AIMS
◆ to promote opportunities for the exchange of knowledge and expertise between members;
◆ to promote a greater appreciation of psychological factors in ageing;
◆ to advise and participate in matters of teaching and training;
◆ to stimulate research and disseminate research findings;
◆ to act in an advisory capacity on issues relating to the well-being and provision for care for older people;
◆ to foster an exchange of information and ideas with other professional and voluntary groups.

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Front cover illustration designed by Valerie Russell.
Letter from the Chair

Steve Boddington

THANK YOU’ to all the contributors to this, special issue of the Newsletter! It is exciting to see our Newsletter taking on a new format, by collating a number of papers on this important theme. In fact, I think it shows, yet again, how the Faculty is growing, that Pauline Thomson has been able to collate such a range of papers, drawing on the excellent conference on Driving and Dementia organised by Pauline, and Sandy McAfee, and chaired by Liz Baikie. For those of us who were unable to attend the event, I’m sure that this collection will be a valuable addition to our bookshelves!

I would like to congratulate Romola Bucks (Newsletter Editor) for her appointment in the Department of Psychology, at the University of Western Australia, Perth. Sadly this means that Romola will not be able to continue her work with the Newsletter that she has so ably undertaken over the past year. We will also miss her contribution to the wider working of the PSIGE Committee. We would love to hear from any full members who might be interested in editing the Newsletter. I’m sure that Romola or Sinclair Lough (our last Newsletter Editor) would be happy to talk to you further, about the nature of this post, if you would like to know more.

Steve Boddington

PSIGE Chair.
Letter from the Editor

This special issue is a bonus Newsletter for the PSIGE membership. It arose out of a conference held in Scotland in 2006. PSIGE is delighted that so many of the speakers were willing to write up their presentations for inclusion in the issue. Thank you, also, to those who sent in their submissions for the PSIGE Research Prize. As I write, we are reading the submissions and will announce the winner shortly.

Do take the time to respond to the call from the Committee regarding the development of a Depression Care Pathway. Your input to such developments is essential. Sarah Dexter-Smith has written about this in the Members’ Updates section.

Lastly but by no means least, congratulations to Dawn Brooker on the publication of her latest book!

Romola Bucks
Editor, PSIGE Newsletter.

Introductory note from the PSIGE Scottish Convenor

This special issue of the Newsletter summarises the proceedings of the conference held on 16 June, 2006. As Convener of PSIGE in Scotland I would like to take this opportunity to thank our two members who organised the conference. Sandy McAfee co-ordinated very efficiently the administration and bookings for the conference, and Pauline Thomson devised a very interesting and comprehensive programme and liaised with the speakers. Their hard work led to a really successful and enjoyable day.

This is the second time that Valerie Russell has designed the cover of a special Scottish issue of the Newsletter in her own time. I doubt there are many psychology secretaries with a degree in graphic art!

I was privileged to chair the conference and hear the experiences of persons and their carers, who had personal experience of issues arising from driving in the context of dementia. Those working in the field covered a wide range of pertinent topics.

I hope you will enjoy reading this special issue.

Liz Baikie
IN JUNE, 2006, a one-day conference on Driving and Dementia was held in Edinburgh. This was organised on behalf of the Scottish branch of PSIGE by myself and my colleague, Sandy McAfee. The conference generated a great deal of interest nationally but unfortunately we were unable to secure places for everyone who had hoped to attend. Those successful in getting places travelled from as far afield as Somerset, Inverness and Wales. As expected, most delegates were from health care, i.e. nurses, occupational therapists, dementia care coordinators, psychiatrists and psychologists, but there were also representatives from Alzheimer’s Scotland, the Scottish Dementia Working Group and Road Safety Units.

In organising the conference we attempted to achieve a number of aims. We hoped to raise awareness of the impact of receiving a diagnosis of dementia on drivers and were keen to hear this first hand from those directly affected. We were fortunate to have two people (James McKillop and Alex Scobbie) who were able to share with us the problems they experienced driving pre-diagnosis and how they adapted their driving behaviour to overcome these difficulties. They also described their very different experiences of the driving licensing process after they received their diagnosis of dementia. Their presentations were invaluable, as were their comments throughout the day. They gave us insight into the emotional impact going through the driving licensing process had on them and their spouses. They highlighted problems with the process and methods employed to assess their ability to drive (e.g. inconsistency in approach; over reliance on the opinion of professionals based on their professional status rather than their knowledge of and contact with the person with dementia, etc.) and also wider issues needing consideration such as the practical implications of losing a licence for the individual and others where they are the sole, or main, driver; and the need for improvement in public transport systems.

