Assessing fitness to drive in dementia: a day at a driving assessment centre

Dr. Rinki Ray
ST6 Trainee, Old Age Psychiatry, Leicestershire Partnership NHS Trust
rinkiray@doctors.org.uk

Dr. Richard Eggar
Consultant in Old Age Psychiatry, Herefordshire Primary Care Trust
richard.eggar@herefordpct.nhs.uk

Introduction
As old age psychiatrists we are frequently asked to assess fitness to drive in dementia patients. The issue of driving is one of the most sensitive and delicate subjects for many elderly people especially if they are undergoing an assessment for a possible dementia.

To give an informed opinion about a person’s fitness to drive especially in the early stages of dementia can be extremely difficult. In preparation I chose to gain first-hand experience of driving assessments for patients with cognitive impairment.

The Driving Assessment Centre
The Rookwood Assessment Centre is a part of the Wales Mobility and Driving Assessment Service. This is a registered charity receiving a Welsh Assembly grant and has five centres located in Wales.

The Assessment Process
The driving assessment is divided into off-road and on-road tests and takes approximately three hours.

The off-road tests are usually performed by an occupational therapist with experience in this field and includes clinical history taking with specific driving history including: time last driven, number of years of driving experience, recent accidents or near misses, current driving pattern and family’s views of the person’s driving ability.

This is followed by a physical examination with special emphasis on visual fields, visual acuity and examination of ocular movements.

The physical examination is followed by an extended cognitive examination using the Rookwood Driving Battery (RDB). The battery includes tests to assess visual perception, praxis, executive functioning and divided attention.
Two on road validation studies have been completed which compared the performance on the RDB with on road driving performance. In both studies a score greater than 10 had predictive value, indicating a highly likely ‘fail’ on the road.

The cognitive assessment is followed by the simulator test. This is a static assessment unit called a rig which looks like an Alpha Romeo 156 and is an automatic drive. The person is tested for emergency stop, hazard perception and reaction times by assessing braking in response to randomly lit lights. I was informed that the rig can also test for modifications which may be needed for people with physical disabilities.

Most people proceed on to the on-road test after the simulator exercise. This takes place in a dual controlled car and is usually done by an experienced driving instructor. The route is pre-planned and includes major and side roads as well as dual carriageways, roundabouts and junctions. The individuals are assessed on technical knowledge and also on their anticipatory decision making, planning, attention and lane discipline.

The individuals are given immediate feedback and letter is sent to the referring professional. No correspondence is made directly with the DVLA (Driver and Vehicle Licensing Agency) unless there is absolute evidence to suggest that the individual is likely to continue driving even after receiving feedback not to. It is the individual’s responsibility to notify the DVLA of the diagnosis and confidentiality should be breached only in those cases where the patient is unsafe and unable to appreciate this.²

Shadowing driving assessments – first hand experience
I observed two assessments. The first referral was from a GP for Mr. S, 57 years old with a diagnosis of Huntington’s disease. Mr. S struggled with the on road test, especially while meeting other vehicles on the road and the driving instructor intervened to end the exercise prematurely. In the feedback session the risks were explained and this experience appeared to help him realise the reasons for stopping driving.

Admittedly I was shaken by my initial experience but managed to muster enough courage to accompany a second person. This was a 75 year old, Mr. D with a diagnosis of Alzheimer’s disease. He had self-referred. Mr. D had been an HGV driver all his life and went on to complete the on road test with faultless driving despite having a score of 12 on the RDB. He was advised that he could continue driving subject to annual reviews with which he agreed to comply.
During this experience I heard from the individuals their own accounts of driving and their reasons for wanting to continue to maintain their independence. Sudden advice to stop driving can be hugely distressing for elderly people and professionals should be extremely sensitive while communicating on this issue. My experience also highlighted that a diagnosis of dementia does not necessarily mean that an individual is unsafe to drive.

**Making clinical decisions regarding fitness to drive**

My session at the Driving Assessment Centre indicated the limitations of simple cognitive screening tools like the MMSE in predicting road safety. I have become more focused on certain areas of cognitive testing like attention and concentration, visuo-spatial skills and executive functioning and have started to routinely perform the clock drawing and Trail B making test while making decisions regarding fitness to drive.

