.0	56.0
	Cannabis, ecstasy, LSD, hallucinogens	17.2	22.5	60.3
	Amphetamines, heroin, morphine, cocaine	15.5	21.6	57.0
	Non-substance misuse psychiatric disorders	19.0	14.7	65.3
Guidelines are reasonable for:	Alcohol	55.6	26.1	18.3
	Benzodiazepines	40.4	36.8	22.8
	Cannabis, ecstasy, LSD, hallucinogens	48.2	31.8	20.1
	Amphetamines, heroin, morphine, cocaine	49.1	29.8	21.1
	Non-substance misuse psychiatric disorders	38.7	36.8	24.6

Many doctors were ambivalent about the guidelines applying to substance misuse. Telling patients that they must not drive was felt to be too great a burden by 20.7% of doctors for alcohol, 18.0% for benzodiazepines, 17.2% for cannabis, ecstasy, LSD and hallucinogens and 15.5% for amphetamines, heroin, morphine and cocaine. For non-substance misuse disorder, 19.0% felt that it was a burden.

Doctors were asked about several factors that might influence their decision to tell patients that they should not drive (Table 3). Of those who expressed an opinion (n=115), 48.7% agreed or strongly agreed that driving-related employment would prevent them from telling the patient; 29.5% would not tell patients if it would reduce reattendance. These results are surprising because only 17.4% wished to reject the role of advising patients on how the DVLA regulations affect them; 57.2% did not agree or strongly agree that it would affect compliance; and 76.5% did not agree or strongly agree that it would damage the therapeutic relationship.

There appears to be widespread ignorance of the regulations and a clear ambivalence by a proportion of those polled to adopt a 'policing role'. Respondents were given the correct driving-free periods at the end of the questionnaire and then asked to comment on their acceptability; the majority felt that they were reasonable. (As can be seen from the poor levels of knowledge, respondents did not change their answers retrospectively!) The notable exception was for benzodiazepine misuse, which attracts a 12-month period of licence revocation: 59.6% (n=68) did not agree or strongly agree that it was reasonable; for non-substance misuse disorders, this figure was 61.4% (n=70).

Discussion

It seems noteworthy that not only was there no statistically significant difference in levels of knowledge between trainees and trainers, but also there was no difference in attitudes to giving patients unwelcome news such as not being allowed to drive. Likewise, there was no difference in the views of how illicit substance use restricted driving and whether this was unreasonable. Whether this reflects ambivalence across the grades or a liberal approach is unclear.

It was clear that doctors in the surveyed trusts were reluctant to accept the responsibility of telling patients that they could not legally drive. The courts have already decided this very point: a doctor has a duty to inform the DVLA that a patient is unfit to drive where a patient will not, and continues to drive (Strawford, 1999). Thus doctors are unable to defend the position that it is not their role or responsibility.

Furthermore, doctors appear not to have realised that should a patient have an accident when he or she may not legally drive then the patient may be uninsured. Doctors may be targets for any injured parties attempting to gain financial compensation, whether or not they belong to a defence agency.

Doctors may be concerned about the effects on a patient's ability to obtain insurance in the future, whether it is offered at all or at a raised premium. In the third report of the Science and Technology Committee, House of Commons (2000), the Association of British Insurers advised that "Since the implementation of the Disability Discrimination Act 1995, insurers are required to justify any different treatment on the basis of actuarial data . . . provided that the DVLA are satisfied that the individual is fit to hold a licence then they should be treated no differently from an applicant without such a condition." It is expected to take 10–15 years to accumulate this data.

Conclusion

Psychiatrists are expected to remain up-to-date with clinical knowledge and their legal obligations. In respect to driving and the public safety implications, there appears to be a significant lacuna. Both the GMC and the Royal College of Psychiatrists have gone to considerable effort to clarify their expectations of responsible practice.

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Psychiatrists need to put aside their ambivalence and fulfil their legal obligations.

References

BARBONE, F., MCMAHON, A. D., DAVEY, P. G., *et al* (1998) Association of road-traffic accidents with benzodiazepine use. *Lancet*, **352**, 1331–1336.

BROWN, P. (1993) Mental illness and motor insurance. *Psychiatric Bulletin*, **17**, 620–621.

CREMONA, A. (1986) Mad drivers: psychiatric illness and driving performance. *British Journal of Hospital Medicine*, **35**, 193–195.

DRIVERS MEDICAL UNIT (1999) *At a Glance Guide to the Current Medical Standards of Fitness to Drive.* Swansea: DVLA.

ELWOOD, P. (1998) Driving, mental illness and the role of the psychiatrist. *Irish Journal of Psychological Medicine*, **15**, 49–51.

GENERAL MEDICAL COUNCIL (1998) *Duties of a Doctor: Confidentiality. Protecting Patients, Guiding Doctors.* London: GMC.

HUMPHREYS, S. A. & ROY, L. (1995) Driving and psychiatric illness. *Psychiatric Bulletin*, **19**, 747–749.

ROYAL COLLEGE OF PSYCHIATRISTS (1996) Public Policy Committee guidance on medical aspects of fitness to drive. *Psychiatric Bulletin*, **20**, 631.

SCIENCE AND TECHNOLOGY COMMITTEE, HOUSE OF COMMONS (2000) *Third Report of the 1999–2000 Session of the Science and Technology Committee. Scientific Advisory System: Diabetes and Driving Licences.* London: Stationery Office.

STRAWFORD, G. (1999) Driving license revoked. *Journal of the MDU*, **15**, issue 1.

THOMPSON, P. & NELSON, D. (1996) DVLA regulations concerning driving and psychiatric disorder. Knowledge and attitudes of psychiatrists. *Psychiatric Bulletin*, **20**, 323–325.

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