A further aim of the conference was to enhance knowledge of the legal implications of receiving a diagnosis of dementia not only for the person receiving it but also for family and professionals involved in their care. We also wanted to raise awareness of the DVLA procedures in such cases. Dr Heather Major (Senior Medical Advisor, DVLA) addressed these issues and also outlined the results of a recent one year study undertaken by an independent organisation reviewing the medical licensing policy in Great Britain. The study made a number of recommendations including some relevant to older drivers and to drivers with diagnoses such as dementia. Dr Major also informed us that the Department for Transport and DVLA intended to take the report forward as a formal public consultation process and saw the conference as an important opportunity to raise awareness for those interested in contributing to the consultation. A consultation document is to be circulated and PSIGE members are to be contacted in this regard.

We were keen to know how the driving ability of someone with dementia is currently assessed; how adequate such methods of assessment are; and which data are used to make policy decisions about people with dementia as drivers. Dr Lynne Hutton (Consultant in Rehabilitation Medicine, Scottish Driving Assessment Service; SDAS) described the assessment protocol utilised by her and her colleagues within Scotland. We also learned about the referral process to the SDAS, the types of referrals made and the outcome of assessments. Janice Rees, Consultant Clinical Psychologist, Gwent Healthcare
NHS Trust, presented recent research findings on the relationship between performance on neuropsychological tests and on-road tests. She specifically spoke about her and her colleague Pat McKenna’s use of the Rookwood Battery. The advantages and shortfalls of the various assessment methods were discussed by Lynn and Janice and the need for neuropsychological measures which reliably predict driving performance was highlighted.

We also wanted to determine to what extent the risk of road accident increased for those with a diagnosis of dementia. Dr Carol Holland (Lecturer, Aston University) considered this by examining information drawn from many sources. This included road accident statistics for drivers with dementia compared to those for other driver groups and medical diagnostic groups; factors such as the stage of the dementia and others unrelated to dementia. She also discussed reasons for the lower than expected accident risk found for drivers with dementia including their driving behaviour, and discussed the implications of the findings for policy decisions.

We hoped to present examples of innovative practice being undertaken by health care professionals working with people with dementia in relation to the assessment of driving and development of protocols for this purpose. Dr Jennifer Borthwick (Consultant Clinical Psychologist, NHS Lanarkshire) described a protocol for driving and dementia being developed with colleagues working in a memory clinic. The process they went through developing the protocol and difficulties encountered along the way were highlighted as were ways of overcoming these. The benefits of having undertaken this work were also discussed.

A final aim of the conference was to examine how clinicians think and feel about discussing driving with their clients who have dementia and to identify their knowledge of DVLA/their own profession’s guidelines and their attitudes towards people with dementia continuing to drive. Sandy McAfee (Consultant Clinical Psychologist, NHS Lothian), presented the findings from a staff survey conducted recently with Claire Atkins, which examined these issues. The level of uncertainty reported about the DVLA’s and their own profession’s guidelines on driving and dementia was highlighted, as was the uncertainty about what advice to give clients. Concerns the different professional groups had about discussing the topic of driving with their clients were also examined. The implications of these research findings for the production of clearer guidelines and for training were discussed.

Feedback from delegates on the day and since, would suggest that our aims were achieved.

There was a feeling on the day that it was important to disseminate as widely as possible the information obtained at the conference. This special edition of the Newsletter is the beginning of this process. All but two of the speakers (Dr Heather Major and Janice Rees) have been able to provide papers. I have included the abstracts provided by them both for the conference and have produced a summary of part of Dr Major’s talk. I hope it is an accurate reflection of what she said. I take full responsibility for any errors in my reporting, if they exist, and shall endeavour to feedback to you any which are identified.

There are some people to whom I wish to offer my apologies and to others my thanks. I apologise to those who were unable to secure places because of the sheer numbers applying. I hope that this special edition will compensate in some way for this. Many thanks to the following: Liz Baikie (Convenor, PSIGE Scottish Branch) for chairing the conference; all the speakers; Philip Byers (National Co-ordinator, Scottish Dementia Working Group) for putting us in contact with James and Alex; Karen Reid (Early Onset Dementia Nurse, East Kilbride) for presenting on behalf of Alex at the conference; those who kindly helped with registration; and Valerie Russell (Liz’s secretary) who at extremely short notice designed
and produced the front cover for this Newsletter. I think you will agree Valerie did us proud once again as she did when she produced the front cover for the Scottish Branch edition of the Newsletter almost three years ago.

I hope you will enjoy reading this special issue.

And finally … I would like to offer my heartfelt congratulations to Alex Scobbie who on the day of the conference was anxiously awaiting the DVLA’s decision on whether or not to renew his driving licence. I learned recently that it had been renewed for a further year.

