

# MINUTES OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING AND PSYCHIATRIC DISORDERS HELD ON MONDAY 8 MAY 2006

**Present:**

Professor M Lader	Chairman
Professor P Howlin	
Professor D G Cunningham Owens	
Mrs J Gall	
Miss P Steel	
<b>Invited Guest:</b>	Dr B Ritson Chairman of the Secretary of State for Transport's Honorary Medical Advisory Panel on Alcohol, Drugs & Substance Misuse & Driving.
<b>Ex.Officio:</b>	
Dr T Carter	Chief Medical Adviser, DfT
Dr N L Read	Research Manager, DfT
Dr H G Major	Senior Medical Adviser, DMDG, DVLA
Dr P Collins Howgill	CAA
Dr B McCarthy	DVLNI
Dr D A Sheppard	DMDG, DVLA (Acting Panel Secretary)
Dr A White	DMG, DVLA
Mr D Bastin	DDPG, DVLA
Mrs A Rook	DMDG, DVLA
Dr C Hyde	ARIF, Present for presentation of literature search only.

## Agenda Item 1. Apologies for Absence.

Apologies were received from Dr P B C Fenwick, Dr P Divall and Dr D Olajide.

It was confirmed that Dr Fenwick was coming to the end of his tenure as a Panel member. Professor Lader noted that Dr Fenwick had contributed valuable expertise to the Panel over a considerable period of time. His expert contributions would be greatly missed.

The Chairman welcomed Dr B Ritson, Chairman of the Secretary of State for Transport's Honorary Medical Advisory Panel on Alcohol, Drugs and Substance Misuse and Driving to the meeting and introduced the acting Panel Secretary, Dr D A Sheppard from DVLA.

## Agenda Item 2. Minutes of the last meeting held Monday 21st November 2005.

The minutes were accepted as a true account of proceedings on 21st November 2005, and were signed by the Chairman.

## **Agenda Item 3. Matters Arising.**

3(a) Dr C Hyde of the Aggressive Research Intelligence Facility (ARIF) would present the results of the literature search as a formal agenda item. (Included at 7.2)

4.1 DVLA confirmed that the covering letter which accompanied the M2C/M2 forms had been amended; this was included in the bundle for the Panel's opinion and comments. The Panel suggested that in paragraph 3, the term "report" should be replaced with the term "response".

Dr Major advised that DVLA had noted that some physicians, particularly psychiatrists, routinely stamped correspondence with a covering caveat, "in confidence, not to be disclosed", regardless of the nature or content of the correspondence. This has created problems through disclosure under the Data Protection Act and also raised concerns that DVLA was being denied access to relevant medical information pertinent to licensing decisions. The Panel was reminded that the Medical Defence organisations do not condone the use of such routine caveats. The Panel considered that there is now a greater openness within medical services and such practices, with regard to correspondence, have markedly decreased.

## **Agenda Item 4 Feedback for the Chairmen's Meeting held on 8 February 2006.**

4.1 The Chairman reminded the Panel that the Chairmen of the Secretary of State's Honorary Medical Advisory Panels meet annually to discuss mutual points of interest.

4.2 The Chairman advised that a report from an independent firm of consultants appointed by DVLA, i.e. Risk Solutions, was presented. This report had been undertaken to provide a review of the medical driver licensing system.

4.3 The Chairman referred the Panel to a summary of this Review report enclosed in the Panel documentation.

4.4 The Chairman stressed to the Panel that the remit of Risk Solutions had not been to address the medical criteria applied with regard to licensing, but to consider the organisation and application of the licensing process.

4.5 The Panel noted that many of the Review's recommendations raised concerns that had previously been voiced by the Panel, e.g. raising awareness of the need to notify DVLA.

4.6 The Panel did however consider some of the recommendations required further clarification.

4.7 The Panel was assured that these were only preliminary recommendations. They are currently being considered by DVLA and the Department for Transport and would be the subject to public consultation later this year. The Secretary of State's Honorary Medical Advisory Panels will have the opportunity to respond to this consultation.

## **Agenda Item 5 – Review of Forms Design**

5.1 The Chairman wished to acknowledge the contribution made by Dr Mitchell with regard to the redesigning of the M2/M2C forms used by DVLA when assessing drivers with mental health problems.

5.2 The Panel approved the re-formatting of these forms, especially with regard to the reclassification of mental illnesses.

