31 May 2021

Mr Tony Marlow
Principal Adviser
Regulatory Services
Waka Kotahi New Zealand Transport Agency
Wellington

By email to: MedAspectsReview@nzta.govt.nz

Tēnā koe Mr Marlow

Re: RANZCP Medical Aspects of Fitness to Drive: A Guide for Health Practitioners

Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback to Waka Kotahi on the proposed updates to Medical Aspects of Fitness to Drive: A Guide for Health Practitioners (2014).

The RANZCP is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry and addiction, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care.

The questions in the Waka Kotahi NZTA SurveyMonkey questionnaire have been reviewed by Tu Te Akaaka Roa - New Zealand National Committee (NZNC), working with representatives from the RANZCP’s New Zealand Subcommittee of the Faculty of Old Age Psychiatry.

The RANZCP’s feedback on the proposed guidelines:

While the format of the SurveyMonkey questions is appropriate for consultation about the more operational aspects of the production of updated guidelines (for example questions on preferred format and price), they do not work well for the detailed clinical feedback we would like to provide. In this submission we have provided specific feedback on those questions relating to the psychological and clinical aspects around capacity to drive.

It is not possible to comment on sections regarding present and future formats or preferences without surveying our membership. However, most College members who assess fitness to drive are employed by District Health Boards (DHB’s) many of which have their own operating procedures and guidelines around providing clinical materials to their staff. [See Appendix].
Updates Resulting from this Review

You have sought guidance on the updates resulting from this Review and have provided two options. **Option one** is to wait till all chapters have been completed before releasing the entire Medical Aspects for use. The benefit of this option is that there is only one current version of the Medical Aspects in circulation at any one time. **Option two** is to release each chapter for use as soon as that chapter has been completed. The advantage of this option is that updated guidance is circulated and in effect with less delay.

**Q23. What are your thoughts on Option one?**

We support Option One. The current guidelines have largely been workable and been in place for a considerable time. It is preferable unless very urgent changes are signaled by this consultation (for example new evidence of serious risk to driving from a particular condition or medication), to have one, comprehensive release to avoid multiple circulating versions of the guidelines.

**Q24. What are your thoughts on Option two?**

We do not support Option two. Regarding possible delay circulating new warnings, the current position whereby urgent medical advisories can be disseminated would still be available.

**Response to particular sections:**

**Q28. What section are you looking to provide feedback on?**

Section 2.8: ‘Medical aspects of assessment of Dementia and other cognitive impairments and fitness to drive’:

**Q29. Provide details on the issue and why it needs to be addressed.**

- More specific guidance is required in conducting a valid assessment of safety to drive, across various levels of cognitive impairment.
- The RANZCP does not support the use of the ‘road sign test’ as a screening tool as the evidence base for its effectiveness is limited\(^1\). Instead we favour signposting assessors to a menu of different tools\(^2\) relating to assessing driving safety from which doctors can choose as appropriate and use as a springboard for discussion with the person and their families/whānau.
- The place of a standardised cognitive screening test (Mini-ACE test is now accepted as nationwide standard in New Zealand) needs to be clarified; emphasising that while this will **assist** in determination of level of cognitive impairment, it cannot be used as a stand-alone test to determine safety to drive.
- More guidance should be provided on when a GP should refer the person to a specialised Occupational Therapist (OT) driving assessment or to a geriatrician or old age psychiatrist.

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Q30. Describe any recommendation or solution you have.

The RANZCP suggests that NZTA amend the text for Section 2.8 as follows:

An introduction to the section noting the following four points would add clarity to the background information and the role of practitioners in assessment of fitness to drive.

1. A wide range of organic brain disorders result in varying degrees of cognitive impairment, which may be accompanied by disturbances of mood and behaviour and periods of more acute confusion. The most common forms in the general population are Alzheimer’s disease, vascular dementia and dementia with Lewy-bodies, all of which become more prevalent with advancing age. Cognitive impairment and dementia may however occur in relatively young people – either due to early-onset degenerative brain disease or to brain damage from alcohol, drugs or traumatic brain injury.