Pauline Thomson
Service users' experiences of driving with dementia

Alex Scobbie

Alex comes from Ashgill in Lanarkshire. He worked as a lorry driver and, for 16 years, as a bus driver. Alex was diagnosed with Alzheimer’s disease at the age of 53 in March, 2002. Prior to that he had been assessed by a Psychologist and a Psychiatrist. He was eventually commenced on cognitive enhancing medication after his wife argued with the Generic/Adult Psychiatrist who wanted to wait six months ‘to wait and see how he got on’.

At the time of diagnosis Alex was experiencing some road rage when he would become verbally abusive to other drivers. This behaviour was out of character for Alex and his wife (Annette) had mentioned this to the GP saying that she found his behaviour upsetting as a passenger. He was commenced on a memory tablet which the GP reviewed with Alex and Annette at an ongoing monthly review at his surgery. Initially Alex experienced some side effects, however, he persevered and after a few months titration the tablets were found to have a real, beneficial effect. He was found to be brighter in mood, less irritated, and more in control.

In September, 2002, he received a letter from the DVLA stating that he could no longer drive. His GP confirmed that he had sent the medical questionnaire back to the DVLA advising that he was unfit to drive. Annette advised Alex that she had told the GP about his earlier behaviour when he was experiencing road rage although this had now resolved and there had been no further incidents. Alex and Annette were surprised that there had been no medical interview or formal assessment before the decision was made and Alex, who had been a safe driver for 30 years, with no points at all on his licence, felt very angry and upset about the decision. He had always been the main driver and although his wife is a confident driver Alex had enjoyed driving and tended to do all the driving when they went out together. Following the DVLA decision Alex, who had never been a good passenger, was even more critical and frustrated at his wife’s driving. Annette felt he was resentful and she became even more determined to help him get his licence back. Meantime Alex planned to use his concessionary bus travel and was quite low in mood and overwhelmed by all the ’phoning and letter writing that Annette was doing to the DVLA at the time.

They discussed their feelings with the GP who agreed Alex’s behaviour appeared to have improved with the medication and certainly his concentration and MMSE scores were maintained and had always been very high even prior to the medication.

In February, 2003, the Psychiatrist, CPN and GP wrote letters to the DVLA all recommending that he have his licence reinstated. Annette phoned the DVLA in April, 2003, to try and find out if they had received the letters and how to proceed with the appeal. DVLA didn’t have any record of the letters and sent out another medical questionnaire to the GP. In May, 2003, Annette again phoned the DVLA voicing frustration and asking if there were any further tests Alex could attend to prove that he was a competent driver.

They discussed this with the GP who agreed Alex appeared to have improved and that there were no further concerns now about his driving. They didn’t know at that time that there would be a long struggle ahead to regain the driving licence. Alex’s driving licence was restored in 2004.
James McKillop

Biography
I am 65-years-old and live in Glasgow. I was diagnosed with vascular dementia in 1999. Since then I have been very active in establishing the Scottish Dementia Working Group, which I chair. I was a speaker at the Alzheimer’s Disease International conference in the Dominican Republic and at a conference of Middle East Alzheimer Societies in Beirut. I spoke about “Advocacy and dementia” at the Alzheimer Europe conference in Killarney in June 2005. I have a keen interest in photography and have published a book of my photos entitled Opening Shutters-Opening Minds. I was a joint author of the Alzheimer’s Scotland booklet Don’t make the journey alone. I was a member of the Citizen’s Jury advising the 21st Century Review Group on Social Work in Scotland. I have spoken to social work students, trainee health visitors, primary school children, various conferences at the Dementia Services Development Centre at Stirling University, Dementia helpline volunteers and many other groups about dementia and have met Scottish Executive ministers as a representative of the Scottish Dementia Working Group.

Presentation
Once you have passed your driving test, the law assumes you are able to drive, unless you are disqualified for some traffic offences or are judged no longer able to drive safely due to certain illnesses.

In my case I did have driving problems, among other problems, such as attempting to drive down the wrong side of a dual carriageway. I was positioned, indicating ready to turn and it was only due to oncoming drivers flashing their lights at me, that I was prevented from making that potentially fatal turn. I also had trouble at large roundabouts and could never remember where to turn off. I used to circle several times and still choose the wrong turning.

My wife, Maureen, started refusing to sit in the car with me if I was driving. Whereas, before, she had felt perfectly secure as I was a safe driver, she was now very uneasy about my driving abilities. She said that when going along, say a motorway, I kept weaving slowly from the edge of the lane to the other side then back again. I couldn’t seem to hold a straight line.

