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the need of additional finance or team time. Second, the improvements were gained at a cost of no extra paperwork. And finally, the audit was prioritised, designed and carried out in a true multidisciplinary setting. The main goal of risk assessment audit, to demonstrate an effect on the actual incidence of violent incidents, needs to be studied in further research.

Recommendations

(a) Taking a full risk of violence history is necessary to manage risk appropriately. Risk assessment forms cannot be completed if the relevant information is not available.

(b) CMHTs should regularly audit the quality of their notes with regard to assessment of risk of violence.

(c) A structured approach to assessment will improve the comprehensiveness of risk assessment.

Acknowledgements

We would like to acknowledge the staff of Tooting/Furzedown CMHT and Anna Gotte and Maria Iliopoulou of Springfield University Hospital Audit Department.

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Psychiatric Bulletin (2001), **25**, 252–254

TIM BRADBEER, JIM ORMSBY AND PHILIP FLEMING

Questionnaire survey of automobile driving among users of a substance misuse service

AIMS AND METHOD

Users of a substance misuse service were asked to complete a questionnaire, detailing information about driving habits as well as attitudes about substance use and driving.

RESULTS

Of 120 subjects, 94 had ever driven, with only 36 currently driving. Fifty-six subjects had been charged with a driving offence but only 18 stated that they had been involved in an accident while intoxicated. The majority would not use drugs before driving and remain within a safe level of alcohol use. Most subjects stated that they were not informed of current legal issues concerning driving and substance use.

CLINICAL IMPLICATIONS

Users of a substance misuse service were reasonably responsible in their driving habits, however, it is still important for clinical staff working in such services to make their patients aware of the danger of driving under the influence of substances.

The latest figures of road traffic accidents from the Department of Environment and Transport (1999) show 3423 fatalities and 39 122 serious injuries annually. The Road Traffic Act 1988 states that:

> "A person who when driving or attempting to drive a motor vehicle on a road or other public place and is unfit to drive through drink or drugs is guilty of an offence."

The dangers of driving under the influence of alcohol have been well recognised for many decades (Cohen *et al*, 1958). There is increasing evidence that drug use, particularly that of tranquillisers, stimulants and cannabis, not only affects responses and judgements, but is also frequently (ranging from 7.4% to 40.9%) being found in the blood of traffic accident victims (AA Group Public Policy, 1998). There have been few studies into the problems of driving and psychiatric populations, particularly patients who misuse substances. A recently published paper by Albery *et al* (2000) demonstrated that in a group of out-of-treatment users, 81.7% reported driving after consuming illicit drugs, 53.3% of whom held a driving conviction, and 41.4% having been involved in at least one road traffic accident.

https://doi.org/10.1192/pb.25.7.252 Published online by Cambridge University Press

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Objectives

The aims of this study were twofold. The first objective was to establish the driving habits of a cohort of patients of a substance misuse service, and second, to establish the level of responsibility towards driving held by the cohort.

The study

Substance misusers who presented to the in-patient detoxification unit or medical out-patients during an 8-week period between November 1999 and January 2000 were asked to fill in the questionnaire. The questionnaire, amended after an initial pilot, asked about current drug use (illicit and prescribed), alcohol use and driving habits, particularly whether they had driven under the influence of drugs or alcohol; been charged with a driving offence; or been involved in an accident. Questions also asked about what they would consider a safe level of drug or alcohol use before driving and if they had been given information about legal issues concerned with substance use and driving. The Leeds Dependence Questionnaire (Raistrick *et al*, 1994), a 10-item instrument designed to determine the level of dependence for a variety of substances, was also completed.

Findings

The population

One-hundred-and-twenty patients out of a total of 130 agreed to complete the form. The majority of patients were male (a total of 70%), with 54.2% being treated as in-patients. Of the sample, 44.2% were aged 40 and over, with only 28.3% being under 29 years. Table 1 shows the distribution of primary substance in current use by the sample. A total of 56 (47.7%) subjects were using more than one substance, the range of substances used being 0–5, a mean of 1.8 substances per subject. Primary alcohol use was defined as a total weekly consumption exceeding 40 units of alcohol; 16 subjects were drinking less than this and were not using drugs. According to the response to the Leeds Dependence Questionnaire 40.3% of patients scored 20 or over – the cut off for severe dependence.

Driving habits

Twenty-six people had never driven a car and only the remaining 94 completed the rest of the questionnaire. Of those that had driven, only 36 (38.3%) were current drivers. The majority (75%) of current drivers used their vehicle on a daily basis. Table 2 shows the response to the questions about driving habits. Of the 56 people who were charged with a driving offence, 50% had a drink–drive charge. Only 18 (19.1%) of the subjects stated that they had been involved in a road traffic accident while intoxicated, five while under the influence of drugs, seven under the influence of alcohol and six influenced by drugs and alcohol.