5.3 The Panel confirmed their advice regarding the definition of "rapid cycling" as defined in the "At a Glance Guidelines". The Panel's advice was sought as to whether ICD10 or DSM classifications should be applied when assessing patients with mental health conditions.

5.4 The Panel advised that it was appropriate to use ICD10 coding as this was endorsed by the Royal College of Psychiatrists and is the coding most generally used in both primary and secondary care. The Panel commented that both the ICD10 and DSM codings are converging in their definitions.

## **Agenda Item 6 – Future Direction of the Panel**

6.1 Dr Major reiterated the Chairman's thanks to Dr Ritson for attending the meeting. She then outlined the background for the consideration being given to an amalgamation of the Alcohol, Drugs and Substance Misuse Panel with the Psychiatric Panel.

6.2 The Panel was reminded of the background of the High Risk Offender (HRO) Scheme and the challenges that had been experienced by DVLA when dealing with these cases. The Panel was advised that DVLA is currently

undertaking a review of the handling of cases that fall within the HRO Scheme. In the assessment of the HROs, DVLA has experienced an increase in the declaration of illicit drug usage. It has also been recognised that a number of psychiatric conditions that have been brought to the attention of DVLA have been exacerbated, or caused, by the use of illicit substance misuse and/or alcohol misuse.

6.3 The Panel was reminded that the connection between psychiatric conditions and drug/alcohol usage has been well documented in the medical press and the wider media.

6.4 It has therefore been considered that it may be appropriate to unite the Panels' expertise under a joint chairmanship to bring a broader experience base to the assessment of these cases. The Panel was asked to consider and provide opinion on this proposal.

6.5 Dr Major also advised the Panel that DVLA has recently had meetings with the Disability Rights Committee and the National Institute of Mental Health in England, Social Inclusion Unit, and these meetings have included discussion on broader aspects of rehabilitation that the Panel may wish to consider.

6.6 The Chairman thanked Dr Major for the overview provided and concluded that three questions were being asked of the Panel, (1) should the role of the Panel be extended to include more general and broader advice other than that pertinent to licensing (2) should there be an amalgamation of the Alcohol, Drugs and Psychiatric Panels and (3) if this amalgamation was to occur was there a requirement for extra expertise. This would be determined by the role the Panel was required to undertake.

6.7 Dr Ritson advised the meeting that the proposal of amalgamation had not been formally discussed at an Alcohol and Drugs Panel meeting but he had received individual feedback from the Panel members. He noted that, due to the nature of the cases involved, the Alcohol and Drugs Panel has a closer association with policy and legal/criminal aspects. The consensus of opinion of the members of the Alcohol and Drugs Panel was that they recognised the advantages of an amalgamation but were concerned that agendas of a combined panel might prove lengthy and unwieldy. Individual items of importance could be lost in a large agenda and not receive the attention required to deliberate the issues being raised.

6.8 Dr Major, in her overview, had suggested approaching the relevant Royal College(s) for expert advice with regard to individual or specific points of concern, but Dr Ritson reminded the meeting that, in the past, this approach had not always been most successful.

6.9 Dr Ritson reiterated the Chairman's concerns that any amalgamation would have to be considered in the context of any extension of the role of the Panels. The meeting was also reminded that there have been joint Panel meetings, of a variety of Panel combinations in the past, to address specific issues, as necessary.

6.10 Dr Ritson concluded that via responses that he had received, some members of the Alcohol and Drugs Panel supported an amalgamation where others considered the continuing running of separate Panels to be of benefit.

6.11 The fundamental difference between the two existing Panels is that the Alcohol and Drugs Panel had a sharper focus on legislation than the Psychiatric Panel because of the source of cases. Those discussed at the Alcohol and Drugs Panel often had a criminal contribution, an issue which did not form any part of the discussion of the psychiatric cases.

6.12 Dr Carter suggested that in the future the Panels may be required to offer advice, not only to DVLA, but other areas of the Department for Transport.

6.13 The general consensus of the Panel was that the amalgamation would be beneficial and was welcomed.

6.14 It was suggested that a trial two year period of joint Panel meetings be considered to allow the Panels to experience the wider perspectives. Each Panel could then acquaint themselves with the problems being experienced in the individual Panels.

6.15 Dr Ritson considered it important that these issues be discussed at the next formal meeting of the Alcohol and Drugs Panel in the autumn; a decision on the appropriateness of amalgamating the Panels could then be taken.