When the average person hits problems, they devise ways to get ‘round them. I was no different. What I did at large roundabouts, I would take the first left and if it was not the correct road, I would do a turn and go back and try the next left and so on until I reached the turning I wanted. It was a laborious but safe way of getting through roundabouts. I also started stalling the car, a thing I had never done since my L-plate days. I hit kerbs when turning corners and I just couldn’t fathom out what was going on. I did report my driving problems to my doctor who advised me to stick to roads I knew very well.

It all became clear when I was diagnosed with dementia. I reported my diagnosis to the DVLA and my psychiatrist advised me to stop driving. However, once I knew what the problems were and received medication, I felt ever so much better and more aware of my surroundings, so I persisted with applying to continue to drive. I sat a test arranged by the DVLA and passed it. I was given a licence for 3 years and continued to drive cars and vans. I had no further problems and felt I was driving safely. I no longer undertook long journeys as I felt it was not in my or other road users’ interests to get overtired. But I was very happy in my comfort zone.

However, when the three years were up, I applied to renew my licence, fully expecting to sit another test. I heard nothing for six months and on Christmas Eve, 2003, I received a letter from the DVLA saying they were withdrawing my licence. Why couldn’t they have waited another day after keeping me hanging on for six months? They did tell me I could appeal to the Courts but warned me it can be costly and may be unnecessary. By this time my wife was in charge of the
Service users’ experiences of driving with dementia

finances and refused to give me money for an appeal. I felt this was against my human rights and I should have been given another test. If I had failed it I would have accepted it but daily feel aggrieved I was not given a chance to prove myself. I found out later it was my doctor who had provided the report which barred me. Yet the ironic thing is that after diagnosis by a Consultant, dementia was never once mentioned by my GP. I only saw her when something was hurting me physically. She had no idea of my capabilities.

It is a bitter blow losing your licence and you have no idea how crippling it is until it happens to you. Your mobility is turned upside down. You lose your independence. There are places you can no longer go unless you find someone with the time to take you. If lucky, you go in their chosen time, which usually does not coincide with your preferred option. You are at their mercy.

However, I sit in cars as a passenger and can still anticipate other driver’s manoeuvres and feel I could still drive. Just give me a chance.

In conclusion, the medical person who comments on one’s ability to drive should be the person who sees and treats the person with dementia for the dementia.

If someone is not diagnosed until well on into the illness, they may clearly be unfit to drive. All others should be allowed to sit a test.

If someone has their licence withdrawn without a test and they are able to cope better with medication and treatment, they should be allowed to sit a test and abide by the result.
Dementia and driving: The DVLA position

Heather Major

Editor's note: The following abstract was provided by Dr Major for the conference. Unfortunately she was unable to produce a paper for the Newsletter but agreed to Pauline Thomson, our Guest Editor, to writing a summary. Pauline has kindly produced this summary and hopes it is an accurate account. Any inaccuracies are the responsibility of Pauline Thomson. I am grateful to Pauline for taking on this task.

Romola Bucks, Editor.

There is an increasing public expectation of being able to continue to drive, at all ages. The average age of drivers is steadily rising. Prevalence rates of dementia and other health related impairments also rise, inevitably, with advancing age. The current driver licensing system and underpinning legislation is outlined and different types of relevant impairment explained. The roles and responsibilities of the patient/driver and their doctor are described. A brief overview of DVLA statistics on dementia will demonstrate our experience of the issues as identified through our current processes. The presentation concludes with a high level overview of the Medical Licensing Policy Review, currently underway, and offers an early taster of some of the recommendations likely to form part of the anticipated public consultation on the issue.

Summary of presentation

In Great Britain there are approximately 41 million driving licence holders. Around 3 million are over the age of 70. See Figure 1 for a breakdown of these figures by gender and Figure 2 for a breakdown by age and gender of licence holders over 70. Figure 3 illustrates the number of male and female drivers in Great Britain aged 50 to 69. In the 65 to 69 age range alone there are just over 2.3 million.

As illustrated in Figure 4, by 2010 the number of older drivers, i.e. those over 70, is predicted to rise to 8 million and by 2050 to 10 million. The number of drivers over 60 is predicted to rise to 16 million by 2050.

There is no upper age limit for UK drivers who hold ordinary Group 1 car licences although licences expire at the age of 70 and require three-yearly renewal thereafter. Group 2 Vocational (bus/lorry) driving licences expire at the age of 45 with five-yearly renewal till the age of 65 and annual renewal thereafter. When a medical condition which can affect driving ability is diagnosed, self declaration to the DVLA is required for holders of either type of licence.

Figure 5 shows the current prevalence and incidence rates of dementia in those 65 years and above broken down into age groups.

