DRAFT

MINUTES OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING AND PSYCHIATRIC DISORDERS

Held on Monday 8 October 2012

Present:	Professor D G Cunningham Owens	Chairman
	Professor P Howlin	
	Dr I P Divall	
Lay Members:	Mr B Alexander	
	Dr T J Beanland	
Ex Officio:	Dr P Collins Howgill	CAA
DFT:	Dr J E Morgan	Senior Medical Adviser, DVLA
	Dr A M White	Panel Secretary, DVLA
	Ms J Chandaman	Medical Policy, DVLA
	Mrs Sue Charles-Phillips	Business Change, DVLA

Section A: Introduction

Item 1. - Apologies for Absence

Apologies were received from Professor S Banerjee, Professor G Lewis and the representative from DVLNI.

Item 2. – Matters arising from the Minutes of the Chairmen's Meeting held on 21st June 2012

The Panel was informed that following attendance by a representative of the Tri-Services Speciality Board in Occupational Medicine at the last round of meetings it was felt that the agendas of the Advisory Panels did not coincide sufficiently with the requirements of the Armed Forces and that they would not attend further on a regular basis.

The Panel was apprised of the potential difficulties for licensing that may result from the proposed lowering of the drink/drive limit in Scotland. The Panel discussed the potential difficulties that could arise in relation to the High Risk Offenders Scheme for convicted drink/drivers if different drink driving limits existed within Great Britain.

The Panel was advised on progress on drug driving; there was discussion about the practical application of this proposal. The re-modelled Department for Transport was discussed and potential research opportunities. It was decided to await DFT/DVLA's advice as to what subjects would be suitable for research in the future. The priority for research would be road safety based.

To aid the various Panels it was agreed that the Panel Secretary should prepare a brief presentation on conditions of interest to DVLA for the next meeting. This was felt to be particularly helpful to new members of the Panel. This will take place at the next meeting.

Item 3. – Minutes of the last Meeting held on 14 November 2011

The Minutes were accepted as a true record of the proceedings and signed by the Chairman.

Item 4. – Matters arising from the Minutes

The Panel was advised that the proposed joint meeting between representatives of the Psychiatry Panel and Drugs & Alcohol Panel had not taken place.

The Panel was advised that the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' now included a section providing advice on the cumulative effect of multiple medical conditions on driving.

Finally, clarification was sought regarding the latest COPSAC guidelines. It was confirmed that the final version had been produced and that a link would be circulated to all Panel Members.

SECTION B: Ongoing Discussion Topics

Item 5. – Panel Member Recruitment

It was noted in previous meetings that the Psychiatry Panel is one of the smaller Advisory Panels, therefore a decision was made to increase the membership from current levels. The Panel was advised that recruitment has proved challenging in the current economic climate. There was and is reluctance on the part of Trusts and Universities to allow their staff to attend in an advisory role where there is no compensation for the lost clinical sessions or no immediate benefit to the ongoing Research Excellence Framework (REF). This difficulty has been recognised by a number of scientific advisory groups across Government.

Expertise in clinical psycho-pharmacology, forensic psychology and in particular general adult psychiatry was felt to be desirable to the Panel. A number of suggestions were received for potential members.

The Panel also stated that attendance at the Advisory Panels provided a valuable, highly relevant and highly cost effective means of Continual Professional Development (CDP) for those involved in transport & regulation.

SECTION C: New/Ongoing Discussion Topics for Decision or Needing Further Information/Research

Item 6. – Licensing during Compulsory Admission or Treatment

The Panel discussed the licensing of drivers whilst detained under compulsory sections of the mental health legislation. It was confirmed that the primary determinant of the licensing status would be the underlying psychiatric problem. This was likely to be debarring for licensing purposes if the severity of the episode was such that a compulsory detention in hospital for treatment was necessary.

The importance of appropriate advice from the responsible clinician regarding driving during Section 17 leave was strongly emphasised. The responsible clinician should give specific advice to the patient regarding driving. It was emphasised that a difference in status existed between Section 17 leave from a hospital and a Community Treatment Order.

The Panel acknowledged that similar issues were relevant to approved passes in those detained under comparable jurisdictions within the United Kingdom.

Whilst an inpatient subject to a compulsory detention order, licensing would not normally be appropriate. Consideration can be given to licensing as part of a rehabilitation programme where re-starting driving was part of a planned process for re-integration into the community and employment. Licensing would normally take place on discharge from hospital or the compulsory section.

