1686a PSYCHOLOGICAL CONDITIONS – FIT TO DRIVEDonna Morgans. *London for Transport, London, UK*

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The assessment and work implications of Psychological conditions are of key importance in Occupational Health. This is due to the impact such conditions have on fitness for work and their prevalence among the national workforce. It is also true that work itself can impact on psychological conditions in both a positive or negative way. Nowhere is this more important than in the myriad safety critical settings in which we advise, including fitness for Occupational driving and Train driving. Creating evidence-based standards and guidance in relation to work and psychological ill health is considered integral in ensuring safety and equality. In Transport for London Occupational Health the approach to creating standards and guidance relies on close and early collaboration with stakeholders and subject matter experts. Risk assessment and medical literature review are also an important part of the process. This guidance outlines the assessment criteria and the framework for individual risk assessment. Through this approach we hope to achieve high quality occupational health advice that is evidence based and risk appropriate. The advice is also targeted to the individual and their specific work role.

1686b POLITICS AND SAFETY. WHY PRESERVING THE NORDIC MODEL IS MORE IMPORTANT THAN THE DOCTOR'S HEALTH ASSESSMENT FOR TRAFFIC SAFETYOern Foss. *Norwegian State Railway, Oslo, Norway*

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The changes of work conditions in the Nordic countries are a serious threat to the railway security. The Nordic model, characterised by good working conditions, safe employment with a decent wage and well-functioning welfare systems is on a decline. The Nordic model is also based on union and individual worker's involvement, high degree of labour union membership and extensive trust given to the employee to do the job and safety assessments on their own.

Many of the basic requirements for a functioning Nordic model have changed, and are about to change even more in a way that constitutes a threat to the traffic safety; Globalisation, privatisation, change of working conditions, more control systems, and destabilising work environments with up splitting of companies and their medical services are results of political decisions made outside the railway doctor's or other health management's office walls.

With globalisation and the implementation of 'free trade agreements' like TISA and TTIP, the development we have seen in the traffic sector of drastic changes in the working conditions for the employees, is likely to continue. For seamen/sailors and lorry drivers, the changes have been in effect so long that the new situation is 'normal'. For taxi drivers, the code word Über is maybe enough to describe the decline in prestige, social acceptance and working conditions for them. If you want to make a living, you need to be on call and available 24/7 and you can forget family or social life, buying a home with a bank loan or enjoy the benefits of an

employer who takes interest in workplace health promotion programs. Of course, this also has influence on traffic safety.

My worry is that these types of changes have now spread into the air traffic industry (e.g. low-cost airlines like Ryanair), bus transport companies and even in the railway sector with a wide variety between countries and operators up to now. Short-term assignments, increased mobility with flexible (and unpredictable) working hours, often change of operator when tenders are used, less union influence, increased job insecurity and less integrated occupational health professionals in the companies, all contribute to a weaker safety culture. This might lead to more accidents even if the health assessments of the individual driver not have shown any medical contradictions.

So, to me it seems that engaging in political issues with a tough defence of the Nordic model and fight against the globalisation and privatisation waves with their negative effects, is a better way of ensuring traffic safety than keeping up with the doctor's health assessment!

1686c A SYSTEMATIC REVIEW OF EVIDENCE FOR FITNESS TO DRIVE AMONG PEOPLE WITH MENTAL HEALTH CONDITIONS OF SCHIZOPHRENIA, STRESS/ANXIETY DISORDER, DEPRESSION, PERSONALITY DISORDER AND OBSESSIVE COMPULSIVE DISORDERDesmond O'Neill. *National office for Traffic Medicine, Dublin, Ireland*

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A systematic review of evidence for fitness-to-drive among people with the mental health conditions of schizophrenia, stress/anxiety disorder, depression, personality disorder and obsessive compulsive disorder.

Introduction Limited evidence exists regarding fitness-to-drive for people with the mental health conditions of schizophrenia, stress/anxiety disorder, depression, personality disorder and obsessive compulsive disorder (herein simply referred to as 'mental health conditions'). The aim of this paper was to systematically search and classify all published studies regarding driving for this population, and then critically appraise papers addressing assessment of fitness-to-drive where the focus was not on the impact of medication on driving.

Methods A systematic search of three databases (CINAHL, PSYCHINFO, and EMBASE) was completed from inception to May 2016 to identify all articles on driving and mental health conditions. Papers meeting the eligibility criteria of including data relating to assessment of fitness-to-drive were critically appraised using the American Academy of Neurology and Centre for Evidence-Based Medicine protocols.

Result A total of 58 articles met the inclusion criteria of driving among people with mental health conditions studied, and of these, 16 contained data and an explicit focus on assessment of fitness-to-drive. Assessment of fitness-to-drive was reported in three ways:

- factors impacting on the ability to drive safely among people with mental health conditions,
- capability and perception of health professionals assessing fitness-to-drive of people with mental health conditions, and
- crash rates. The level of evidence of the published studies was low due to the absence of controls, and the inability to pool data from different diagnostic groups. Evidence supporting fitness-to drive is conflicting.