the columns

correspondence

Reforming emergency care

Harrison & Bruce-Jones (*Psychiatric Bulletin*, July 2003 correspondence, **27**, 276) have misrepresented much of our editorial (*Psychiatric Bulletin*, March 2003, **27**, 81). We fully recognise the limitations of emergency psychiatry, and support the development of more flexible and responsive services for patients in crisis. None-the-less, the accident and emergency (A&E) department is, and will continue to be, a major interface between mental health services and acute trusts – a fact recognised in the National Service Framework for Mental Health (Department of Health, 1999).

As our locality is well served by home treatment teams and a 24-hour psychiatric emergency clinic, significantly less than 50% of A&E attenders are known to psychiatric services, although importantly many are known to A&E. That homeless patients, refugees, patients who have self-harmed and are intoxicated, and those not registered with primary care, will continue to seek help from A&E is just the way of the world – especially in inner cities. Here too, the police will continue to bring individuals they find disturbed in a public place. Increasingly sophisticated and complicated community services may only have a limited impact on many of these presentations.

It is precisely because we believe that psychiatric patients in A&E should expect the same level of service as other patients that we raise our concerns about the 4-hour wait. We did not advocate 'resistance' to the 4-hour target, nor did we suggest that there is a correlation between the length of an assessment and its quality. We do, however, advocate a thorough and sensitive assessment of the patients' difficulties and there are times when this will conflict with the need for the patient to have left the department within 4 hours. Mental Health Act 1983 assessments take time if due process is to be followed. Were Harrison & Bruce-Jones advocating more frequent use of Section 4?

We agree (and stated in our editorial) that adequate resourcing of general hospital liaison psychiatry is important. However, Harrison & Bruce-Jones sidestep key questions – who should pay for this? and who should be penalised if the targets are not met? Our experience in inner-London leads us to doubt that enhanced community psychiatry will impact greatly on these problems. We suggest that it is vital for psychiatry as a whole to respond to the fundamental issues raised by the imposition of the 4-hour wait in A&E.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health*. London: NHS Publications.

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Using DVLA guidelines

In this age of litigation, we are increasingly concerned to fulfil our duties and follow guidelines when they are available. An example of such a duty is to advise drivers about driving in accordance with Driver and Vehicle Licensing Agency (DVLA) Guidelines (2001).

Humphreys & Roy (1995) found that 25% of psychiatrists never gave any advice about driving to patients with psychiatric illness and Elwood (1998) found that 13% of psychiatric patients who continued to drive did not fulfil DVLA standards of fitness to drive.

We carried out a survey of all in-patients on the acute wards of a 200-bedded psychiatric hospital to determine what they recalled about information given about driving. Of the 88 patients surveyed, 56 (64%) completed the questionnaire and 39 (70%) were drivers. Twenty-six drivers (67%) remembered discussing driving with a professional. We found documentation about driving in medical records in only three case-notes.

Possible reasons for these results were that patients were unable to remember conversations about driving due to the severity of their symptoms. They might not have wanted to admit their knowledge because they were suspicious about the aims of the survey. However, with the lack of documentation in the notes, it seems likely that many patients had not discussed driving with a professional. Failure to discuss driving might have been an oversight, or even deliberate. Either would not be too surprising, as we ourselves find the Guidelines (2001) confusing. Diagnoses do not correspond to ICD–10 or DSM–IV. It is not always clear what professionals should be advising; for example, whether a patient should cease driving immediately or not. Some professionals may even decide that it is not in a particular patient's best interests to discuss driving, as it may interfere with the therapeutic relationship and/or compliance with treatment.

However, many professionals are worried about the possible legal consequences of giving incorrect or inadequate advice about driving. The medical adviser at the DVLA has reassured us that there have been no successful legal challenges in the UK to date. However, this is not the case in the USA (Hollister, 1992). Increased clarity in the guidelines would enable us to be sure we can fulfil our duties. We have decided to give written information about driving to all in-patients and will audit the results of this intervention.

DRIVER AND VEHICLE LICENSING AGENCY (2001) *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.

HOLLISTER, L. E. (1992) Automobile driving by psychiatric patients. *American Journal of Psychiatry*, **149**, 274.

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

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Pre-registration house officer training in psychiatry

I was struck by Rebecca Mason's claim (*Psychiatric Bulletin*, October 2003, **27**, 394–395) that, in 1981, she was involved in one of the first pre-registration house officer posts in psychiatry in this country. In fact, in 1960, at the Sefton General

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