I am more aware of the need to gather a detailed history and collateral information regarding driving. Recent evidence suggests that carers’ rating of an individual’s driving as marginal or unsafe, history of traffic citations or crashes, reduced mileage or self-reported situational avoidance and any history of aggression or impulsivity on the road are important factors for a risk assessment regarding driving. I am more confident of reminding patients of their responsibility to inform the DVLA of their diagnosis and implications for their car insurance. I am also aware that we can discuss difficult cases without disclosing identity of our patients with DVLA medical advisors.

I use the decision making grid below in daily practice. It incorporates most of the above information.

**Conclusion**

Driving is a complex activity and it is difficult to achieve balance between rights of the driver and the imperative to maximise road safety. This becomes more challenging in dementia since we know that the cognitive skills will decline at some point affecting the person’s driving abilities. My experience at the centre has taught me much on this issue. It is a valuable learning opportunity for all higher trainees within old age psychiatry.
<table>
<thead>
<tr>
<th>Pre-diagnosis:</th>
<th>Evidence of good driving skills from patient and informants</th>
<th>Limited collateral information</th>
<th>Collateral history</th>
<th>Collateral history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client undergoing assessment at memory clinic</td>
<td>No evidence of good or poor driving skills – History and cognitive assessment does not suggest otherwise</td>
<td>No evidence of good or poor driving skills, but no major risks or accidents reported</td>
<td>Major evidence of poor skills, serious risks involved – accidents or near misses reported</td>
<td></td>
</tr>
<tr>
<td>· Advise regarding implications of the diagnosis of dementia and continuing driving safely in future.</td>
<td>· Advise regarding implications of the diagnosis of dementia and continuing driving safely in future.</td>
<td>· Advise regarding implications of the diagnosis of dementia and continuing driving safely in future.</td>
<td>· Tell not to drive</td>
<td></td>
</tr>
<tr>
<td>· Information leaflets may be helpful, mentioning impact on insurance.</td>
<td>· Encourage to go for a driving assessment to gather objective evidence of good skills.</td>
<td>· Encourage to go for a driving assessment to gather objective evidence of good skills.</td>
<td>· Advise driving assessment before resuming to drive</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-diagnosis:</th>
<th>Must inform DVLA of diagnosis</th>
<th>Must inform DVLA of diagnosis</th>
<th>Must inform DVLA of diagnosis</th>
<th>Must inform DVLA of diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The diagnosis of dementia has been made and explained to patient.</td>
<td>Clear documentation in the notes. Looking at ways to maintain the current skills</td>
<td>Urge to go for a driving assessment and offer referral to the centre.</td>
<td>· Tell not to drive</td>
<td>· Advise driving assessment before resuming to drive</td>
</tr>
<tr>
<td>· Drive short distances on familiar routes frequently</td>
<td>· The potential benefits of gathering an objective evidence of safe driving must be explained.</td>
<td>· The potential benefits of gathering an objective evidence of safe driving must be explained.</td>
<td>· If not willing to comply then consider breaching patient confidentiality to inform DVLA.</td>
<td>· If not willing to comply then breaching confidence to inform DVLA is justified</td>
</tr>
<tr>
<td>· Avoid motorways</td>
<td>· More detailed information from neighbours and acquaintances if possible</td>
<td>· Potential breach of confidence may be justified if reluctant to inform DVLA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Avoid night driving</td>
<td>· Breaching confidence may not be justified if reluctant to inform DVLA</td>
<td>· Discuss with DVLA without disclosing patient’s identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Encouragement from family</td>
<td>· Discuss with DVLA without disclosing patient’s identity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· If has not informed DVLA breaching confidence is not justified under these circumstances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References

1. McKenna P, Bell V. Fitness to drive following cerebral pathology: The Rockwood Driving Battery as a tool of predicting on-road driving performance, *Journal of Neuropsychology* 2007; 1: 85-100

2. Drivers Medical Group DVLA. For Medical Practitioners: *At a Glance Guide to Current Medical Standards of Fitness to Drive*. DVLA 2011