## **Agenda Item 7 – Research Update**

7.1 Dr Read provided an information leaflet that detailed recently completed and on-going research projects.

7.2 The Panel was advised that the project on "Attitudes of Health Professionals to Give Fitness to Drive Advice" has experienced ethical approval delays. A very positive progress report meeting which had been held the previous week suggested the project should provide a useful source of information for the Department.

7.3 Dr Read also advised that the Department had obtained funding to undertake a pilot study to determine if a link could be made between road accident data and GP data held on individuals who have been identified as having been involved in a road accident. Ethical approval was being sought. It was hoped that the study may identify medical conditions which appear to be associated with a higher accident rate.

## **Agenda Item 8 – Literature Search**

8.1 The Panel was reminded that ARIF provide a literature search facility to all of the Secretary of State's Honorary Medical Advisory Panels. The first year of a three-year contract had just been completed, during which ten literature searches were undertaken. The report of this first year's work had been presented at the Chairmen's meeting in February 2006.

8.2 Discussions at the Chairmen's meeting produced a number of suggestions which included a two stage approach to the literature search. This would involve ARIF's producing an interim report, which could then be reviewed by nominated Panel experts before continuing and completing the study. The attendance of a representative of ARIF to present to the Panel the completed study at the appropriate Panel meeting was also considered to be of benefit.

8.3 Dr Hyde advised the Panel as to the background of ARIF with regard to the general nature of their work undertaken and their particular expertise.

8.4 The ARIF literature search on accuracy of cognitive screen test as predictors of unfitness to drive had been commissioned on 1 December 2005. Dr Hyde advised that it had been built on the "Fitness to drive and cognition" report of the British Psychological Society, 2001. In his presentation Dr Hyde highlighted the problems in assessing test accuracy in the individual studies.

8.5 It was noted that many of the screening tests were more time consuming than actual on-road assessment which raised questions of cost effectiveness.

8.6 In discussion, it was recognised that loss of a driving licence following an adverse on-road assessment would be more likely to be accepted than the loss following failure on a screening test.

8.7 It appeared that although screening tests may identify drivers who were unfit to drive due to cognitive impairment, it would not be possible in all cases to make this decision without the additional on-road driving assessment.

8.8 Dr Collins Howgill advised that the CAA use both cognitive screening tests and a simulator assessment when assessing fitness to fly.

8.9 The view was expressed that it would be helpful to identify screening tests which could be used positively in the assessment of drivers with cognitive function. However, it was recognised that when considering licence refusal, unless the situation was clearly unsafe, then an on-road driving assessment would be required as being the most acceptable mode of decision making, offering greatest face validity.

8.10 Dr Carter suggested the publication of the results of this literature search could be of benefit to guide further research and studies. The predictive power of functional tests generally also merits further study.

8.11 The importance of differentiation between the underlying medical conditions affecting cognitive function, e.g. stroke, dementia, was considered paramount in determining the assessment screening procedures.

8.12 The Panel concluded that the literature research had been very helpful but unfortunately it would appear that the necessary studies have not been undertaken to provide a definitive answer to the question originally posed by the Panel. On the evidence available, it would appear that there is currently no identified screening test that can reliably predict driver performance and which could be used as a substitute for on-road driving assessment.

8.13 The Chairman asked the Panel whether, as a result of the literature search, any further searches were currently required by the Panel. None was forthcoming at this stage.

8.14 The Chairman suggested that the Panel consider any further requirements for a literature search prior to the next meeting.

## **Agenda Item 9 – Any Other Business**

9.1 Dr Major advised the Panel that DVLA has been approached by the National Institute for Mental Health in England, Social Inclusion Unit. They expressed concerns regarding DVLA's processing of licence holders requiring medication for mental health problems. In view of these concerns they were invited to visit DVLA for discussion.

9.2 The meeting was very productive and resulted in clarification of a number of misunderstandings.

9.3 DVLA had confirmed that it has contact with numerous patient support groups and offers advice on patient information leaflets produced by these groups.

9.4 The representatives of the Unit expressed an interest to attend a meeting of the Psychiatric Panel.

9.5 It was agreed that if the Social Inclusion Unit wished to raise specific issues then this could be addressed as an agenda item at a forthcoming meeting.

9.6 The Chairman advised the Panel that he had been invited to speak on the working of the Panel to a group of psychiatrists. He would hope, subsequently, to be able to feed back to the Panel any of their concerns about the notification of cases to DVLA. The Panel was content with this proposal.

## **Agenda Item 10 - Date of next meeting.**

The next meetings will be held on 20 November 2006 and 14 May 2007.