CATEGORY G
PSYCHIATRIC OR EMOTIONAL CONDITIONS

1. There is no certain way of predicting which person with psychiatric illness will have accidents, but many high risk drivers are such because of psychiatric conditions. Consistent application of the point system reflecting accident involvement and reckless driving with imposition of appropriate driving restrictions will help to identify and control many of the psychiatric population at risk.

2. The involuntary hospitalization or commitment law presently in effect in the State of Utah requires that the individual to be committed must have a major mental illness, lack insight into their condition, be untreatable or inadequately treated in programs involving less restriction of personal freedom, be an imminent danger to themselves or others, or be incapable of self care. The coincidence of these four criteria adjudicated at a court hearing would be strong grounds for the withholding of the driving privilege during the duration of the commitment. Those committed for treatment without in-patient hospitalization should be evaluated individually as to risk. Termination of committed status does not mean that the patient is necessarily mentally well but merely improved. Such individuals should be medically screened before resuming driving privileges.

3. There is a large population of individuals with psychotic illness who are being maintained on anti-psychotic medications in an ambulatory status in the community. All of these drugs, as well as the tricyclic anti-depressants, have varying degrees of sedative side effects and potentiate other CNS depressants. The quality of the remission being maintained by medication varies widely. Some of the individuals continue to have significant mental disability. These persons should be screened in terms of severity of side effects incident to medication and the adequacy of the remission in terms of a reasonably stable, reality oriented, socially responsible and impulse controlled adjustive style.

4. Benzodiazepines have been implicated in automobile fatalities to a degree comparable with alcohol. Research shows the major period of risk is the first three weeks, after which tolerance generally develops to the sedation and dysfunctional effects on coordination.

5. There are a variety of behavioral conditions, extremes of mood and impairments in thinking associated with psychiatric disorders which may correlate with accident proneness or driver risk. These include:
   a. Inattentiveness which may accompany even minor mental disturbances;
   b. Impulsivity, explosive anger, and impaired social judgment characteristic of personality disorders, especially antisocial personality (difficult unless a track record is confirmed by history of arrests);
   c. Suicidality, perceptual distortions, psychomotor retardation or frank irrationality in addition to the previously described symptoms which are common features of major psychiatric illnesses such as schizophrenia, major depressive disorder, bipolar (manic depressive) disorder and organic brain syndromes.

6. **The applicant's prior accident and violation records are more valid "predictors" of driver risk than psychiatric status**. This record should be a major factor in placing restrictions upon driving. The combination of a bad driving record and mental disability could be a particularly lethal combination. If an applicant reports accidents or moving violations, the health care professional should be alert to possible psychiatric problems.

7. If a health care professional believes there may be a problem, but is not sufficiently familiar with the patient's psychiatric status to make a valid judgment, they should refrain from doing so until they gain access to current psychiatric information or records or makes an appropriate referral for evaluation.