
be returned to the author WITHOUT EXCEPTION".

I have looked at the two sets of guidelines and obviously there is some overlap but I am left with the feeling that the left hand does not know what the right hand is doing!

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Driving and dementia: DVLA guidelines?

Sir: Paul Thompson and Deborah Nelson (*Psychiatric Bulletin*, June 1996, **20**, 323–325) report their questionnaire survey of psychiatrists' knowledge of DVLA regulations. They state that in early dementia "driving is permitted if no significant disorientation and insight and judgment are retained". This is a quotation from the literature, forming part of a discussion in *Medical Aspects of Fitness to Drive* (Taylor, 1995), but is by no means a clear guideline. There is no clear relationship between the degree of dementia and driving ability, nor is psychometric testing particularly helpful (Friedland, 1988).

It seems at the moment that the best ways of assessing fitness to drive in dementia are a combination of history of driving ability from the patient and caregiver, and in uncertain cases on-road or off-road driving tests (Odenheimer, 1993). There is also the possibility of a driving simulator test, although this is not routinely used in this country.

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ODENHEIMER, G. L. (1993) Dementia and the older driver. *Clinics in Geriatric Medicine*, **9**(2), 349–364.

TAYLOR, J. F. (ed.) (1995) *Medical Aspects of Fitness to Drive*. London: The Medical Commission on Accident Prevention.

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Care Programme Approach (CPA) in the community

Sir: We were interested to read the correspondence from Mark Evans and his colleagues on the CPA (*Psychiatric Bulletin*, July 1996, **20**, 444–445). We have recently conducted a survey of members of staff about their opinions on the benefits and problems associated with CPA implementation. Our survey indicated that many staff were experiencing severe logistical difficulties with the Care Programme Approach. Ninety-

three per cent of the sample ($n=45$) agreed that administrative tasks, such as arranging and attending meetings and completing documentation, were putting extra demands on their time, to the degree that it decreased their contact with patients. The reason for this appeared to be the policy of assessing and recording the needs of every patient within a large Trust, currently having over 9000 contacts each year. It seemed to us that attention was being paid to the bureaucratic external manifestations of the CPA for all patients, to the detriment of improving service provision for those in most need.

The demands made on professionals by CPA administrative tasks are impractical. For example, discussion of CPA generated matters added 110 minutes to a multidisciplinary meeting involving 14 professionals, some of whom had cancelled ward rounds and home visits to be there. Thus, in one day 25.7 hours of time had been effectively lost to patient care.

In our view, given the limited resources and manpower available, care programming must be effectively targeted at the most vulnerable patients. The ideal of always tailoring care to the needs of every individual patient, while laudable, may not always be realistically achieved.

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Supervision registers

Sir: I read with interest Mr Vaughan's survey of the application of the supervision register in four Regional Health Authorities (*Psychiatric Bulletin*, March 1996, **20**, 143–145). I have also addressed the question of how the Health Service Guidelines concerning supervision registers have been implemented by auditing the register of one Trust. This revealed similar findings to Vaughan's study – a register "absorbed organisationally but less accepted professionally".

The Trust in which I conducted the audit serves a catchment area of 100 000 people. There are three consultant psychiatrists. The supervision register was implemented in accordance with the Health Service Guidelines on 1 October 1994. In May 1995, 12 patients were registered – one 54-year-old woman and 11 men, six of whom were in their forties. Six of the patients had a diagnosis of schizophrenia, two had a diagnosis of affective disorder and two had a diagnosis of alcohol abuse or dependency. Seven had been detained under the Mental Health Act 1983 at the time of inclusion on the register. For each patient the reason for inclusion on the register was clearly documented – significant risk of suicide, serious harm to others and/or risk of serious self-neglect.