



that child and adolescent psychiatrists can help to disseminate good practice within tiered child and adolescent mental health services.

Research

Training guidelines allow for one day per week to be spent on research. Thirty-one per cent of trainees reported they did not receive formal research training. Twelve per cent of trainees were not certain they would have the equivalent of one day per week for research and 18 trainees appear to be taking research time without having a project. Given the cost of providing one day per week as research time, it is questionable whether this is the most efficient way of promoting either research in child and adolescent mental health or trainees' understanding of research methodology. While registration for a higher degree or publication of papers cannot be taken as absolute indicators of the quality of research, a significant number of trainees appear to be undertaking research which does not result in published papers and are doing so without formal teaching.

Knowledge of training guidelines

It is particularly concerning that many trainees had not seen the CAPSAC advisory papers or the HST Handbook, since these set out training requirements. At this advanced stage in training, it may be argued that trainees should be taking more responsibility for ensuring their training meets the guidelines. The confusion apparent between trainees on the

same scheme as to what is available and trainees' generally poor knowledge of CAPSAC and training issues suggest this may not be the case.

In conclusion, despite clear guidelines, trainees are not universally and consistently receiving the training experiences expected. Improvements have been made since 1990, notably in provision of supervision and access to a range of clinical experiences. Clearer dissemination of information on available training experiences is important but also trainees' personal responsibility for ensuring their training meets guidelines and equips them to be child psychiatrists of the future.

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Driving in Somerset

AIMS AND METHODS

The number of drivers on our roads with dementia is likely to increase as the elderly population grows. We performed a retrospective analysis of patients referred to our Memory Clinic in Taunton who were still driving despite a high suspicion of dementia.

RESULTS

Twenty per cent of the patients were still driving at the time of their assessment. Ten per cent had a diagnosis of Alzheimer's disease and 10% mild cognitive impairment. The patients and/or carers stated that the patient had not been told to stop driving and none of the referral letters documented any advice about driving.

CLINICAL IMPLICATIONS

Referrers should advise all patients with possible dementia to refrain from driving until assessment by a specialist team is completed. They should be informed of the risk of medico-legal consequences if they continue to drive.

The new millennium has seen the number of people aged 65 years and over grow to be about 423 million, nearly half of whom live in developing countries (World Health Organization, 1993). As Alzheimer's disease increases exponentially with age, dementia will become more common (Evans *et al*, 1989).

Many studies reveal an increased motor vehicle accident (MVA) rate for drivers with dementia compared with those without dementia (Gilley *et al*, 1991; Logsdon *et al*, 1992; Friedland *et al*, 1998). Although 50% of the former stop driving within three years of onset of dementia the risk

of an MVA increases with the duration of driving after onset, especially for male drivers (Carr, 1997).

In a Finnish study of men over 70 years old who had stopped driving the most frequently stated reason for stopping driving was deterioration in health (Hakamies-Blomqvist & Wahtstrom, 1998). However, only 6.9% of the ex-drivers had received professional advice to stop driving. In one study, drivers who scored in the lowest 10% on specific cognitive testing were found to be 1.5 times more likely to experience MVAs than those drivers in the highest 10% (Stutts *et al*, 1998).



The Driving and Vehicle Licensing Agency (DVLA) guidelines for medical practitioners (DVLA, 1998) state: "It is extremely difficult to assess driving ability in those with dementia. Those who have poor short-term memory, disorientation, lack of insight and judgement are almost certainly not fit to drive. Disorders of attention are important. In early dementia when sufficient skills may be retained, a formal driving assessment may be necessary".

The DVLA Medical Advice Unit suggests that people with a suspicion of dementia should stop driving until a diagnosis of dementia is excluded.

Aims

The aims of our study were to find out how many patients referred to our Dementia Memory Clinic were still driving at time of assessment despite having cognitive impairment and how many of these were advised to stop by their referrers until assessment had been completed (in accordance with the DVLA Medical Unit's advice).

The study

In a retrospective analysis, the notes of all new referrals to the Dementia Clinic at Pyrland House Old Age Psychiatry Unit, Taunton and a satellite clinic at the district general hospital between June 1998 and May 1999 were scrutinised.

All of those still driving were classified using the ICD-10 (World Health Organization, 1992) and according to results on psychometric testing using Mini-Mental State Examination (Bleeker *et al*, 1988) and Cambridge Cognitive Examination of the Elderly (CAMCOG) (Hupper *et al*, 1995) assessment scores. Carers were contacted and referral letters scrutinised to see if any advice concerning driving had been given.

Findings

A total of 84 cases were referred to the clinic. Seventeen (20%) patients were still driving at the time of the assessment (5 female, 12 male).

Of the 17, using the above mentioned criteria, the diagnoses were: seven with dementia in Alzheimer's disease with late onset (two female, five male); one with dementia in Alzheimer's disease of a mixed type (male); one patient was found to have no actual cognitive impairment (female); and eight had a mild cognitive disorder (two female, one male).

Of the eight patients in the mild cognitive disorder group CAMCOG scores ranged from 82–101 out of 106 (cut-off for dementia being 80 with up to a 10-point variation for age, socio-economic status and education (Hupper *et al*, 1995)). These variables were not assessed in the study.

Regarding referral letters: one could not be found, two were referrals from general physicians and 14 were from general practitioners.

Although two letters mentioned that the patient was still driving none mentioned that they had advised them to stop driving.

Discussion

This simple study illustrates that when doctors (usually general practitioners) refer a patient with a likely diagnosis

of dementia to the Memory Clinic in Taunton they do not document in the letter to the clinic that they have told the patient to refrain from driving until dementia is excluded (admittedly the referring doctor could have documented this in his or her notes and the patient may forget or ignore the advice). In our opinion, if no documentation exists then medico-legal liability may become an issue should an MVA occur.

Our study showed that eight (almost 10%) of the referred patients who were still driving were probably unsafe to do so, as they had a definitive diagnosis of dementia. The group with mild cognitive disorders (almost 10%) showed quite a large variation in CAMCOG scores – these patients we found difficult to decide on how to advise. Storandt & Hill (1989) showed that it is difficult to decide who has normal ageing and who has early dementia. Further investigation of the DVLA guidelines and the DVLA medical advice made the following clearer:

- (a) Where there is a suspicion of dementia the person should be advised to stop driving until assessment by a psychogeriatric team is completed. We suggest that this advice should be documented.
- (b) All patients diagnosed as having dementia should be told to stop driving and to inform the DVLA. If they disagree that they are unsafe they should ask for a driving assessment from the DVLA, but they should still be advised not to drive until the DVLA has completed its assessment. If the patient passes this assessment then the DVLA may award a time-limited driving licence which may be renewable every six months or so, for example, pending further assessments.
- (c) All cases that fall into ICD-10 mild cognitive disorder should be assessed to see if they only have age-related memory loss with no other significant areas of cognitive deficit. If this is the case then the psychogeriatric team does not have to advise them to inform the DVLA. However, these patients should undergo a periodic review as their cognitive performance may deteriorate further.

The group with mild cognitive disorder who show cognitive losses in areas other than memory and/or those who have loss of normal daily living skills should be advised in the same way as those with dementia.

The latest General Medical Council guidelines state that it is the doctor's job to inform the patient that the DVLA needs to be informed and that they should refrain from driving pending the DVLA assessment. If they continue to drive then the doctor should tell them that he or she has no choice but to inform the DVLA.

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