Table 1. Primary substance use

Substance	*n*=120	%
Prescribed methadone	24	20.0
Alcohol – over 40 units	18	15.0
No substance use	16	13.3
Heroin – intravenous	16	13.3
Heroin – inhaled	14	11.7
Cannabis	10	8.3
Prescribed benzodiazepine	8	6.7
Illicit amphetamine	6	5.0
Prescribed amphetamine	3	2.5
Illicit opiate	3	2.5
Prescribed opiate	2	1.7

Table 2. Responses to driving questions

Positive response	*n*=94	%
Holding a valid licence	48	51.0
Currently driving	36	38.3
Drives under the influence of drugs	60	63.8
Drives under the influence of alcohol	46	48.9
Charged with driving offence	56	59.6
Involved in a road accident while intoxicated	18	19.1
Given information about legal matters	43	45.7

Table 3. Responses to levels of safety prior to driving

	Substance	%
Alcohol (*n*=90)[1]		
No use	40	48.2
Less than 5 units	28	33.7
5 or more units	15	18.1
Drug (*n*=83)		
No use	49	54.5
Current use or less	30	33.3
More than current use	11	12.2

1. This represents the only missing data – four unanswered responses for alcohol and 11 for drugs.

Responsibility

Six subjects, 16.6% of those currently driving, did not hold a current driving licence. Table 3 details the response to the questions of safety and substance use. For the presentation of results, the amount of alcohol use was divided into three categories: none; fewer than 5 units; and 5 units or more – which is most likely to lead to a blood alcohol level over 80 mg, the current legal cut off. There are no such legal measures for drugs, so responses were divided into none; a level less than or equal to the individual's current use; and a level that was more than the current use.

https://doi.org/10.1192/pb.25.7.252 Published online by Cambridge University Press

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Discussion

Relatively few (7.7%) declined to answer the questionnaire, so we achieved a good representation of those accessing the service. The population was unremarkable as a substance misuse group in contact with services, 40% being severely dependent, the majority being male and over the age of 30. There was a wide spread of substance use – opioids and alcohol most frequent – reflecting the emphasis of treatment within a clinical service. The first issue, of driving habits, shows that few were currently driving, which may be for financial or legal reasons as opposed to actual choice. Most had driven while influenced by either drugs or alcohol and had charges for driving offences, often drink–driving. This would suggest that most would feel safe combining substance use with driving even though legally many are being challenged. The low reporting of the traffic accidents suggests either a fairly high level of driving competence or an underestimation of accidents.

The second aim was to establish the degree of responsibility. Contrary to the above, responses suggest a high level of awareness of safe levels of substance use before driving, with only a small proportion seeing excess drug or alcohol use as safe. Despite this, substance misusers continue to drive following usage, possibly minimising the perceived risks attached to driving while intoxicated. One explanation of this, as proposed by Albery *et al* (2000), is that:

> "Actual experience of driving after taking drugs could create realistic knowledge and hence a more accurate perception or judgement of the different impairing effects of various illicit drugs."

It is standard local practice at the first interview to run through driving issues with each user and so it is surprising that most people reported not being given information about legal matters. This could be explained by the regularly demonstrated poor retention of information following clinical interviews. The Driver and Vehicle Licensing Agency (1999) widely distribute information regarding fitness to drive – group one licence holders (motor car and motor cycles) who persistently use cannabis, ecstasy and other hallucinogens will have their licence revoked for 6 months. This period increases to 1 year in use of amphetamines, heroin, benzodiazepines, cocaine and methadone (except supervised oral methadone users, who are subject to annual reviews). This must be crucial information to impart to such a population.

Comparing the results to those of Albery *et al* (2000), the two studies show very similar proportions of subjects that held driving licences, had used drugs prior to driving and had driving convictions, although they found a much higher rate of substance related accidents.

This study begins to look at how substance users may assess risks and responsibilities with regard to driving. With increasing prevalence of substance misuse the danger of driving while under the influence of substances merits further investigation. Clinicians have a responsibility to alert their patients to the risks.

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Psychiatric Bulletin (2001), **25**, 254–256

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How many patients self-medicate with St John's wort?

AIMS AND METHOD

St John's wort is popularly taken as a herbal remedy, but it interacts with prescribed drugs. The aim of this survey was to estimate the prevalence of patients self-medicating with St John's wort. All new referrals to a community mental health team over 5 months were asked about any use of St John's wort.

RESULTS

Fifteen patients, of 101, had taken St John's wort at some time and of those seven were currently taking it. Patients who used St John's wort tended to be younger and female. Only nine of the 15 patients took it for depressive symptoms and none had received medical advice. One patient was taking an interacting medication.

CLINICAL IMPLICATIONS

A significant number of patients are taking St John's wort. In order to prevent drug interactions, doctors should ask all patients whether they use it, especially young women who may be on the contraceptive pill. Patients need better education about its risks and benefits and it should be taken with medical advice.

https://doi.org/10.1192/pb.25.7.252 Published online by Cambridge University Press