It was stressed that all cases would be considered on an individual basis and the licensing decision tailored to the individual circumstances.

Clarification was also provided to the Panel over the role of the Traffic Commissioner in licensing drivers for Passenger/Carrying Vehicles. This was felt to be a further safeguard to inappropriate licensing.

Item 7. – Minimal Cognitive Impairment and the Assessment of Cognitively Impaired Drivers

As an example the Panel discussed a scenario of an elderly driver stopped by the Police for erratic driving and where a mild impairment of cognition was felt to have possibly been a factor. In the scenario reports from the driver's doctors did not highlight any formally diagnosed conditions however, objective on road driving assessment highlighted significant difficulties. Discussion took place as to whether a licence could be revoked on the basis of the driving performance or whether in the absence of a recognised diagnosis a recommendation to retain the licence would have to be made. The erratic driving may require disqualification by the Courts if there is no recognised medical cause apparent. Panel reiterated that age alone was not reason to remove a licence entitlement and should never be.

There was a wide-ranging discussion around the various methods of assessment available to the clinician. Panel stated that the absence of a recorded diagnosis may not correlate with the absence of pathology, the index event being the first presentation of possible problems. It was noted that driving is a high level skill and that difficulties present in forward planning and the processing of the multiple, complex sensory inputs required for safe driving may pre-date the formal recognition and diagnosis of cognitive impairment or dementia by a doctor. The Panel indicated that the commonly used assessment tools, particularly those used by non-specialists e.g. the Mini Mental State Examination (MMSE) rating skill were designed as screening tools for dementia and do not correlate with driving ability and have a limited role.

Cognitive abilities of particular relevance to safe driving are executive skills, frontal lobe function and the ability to forward plan particularly in new situations. These were not measured accurately by the MMSE rating scale. Panel indicated that the Addenbrooke's

Cognitive Examination and Montreal Cognitive Assessment are probably better at assessing driving related functions. Panel stated that the most relevant assessment to determine whether a driver was able to drive safely in traffic was a functional assessment of ability by means of an on road driving assessment or similar process. Parallels were drawn with the assessment of commercial pilots and the use of simulators in assessing performance.

The MMSE rating scale is dependent on a subject's language skills and pre-morbid functioning. A subject with a high level of pre-morbid function may still experience a significant loss in function before it becomes apparent via the rating scale.

The Panel discussed the concept of mild cognitive impairment (MCI), the discussion was wide ranging and reflected the difficulties in balancing a strictly research based definition with a functional day to day definition. It was agreed that the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' would be amended to reflect the more functional approach required in daily practice.

The Panel emphasised the value of clinical examples in illustrating practical licensing points and expressed their willingness to consider further cases.

SECTION D:

Item 8. - Research Update and Papers

European Older Drivers Survey Report June 2012

The Panel received the report. This provoked a wide ranging discussion; the Panel noted the wide variability of licensing practices across Europe and the fact that the United Kingdom is one of the few countries to fund investigations into a driver's medical licensing status. In the majority of European countries, the licence holder is required to fund the enquiry process. It was also noted that the United Kingdom and the Isle of Man were the only countries to utilise self-declaration by the driver as a major part of the enquiry process.

Item 9. -Any Other Business

The Panel discussed the practical implications of a potential extension in the licensing period available in the case of review licences to a maximum of ten years. It was recognised that the majority of mental health conditions are not progressive in nature but rather intermittent relapsing conditions in which a longer review period may not provide an operational benefit. Most drivers being issued either with short period review licence of between one to three years duration following an acute event and then once stability is attained, a long duration 'Till 70' licence issued.

The Panel also discussed at this juncture licensing in Personality Disorders. There was discussion over the nature of these conditions and their duration. The Panel was informed that operationally a short period licence is issued if there has been a recent deterioration or admission however; the vast majority of licences issued are of the 'Till 70' duration.

Item 10. – Dates and Times of Next Meetings

These were confirmed as the 18 March 2013.

The Panel confirmed an intention to return to meetings twice a year.

The Panel recognised the valuable service of Dr Paul Divall over the past 11 years; this was his last attendance at Panel. The Panel and the Department extended their appreciation for his long service and wisdom over the years.

DR A M WHITE
Panel Secretary

15 November 2012