Role of the DVLA

The DVLA facilitates road safety through the application of the Regulations and the recommended medical licensing standards to minimise the risk of an accident occurring through medical problems. Dementia is one of a number of types of driver impairment relevant to driving fitness (See Table 1). The DVLA is involved in cases where there is sudden incapacity or ‘chronic’ impairments affecting vision, cognition or movement.
Figure 1: Total GB licence holders.

Figure 2: GB licence holders age 70+.
Figure 3: GB licence holders age 50–69.

Figure 4: Current and predicted proportion of 'elderly drivers' by 2010 and 2050.
There is a range of legislation relevant to medical licensing:

(a) Annex III of the 2nd EC Directive 1996: Mental Disorders and Driving states that driving licences shall not be issued or renewed for applicants or drivers who suffer from:

- Severe mental disturbance, whether congenital or due to disease, trauma or neurosurgical operations;
- Severe mental retardation;
- Severe behavioural problems due to ageing; or personality defects leading to seriously impaired judgement, behaviour or adaptability.

(b) The Road Traffic Act 1988 sections 92-94 and amendments place a:

- Legal obligation on drivers/applicants to notify/declare to DVLA any medical condition that may affect driving;
- It gives the power to DVLA to issue or refuse/revoke licences or;
- To issue short duration licences;
- It also gives licence holders and applicants the right of appeal.

(c) The Road Traffic Act 1988 also gives DVLA powers to investigate a driver though:

- Drivers must give consent to medical enquiries; and,
- Must attend for a medical examination, if requested;
- A full license holder must also undertake a driving test, if requested.
(d) Section 94(4) of the act requires ‘reasonable grounds’ that the licence holder suffers from a relevant or prospective disability before medical enquiry is made.
(e) The Motor Vehicles (Driving Licences) Regulations 1999, Sections 709–775 definition of Severe Mental Disorder includes mental illness, arrested or incomplete development of the mind, psychopathic disorder and severe impairment of intelligence or social functioning.
(f) Human Rights Act:
Holding a driving licence is not an absolute right.
(g) Guidelines relating to medical licensing have also been included in guidelines produced by professional bodies such as the General Medical Council’s Guidance for doctors on confidentiality.

Sources of notification to DVLA
Each year the DVLA deals with a substantial number of medical cases. In 2004–2005 there were approximately 500,000 notifications of medical conditions. Table 2 gives examplar data showing where these usually came from.

Role and responsibility of doctors
On diagnosis of dementia, a doctor (and all other health care professionals) has a duty of care to their patient. They should confirm if their patient is a driver and ensure they understand that the condition may impair their ability to drive. If appropriate, they should advise their patient to cease driving and explain their legal obligation to notify DVLA. If the person continues to drive against advice, the doctor should follow GMC guidance in notifying DVLA directly. There is, however, no legal obligation to do so.

Role and responsibility of the patient/driver
The person with dementia has a moral responsibility to follow their doctor’s advice and cease driving if appropriate. They also have a legal obligation to notify DVLA and their insurers. They are also required to complete the DVLA medical enquiry form, once received, and to provide consent for medical enquiry.

Role and Responsibility of others, e.g. family
Others have no legal obligation to inform the DVLA when a person receives a diagnosis of dementia, or if they have concerns about their ability to drive. However, they do have a moral responsibility. If they contact DVLA, however, their anonymity is retained and the driver will be sent out a routine questionnaire asking about existing medical conditions.

DVLA assessment process
Once DVLA has been informed that a person has a medical condition which affects

<table>
<thead>
<tr>
<th>Source</th>
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<tr>
<td>Licence holder</td>
<td>70,000</td>
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<tr>
<td>Police</td>
<td>3,000</td>
</tr>
<tr>
<td>Medical profession</td>
<td>2,500</td>
</tr>
<tr>
<td>Other third party*</td>
<td>10,000</td>
</tr>
<tr>
<td>Courts (ss. 22 RTOA 1988)</td>
<td>65</td>
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<tr>
<td>Courts HRO scheme</td>
<td>30,000</td>
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*Those in the ‘Other third party’ category were most often a family member. This was usually a son or daughter and rarely a spouse. In such cases anonymity is retained.
driving they seek the person’s self-declared information and obtain their consent to make medical enquiry of their GP, consultant, psychologist, etc., as required. They refer for up-to-date clinical assessment and for independent clinical assessment and can refer for on-road driving assessment at one of the driving assessment centres in Great Britain.

Disclosure of a diagnosis of dementia does not necessarily mean that an individual will be considered unfit to drive, particularly if disclosure is in the early stages. As the disease progresses, their fitness to drive will inevitably decrease.

Upon completion of the assessment there are a number of possible licensing outcomes. The licence may be retained, refused or revoked by the DVLA. The person may also voluntarily surrender their licence. In cases where a person retains their licence a medical review generally takes place, usually following one year but can be two or, in rare cases, three years later.

