Mental illness and driving – compliance with RSA and IMC guidelines

McGuire E [1], Fatoki O[1], Kaka N[2], Curtis C [1]

1 Mayo University Hospital, Castlebar

2 National University of Ireland, Galway

01 INTRODUCTION

For most people, driving is an important physical activity which impacts on psychological, social and economic well-being. Is also a complex task that requires the use of higher cognitive and executive functions. Unfortunately, many psychiatric illnesses and medications can impact on these functions[1, 2] potentially causing a range of detrimental effects, such as sleepiness when driving and poor judgment [3, 4, 5]

In Ireland, the issuing of driving licences is governed by both EU law and local regulations as laid out in the Road Traffic Act, 2016[6]. Prior to the granting of a licence, a medical certificate of fitness to drive must be obtained from a medical practitioner.

"Slainte agus Tiomaint"[7], a booklet created by the government, to assist medical practitioners in fitness to drive (FTD) assessment, advises that doctors and pharmacists have a

"duty of care"

to ensure that *patients are made aware of the possibility of any adverse reactions* from prescribed medication that might interfere with their ability to drive. They state that while

it is the responsibility of the doctor to assess and advise the patient in relation to their driving ability

it is the duty of the individual to advise the NDLS (National Driving License Authority) of any such circumstances.

Importantly, however, it should be noted that ***the* Irish Medical Council *advise direct reporting to the NDLS by a doctor in certain circumstances***[8]. These include situations such as the patient

- being unable or unwilling to appreciate the impact of their condition on their fitness to drive,
- being unable or unwilling to take notice of the doctor's recommendations
- continuing to drive despite appropriate advice, leading to circumstances which may be likely to endanger the public[8].

They advise that reporting should be taken in the interest of public safety and with the consent of the driver wherever possible[8].

Our aim was to

- assess the level of compliance with RSA guidelines within a community mental health service.
- to raise awareness of our duty of care as clinicians.

02 METHODS

The study was approved by the hospital's ethics committee. 55, randomly selected patient charts were reviewed, the only inclusion criteria being that the patient had attended the service as either an in-patient or out-patient within a specific 6-month time frame. Data collections were carried out using case notes and correspondence. The same process was repeated 6 months later to complete the audit cycle.

A questionnaire was devised using standards set from national RSA guidelines. This was utilised by two authors to gather information on

- driving status
- number of patients prescribed a psychotropic medication
- numbers of medication prescribed to each person
- psychiatric diagnosis
- current use of recreational drugs
- types of recreational drugs used
- documentation of advice given regarding driving while using prescribed medication
- documentation of advice given regarding illness and driving

The first intervention consisted of an **educational session** where we presented the results of the first cycle of the audit. This was well attended by doctors of all grades, nurses, pharmacists and other members of the multidisciplinary mental health teams

A second intervention saw that a **tick box** to indicate that advice regarding driving had been given was incorporated into the local discharge document.

Six months later, the same information was gathered using the identical methods as outlined above.

03 RESULTS

In each cycle, 55 patient charts were reviewed. Of this group, 47% (n=26) were female and the majority of patient were in the 18-24 year old or 45-54 year old category, both accounting for 23% (n=13) of cases. Diagnoses are outlined in Table 1. Many patients had more than one diagnosis.

Most patients were prescribed at least one medication (89%, n=48), with 87% (n=47) receiving 2 or more medications. Eleven per cent (n=6) were prescribed 5 or more medications. Table 2 outlines levels of prescribed drugs. The majority of patients (79%, n=43) were prescribed oral medications alone, with (16%, n=9) receiving a depot alone and 4% (n=2) receiving both oral and depot medications.

Twelve percent of patients (n=6) admitted to on-going recreational drug use, all of whom were using cannabis on a regular basis, with one third (n=2) of those also using amphetamines. Sixteen percent of this group (n=1) admitted to the use of opioids and a further 16% (n=1) to the misuse of benzodiazepines, Table 3.

Driving status was documented in 20% (n=11) of charts. There was evidence that 11% (n=6) of patients had received advice regarding medication but unfortunately, there was no evidence that advice had been given to any patient regarding driving and illness.

During the re-audit period, documentation of driving status rose to 36% (n=20). There was only a slight increase from 11% (n=6) to 14% (n=8) in documented advice regarding medication and driving. Similarly, a rise from 0% (n=0) to 7% (n=4) was noted regarding documentation of driving and mental illness. Table 4

Table 1

Psychiatric diagnosis	Cycle 1 (n=55)	Cycle 2 (n=55)
Affective	33	28
Schizophrenia	22	12
Neurotic	14	11
Substance related	5	10
Personality disorder	4	4
Neurological disorder	2	0