2. Assessment of fitness to drive can be difficult, especially with milder cognitive impairment; as explained above there is no single test that is universally applicable. Whilst memory impairment is a common finding amongst older drivers, driving safety correlates more closely with other cognitive domains, such as executive function, visuospatial function, information processing speed, and judgement.

3. The family health practitioner will have an important part to play in coordinating the assessment process, but clinical and ethical challenges often arise. The issue of driving should preferably be raised at the early stages of cognitive decline when the person has sufficient cognitive and reasoning ability to make decisions about their driving future.

4. When a person is deemed unfit to drive it is important to review compliance, and it will often be necessary to enlist the help of the family/whānau with this activity. It will be necessary to report to NZTA if an unfit person continues to drive.

Suggested additional material for Inclusion

The RANZCP suggests additional avenues for exploration to include in an assessment:

- **Family/whānau insight:** Reports of actual driving behaviour from reliable, objective sources are critical. Often, concerns will be proffered by family/whānau or others close to the person, but if not, it will be important to seek such information, for example, by asking if the person could be entrusted to drive with a child as a passenger.

- **Driving ability changes:** Determine whether the person is driving much more slowly or hesitantly; making minor errors of driving judgment; avoiding of more taxing driving situations; having minor near-accidents or accidents, getting uncharacteristically lost or forgetting where the vehicle is parked.

- **Driver insight into their competence to drive:** When interviewing the person, check if they have insight into their medical conditions which might impact driving safety; whether they can find and show you their driver licence; and whether they can give a clear account of what driving they do.

- **Driver cognition:** More generally, assess whether they can give reasoned, independent answers to questions or are vague and hesitant; whether they are struggling with complex living skills other than driving, and therefore needing more supervision or prompting.
• **Severity of cognitive impairment**: When there are concerns about cognitive impairment, it is vital to assess severity (i.e. assess whether there is this mild cognitive impairment, mild dementia, moderate dementia or severe dementia). Carrying out a cognitive screening test will be an important component of this assessment. The Mini-Addenbrooke’s Cognitive Examination (M-ACE) is the current nationwide standard instrument.

• **Limits of diagnostic tools**: It is important to note that a M-ACE score, of itself, cannot determine safety to drive. Similarly, other pencil-and-paper tests that purport to test driving capacity do not have validity when used alone, and these should be supplemented by the additional assessments described above to form a fuller picture.

**Comments on Section “When to refer”**

In reference to the section on “When to refer” we have the following comments:

Sometimes it is difficult to make a valid assessment of fitness to drive in a cognitively impaired person from an office consultation alone. In such cases, a full assessment of driving skills by an appropriately trained occupational therapist is the gold standard for determining whether a person may continue to drive a motor vehicle. A report from a driving instructor who has undertaken a coaching session with an older driver is not a valid substitute for an OT assessment.

We suggest there are other barriers when assessing a person’s capacity to drive: the person’s non-cooperation; unavailability of additional information (for example from family/whānau). Where knowledge of the person indicates there may be potential damage to the doctor-person relationship if the doctor be held responsible for deeming a person unfit to drive, and where this may impact adversely on their ongoing medical care, a referral for a comprehensive assessment by a geriatrician or old age psychiatrist may instead be appropriate.

**Medical standards for individuals applying for or renewing a class 1 or class 6 licence and/or a D, F, R, T or W endorsement (see appendix 3)**

A clearer introduction to this section is required detailing when persons renewing the above classes or endorsements of licence should cease driving; noting that the RANZCP’s view is that a person holding such a licence should cease driving in **all cases** of moderate or severe dementia.

A person may be permitted to drive in cases of mild cognitive impairment or mild dementia, provided that the health practitioner is satisfied that adequate driving skill and judgment is retained. However, regular medical review will be necessary.

**Medical standards for individuals applying for or renewing a class 2, 3, 4 or 5 licence and/or a P, V, I or O endorsement**

For the above licence classes, the RANZCP’s view is that the person should cease driving in **all diagnosed cases of dementia**. When milder cognitive deficits are identified, then the person’s driving capacity should only be endorsed by an OT driving assessment. Regular medical review will be necessary.
Q31. Outline the effects your solution or recommendation may have on:

- Health Practitioners
- Licence applicants
- The NZTA

We would like to make the following comments on possible impacts on health practitioners:

a) Emphasising the obligation for regular medical review in cognitively impaired individuals may add to health practitioners’ clinical burden. We advocate for additional clinical resource to be made available if necessary to carry out this vital function.

b) By emphasising the value of a specialist OT driving assessment, the RANZCP note that in many parts of New Zealand this will challenging to applicants due to high costs and limited availability of OT assessments. Driving contributes considerably to older peoples’ social functioning, therefore balancing this benefit against risk to self and others is a serious responsibility.