The driver and their GP are always notified of the outcome. The driver has the right of appeal to the courts. However, this can be a costly procedure. There are also cases were there has been a reconsideration of a decision e.g. as in Mr Scobbie’s case (see page 6).

The majority of dementia cases seen by DVLA are Alzheimer’s disease, Vascular dementia and Parkinson’s disease. Those with Huntington’s disease, Pick’s, Lewy body disease, CJD, HIV dementia, endocrine/nutritional disorders, toxic (e.g. alcohol), and post-brain injury are less commonly seen. Figure 6 shows the number of dementia and cognitive impairment cases seen by DVLA in the years 2001–2005 split into age groups. Of the total number seen (N=22,968) the majority (20,843) of these drivers were 65 years of age and above. Of these cases, irrespective of age, five per cent kept their licence, 40 per cent had their licences revoked or refused and the remainder had regular reviews.

Figure 6: Dementia and cognitive impairment cases assessed by DVLA 2001–2005.
Table 3: Recommendations from a review of the DVLA’s medical licensing process.

- Need to raise drivers’ and doctors’ awareness of medical licensing standards and of need (for drivers) to notify.
- Improve guidance needed (from DVLA).
- Monitor self-declaration.
- Consider restricted licences.
- Make greater use of functional assessment to include ...  
  - office-based cognitive tests  
  - behind the wheel tests.
- Change licensing arrangements for older drivers, suggesting licences expire at 75 then five-yearly renewal.

**Review of DVLA’s medical licensing process**

A review of the DVLA’s medical licensing process was undertaken during 2005. This compared other licensing authorities and equivalent industries and considered the views of drivers, doctors and interested groups. A public consultation document was being prepared and consultation was expected towards the end of 2006. Table 3 outlines the recommendations from this process.

**Further information**

Further information on medical licensing can be obtained through the following sources:

- ‘At a Glance Guide to the Current Medical Standards of Fitness to Drive’
- www.dvla.gov.uk or www.direct.gov.uk
- medadviser@gtnet.gov.uk
- 0870 600 0301 general medical enquiries
- 01792 761119 (medical professionals line)
- Professional organisations/colleges.

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The Scottish Driving Assessment Service (SDAS) was established by my predecessor, Dr John Hunter, as the Edinburgh Driving Assessment Service in 1983, based at Astley Ainslie Hospital, Edinburgh. The Service remit remains the same to this day – ‘to advise referring General Practitioners and Hospital Consultants on their patients’ fitness to drive and to help people with disabilities commence or resume driving after illness or accident’. The service expanded to include a mobile service to see patients within their local Health Board area in 1986, and the number of venues now visited by the peripatetic service has increased to seven venues in addition to our base in Edinburgh. The service receives approximately 85 per cent of its referrals from medical staff throughout Scotland, and approximately 15 per cent of its referrals from the Medical Advisors at DVLA as part of their investigations into a patient’s medical fitness to drive. SDAS is a fully accredited member of the Forum of Mobility Centres, a network of 17 independent organisations which offer information, advice and assessment regarding ability to drive, access or egress a motor vehicle (www.mobility-centres.org.uk). There is no charge for any assessments undertaken by SDAS.

Scottish Driving Assessment Service (SDAS) Demographics

At present the SDAS workforce consists of:
- 2.5 WTE Therapists (5 x part-time Senior 1 Occupational/Physio Therapists);
- 2 Doctor days per week (Consultant, Clinical Assistant);
- 1 Development Manager/Information Officer;
- 0.5 WTE Secretary.

In the year 2005–2006 the SDAS undertook 893 assessments, of which 863 were driving assessments (the other 30 being passenger assessments for patients with physical impairments that prevent them from accessing a standard vehicle). A telephone information service is available on weekdays. The assessments take place throughout Scotland at the following locations:
1. Astley Ainslie Hospital, Edinburgh.
2. Dykebar Hospital, Paisley.
3. Royal Victoria Hospital, Dundee.
4. Woodend Hospital, Aberdeen.
5. Raigmore Hospital, Inverness.
6. Royal Crichton Hospital, Dumfries.
7. Ayrshire Central Hospital, Irvine.
8. Caithness Hospital, Wick.

Map of Scotland showing all assessment sites.
Area shaded is geographical area covered by Edinburgh centre.
Outside Edinburgh the clinic room elements of the assessment take place within our mobile unit. This is wheelchair accessible and pictured below.

The mobile unit.