table 2

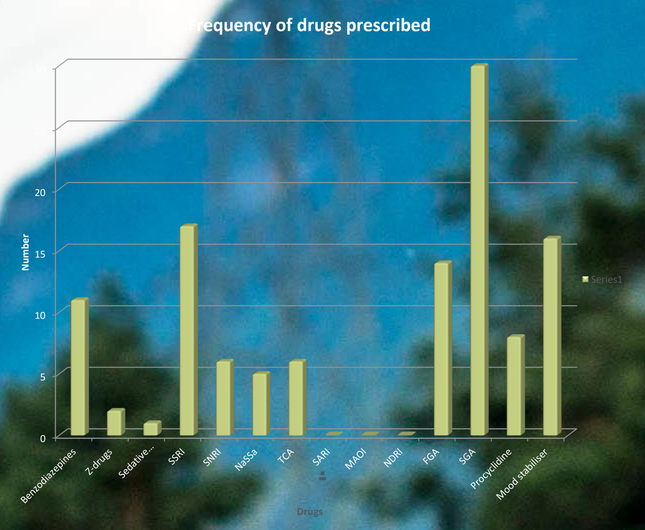
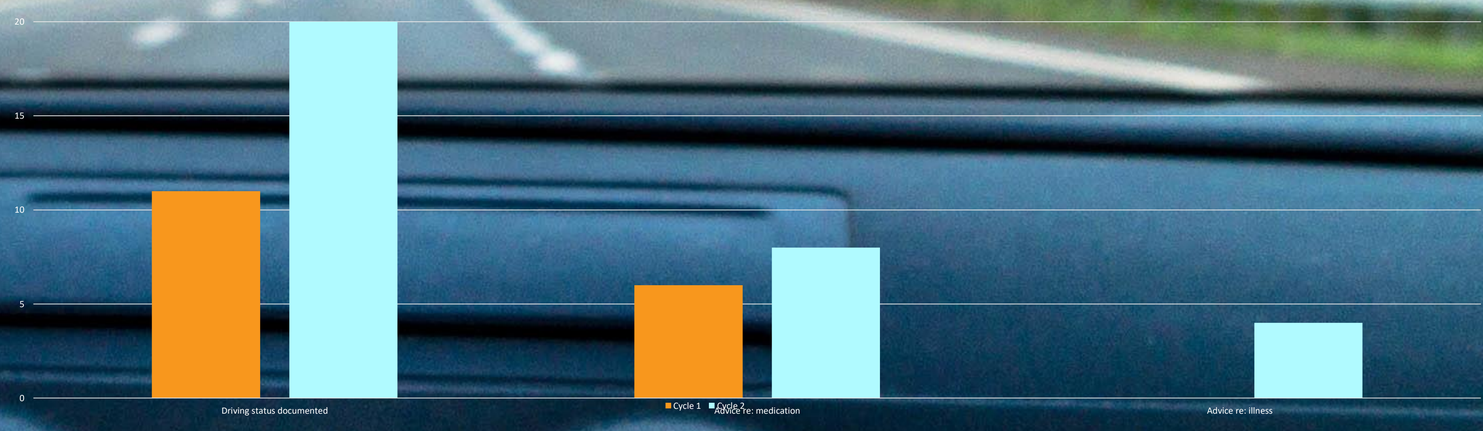


Table 3

Table 4

Compliance with guidelines



04 DISCUSSION

Our study showed that compliance with RSA guidelines was poor both at baseline with some marginal improvements at repeat audit.

It is important to note that the low levels of documentation of driving status in both the initial (20%) and subsequent (36%) audit make it difficult to comment on the appropriateness of the ensuing documentation. This emphasises the need for clear record keeping in order to facilitate accurate data collection.

Given the high rate of prescription of psychotropic medications, the lack of documentation around discussion of side effects is worrying. Similarly, the absence of documented discussion regarding the potential effect of a patient's illness on their driving ability is concerning.

The RSA guidelines clearly state that "doctors and pharmacists have *a duty of care* to advise drivers of the potential dangers of adverse effects from medication and interactions with other substances"[7]. This suggests that a failure to provide such advice could result in a breach of this duty which may result in ***the clinician being found negligent*** in any circumstances arising from this breach of care.

In spite of two active interventions, there was no significant improvement in the results on the re-audit cycle. This reflects the findings of Gallagher et al[9] who, like Orr & Elworthy[10], achieved poor success in implementing change through educational intervention. The addition of a tick box in the discharge summary, to indicate that advice about driving had been given, did not improve our results. While Langan[11] suggested that deficiency in documentation may be related to time constraints, it seems unlikely in this case, given the convenient placement and simple procedure required to tick a box. It is possible however, that this box was lost in the sea of paperwork that requires completion on the discharge of a patient.

While many studies have highlighted a lack of awareness amongst clinicians of medical fitness to drive guidelines[12, 13], we assume that this was not the case in our audit, as the educational intervention was well attended.

Studies[14] have suggested that some clinicians have questioned the validity of the guidelines, deeming them to be too harsh. Ryan et al[15] found a high degree of variability of opinion amongst clinicians with regards to driving guidelines and psychiatric conditions. They suggested that consensus may be improved by utilising the opinions and experience of these clinicians when developing future guidelines. Engaging stakeholders in this way may help to improve the enactment and utilisation of these guidelines.

05 CONCLUSION

In conclusion

- it is the duty of the driving licence holder to notify the RSA of any medical condition or medication that may impact on their ability to drive. Failure to do so is an offence.
- Clinicians have a duty to advise patients of this
- Clinicians have a duty to advise patients of the dangers associated with use of psychotropic medication and psychiatric illness responsibility and failure to do this may be viewed as negligence.
- Clinicians are duty bound to protect the public from unsafe drivers and provision is made by the Medical Council to breach doctor patient confidentiality and report directly to the NDLS in such circumstances.

Our review showed poor compliance with RSA guidelines. Given the poor results from the multiple aforementioned studies which are similar to our own, it is time to consider other strategies, in order to better engage stakeholders and improve compliance with these guidelines.

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