Q32. Provide any supporting evidence or information you have.

We refer you to DHB advice on cognitive impairment and safety to drive on HealthPathways; summarised in the Appendix below - *Driving recommendation by functional and cognitive level*.

In summary:
The RANZCP welcomes the updating of these guidelines. We are available to meet with you to expand upon the cognitive impairment issues that may arise when assessing a person’s capacity to drive. If we can be of further assistance, please contact the National Manager, New Zealand, Rosemary Matthews who supports the New Zealand-based Committees.

Rosemary can be contacted on 04 4727 265 or by email rosemary.matthews@ranzcp.org.

Ngā mihi nui

[Signature]

Dr Alice Law, FRANZCP
Secretary - Tu Te Akaaka Roa - New Zealand National Committee
## Appendix - Driving recommendation by functional and cognitive level

<table>
<thead>
<tr>
<th>Dementia Stage</th>
<th>Cognitive Score</th>
<th>Cognitive and Functional levels</th>
<th>Driving Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Dementia</td>
<td>M-ACE typically &gt;24/30</td>
<td><strong>No cognitive impairment:</strong> Normal memory and cognition Independent function Competent in home, work and hobbies</td>
<td><strong>May continue to drive</strong> Check for other Medical Conditions</td>
</tr>
<tr>
<td>Mild Cognitive Impairment</td>
<td>M-ACE typically 21-25/30</td>
<td><strong>A mild but noticeable decline in cognition:</strong> Mild forgetfulness Mild disorientation Mild impairment in problem solving Generally independent in most activities May struggle with complex tasks</td>
<td><strong>Most people Safe to Drive</strong> Consider OT driving assessment. Restricting or stopping driving if: Family concerns Recent accidents or near misses Functional impairment in some complex tasks Behavioural disinhibition – “risk-taking” Notify NZTA</td>
</tr>
<tr>
<td>Mild Dementia</td>
<td>M-ACE typically 18-22/30</td>
<td><strong>Definite cognitive decline and impairment</strong> Moderate memory loss and disorientation Impaired problem solving Mild impairment in household tasks / personal cares Requires prompts or supervision with some tasks Complex tasks and roles much more difficult Social interactions often well preserved</td>
<td><strong>Driving safety is uncertain</strong> Some people safe, others unsafe to drive Safety not predicted by cognitive test score Person needs further investigation / review OT Driving Assessment preferred Further collateral history Clarification of functional level in other areas Driving questionnaires Further cognitive testing Alternative on-road driving assessment Second opinion from geriatrician/psychogeriatrician Clinical Decision needs to be made: Continue Driving – Review Date Restricted Driving – Review Date, or Notify NZTA</td>
</tr>
<tr>
<td>Moderate Dementia</td>
<td>M-ACE typically 10-18/30</td>
<td><strong>Significant impairment of cognition/function</strong> Marked memory loss Disorientation to time and place Decreasing ability to make judgements Decreasing ability to engage socially Decreasing ability to function independently Needs assistance with personal cares Requires supervision when leaving home May get lost when away from home Limited capacity to complete tasks in home No longer able to participate in usual activities</td>
<td><strong>Must Stop Driving! Notify NZTA</strong></td>
</tr>
<tr>
<td>Severe Dementia</td>
<td>M-ACE typically &lt;12/30</td>
<td><strong>Profound impairment of cognition / function</strong> Severe memory impairment / disorientation Spoken language limited or lost Incontinence Minimal capacity for making judgements High dependency on others for personal cares Unable to contribute to household chores Often unable to recognise family members Increasing loss of psychomotor skills Frequent behaviour or psychiatric complications</td>
<td><strong>Must Stop Driving! Notify NZTA</strong></td>
</tr>
</tbody>
</table>