SDAS Driving Assessment Protocol
Irrespective of the venue of the assessment, or the profession of the assessor, each driving assessment follows the same format, with different emphasis being placed on each section dependent upon patients’ impairments, e.g. increased relevance of physical examination in a patient post-stroke with a residual hemiparesis where, in addition to medical fitness to drive, a method physically to control the vehicle may also need to be identified. The assessment comprises:

1. **Medical history** – this allows identification of a disqualifying medical condition, e.g. recent seizures; recurrent, transient ischaemic attacks; faints, etc., and allows the assessor to begin to understand the potential physical and cognitive impairments that may affect the patient’s ability to drive safely. It will also include a driving history as previous experience will impact on patients’ ongoing abilities and expectations.

2. **Physical examination** – the examination begins the assessment of the best manner in which the patient should control the vehicle, and often includes power in all limbs, proprioception, tone (including spasm) and range of movement across joints. If there is any dubiety a variety of control methods can be identified and then trialled on the static rig and/or in an appropriate vehicle.

3. **Visual examination** – all patients are asked to read a standard registration plate with figures 79.4 mm high, and 57 mm wide, at a distance of 20.5 m as per the legal standards for driving\(^1\) (equivalent to approximately 6/11\(^2\)). If this standard cannot be met then the patient cannot proceed to the in-car assessment and is advised that they must NOT drive unless they can have their visual acuity corrected with spectacles/lenses to meet the standard required.

Visual fields are examined with confrontational testing to ensure that the required field of 120° of the horizontal, with 20° above and below the meridian is present. Visual inattention is also excluded. If there is any concern that the visual field is compromised, then fields should be measured with Esterman equipment (or Goldman perimetry with strict criteria). If the visual field requirements cannot be met then the patient has the option to request that DVLA consider their case as ‘exceptional cases’ if they hold, or held a full driving entitlement and the field defect has been present for at least 12 months. The defect must have been caused by an event, or non-progressive pathology, and there must be no other condition or pathology present which is regarded as progressive and likely to affect visual fields. When being considered as an exceptional case, DVLA require confirmation of full functional adaptation and a satisfactory driving assessment. At SDAS the in-car component of driving assessments for people being considered for licensing in this category are always performed with two assessors in the vehicle.

If diplopia is present then this must be declared to DVLA and driving can only occur if it is corrected by glasses/prisms or patching which the driver undertakes to wear when driving. If patching is used then

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the remaining eye must meet all the standards above for acuity and fields. Exceptionally a stable uncorrected diplopia of six months or more duration may be compatible with driving if there is consultant support indicating satisfactory functional adaptation.

4. **Higher cognitive assessment** – As the protocol for driving assessment in Scotland has developed over the past 23 years there has been an increasing use of a variety of cognitive tests within the assessment. The current battery is:

- Road sign recognition (adapted from the Stroke Drivers Assessment Battery);
- Set passage recall;
- Finger tapping;
- Second highest number;
- Block design (from the Rivermead Perceptual Assessment Battery);
- Mini mental state examination;
- Trail Making B Test;
- National Adult Reading Test.

The battery of tests used reflect some of the cognitive skills that are required for driving, but at present there are data available to predict the outcome of the assessment based on the results of cognitive tests. Thus, all patients are made aware that the cognitive tests do not have a pass/fail mark, but they do help the assessor identify areas of cognitive impairment that may affect ability to drive safely. SDAS are currently undertaking a prospective study to ascertain if any (individual or group) of the tests used are predictive of the assessment outcome. This has involved all patients assessed over a six-month period undertaking all of the tests in the battery irrespective of whether a cognitive impairment was suspected or not. Prior to the study the assessor could use their discretion as to which, if any, of the tests were performed dependent upon the patient’s diagnosis and presentation.

5. **Reaction times** – The static assessment rig (pictured alongside) allows the measurement of the time taken for the patient to respond to a visual stimulus (i.e. red light on ‘windscreen’) by moving from the accelerator to brake. This can be in the traditional method, that is moving the right foot from accelerator to brake pedal, or could be using an adapted method, e.g. hand controls, left foot accelerator, right foot accelerator and left foot brake, etc. The stimulus distribution over the ‘windscreen’ also helps when assessing potential visual field deficits and visual inattention. The assumed norm for this reaction is one second. There is a research group within Forum that is looking to develop standardised norms for this reaction time with which SDAS is participating. (The rig can also measure a variety of other variables including steering resistance, braking/accelerating pressures, which assist people trying to overcome physical impairments when controlling a vehicle).

6. **In-car assessment** – If the patient holds a valid driving licence, and no legal bar to driving (e.g. recent seizure, failed visual acuity standard) has been identified then the patient proceeds to an in-car assessment. This is undertaken in one of the service vehicles, with dual brakes, and appropriate adaptations that may have been identified during the assessment. The patient drives within the hospital grounds at the assessment centre to familiarise them self with the vehicle controls, and if satisfactory control is achieved then proceeds over a pre-determined test route on public roads. Each route
involves negotiating a wide variety of road traffic situations including roundabouts, traffic light controlled junctions and feeding into fast moving traffic, over a period of at least 40 minutes. For each route there is an assessment sheet which the assessor completes, so the same skills are assessed at the same points on the route.

At the end of the assessment process the outcome is discussed with the patient, and family/carers if wished, and advice offered regarding tuition required, vehicle adaptations required, Motability scheme, etc. If the driver was unsafe the patient will be advised to stop driving. The entire process can take up to two-and-a-half hours.

**SDAS patient demographics**

In the year 2005–2006 SDAS undertook 893 assessments (of which 863 were driving assessments and 30 passenger assessments) and the ages of patients ranged from six to 94 years. The youngest driving assessment patient was aged 16, as people with high rate mobility component of Disability Living Allowance can apply for a driving licence from age 16 (see Figure 1 below).

The average age of patients seen continues to increase year on year. The gender of patients remains dominated by men (probably reflecting the historical trend of more men holding driving licences than women), but the proportion of women being seen by the service is also increasing (see Figure 2).

**Figure 1: Number of patients seen by age group by SDAS in year 2005–2006.**

![Figure 1: Number of patients seen by age group by SDAS in year 2005–2006.](image)

**Figure 2: Number of patients seen by gender group by SDAS in year 2005–2006.**

![Figure 2: Number of patients seen by gender group by SDAS in year 2005–2006.](image)
When SDAS began, the majority of patients assessed had a physical disability that prevented them from driving a vehicle safely with standard controls, e.g. right lower limb amputation, muscular dystrophy, etc. As society and the service have developed, the diagnoses of patients seen by SDAS have changed to include more patients with cognitive as well as physical impairments, and patients with dementia now make up the second biggest neurological diagnostic group seen (see Figure 3).

The outcomes of the assessment are classified as below (see Figure 4). The category of ‘May be suitable’ reflects those patients who make minor mistakes during the on-road assessment but the drive was basically safe. It is also used for those patients who are adapting to a new physical control method and thus require a period of tuition prior to a final decision being made. These patients may also be coded as ‘review recommended’ if the assessor wishes to see the patient after tuition with an approved driving instructor. This is rarely recommended if the patient has a significant cognitive impairment that would make learning new skills less likely. For those patients whose driving skills are unsafe, and who do not have the potential to learn, it is important that the assessor explains this to the patient and advises them to stop driving. If the patient agrees then family members/carers/friends should be present for this discussion. Some patients attend for assessment who do not meet legal requirements, e.g. do not meet visual requirements, or had a recent seizure. These patients are told that they must not drive, and if they have not done so, to advise DVLA of the disqualifying medical condition.

**Figure 3: Neurological diagnostic groups of patients seen by SDAS in year 2005–2006.**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of patients assessed 2005–2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>213</td>
</tr>
<tr>
<td>Dementia</td>
<td>90</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>77</td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td>47</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>33</td>
</tr>
<tr>
<td>Spinal cord injury</td>
<td>31</td>
</tr>
<tr>
<td>Frail elderly</td>
<td>26</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>26</td>
</tr>
<tr>
<td>Psychiatric conditions</td>
<td>17</td>
</tr>
<tr>
<td>Other neurological</td>
<td>150</td>
</tr>
</tbody>
</table>

**Figure 4: Assessment outcomes for all patients in 2005–2006.**

<table>
<thead>
<tr>
<th>Assessment outcome</th>
<th>Number of patients in 2005–2006</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable to drive</td>
<td>437</td>
<td>51%</td>
</tr>
<tr>
<td>May be suitable</td>
<td>161</td>
<td>17%</td>
</tr>
<tr>
<td>Review recommended</td>
<td>82</td>
<td>9%</td>
</tr>
<tr>
<td>Should not drive</td>
<td>163</td>
<td>19%</td>
</tr>
<tr>
<td>Legally excluded</td>
<td>31</td>
<td>4%</td>
</tr>
</tbody>
</table>

---
The process of driving assessment in Scotland

Thus, more than two-thirds of the total number of patients assessed by SDAS in 2005–2006 were advised to continue driving. However, when specific diagnostic groups are identified the outcomes differ. When considering the group of 90 patients whose primary diagnosis was dementia, the age ranges of the patients seen changes to a range of 47 to 94 years, with the majority being older than 66 years. The assessment outcomes also change, as below (see Figure 5).

The assessment outcomes can also be quantified for patients in specific diagnostic groups. Outcomes for patients with diagnoses that may include cognitive impairment, such as cerebrovascular disease and multiple sclerosis can be compared to the outcomes of patients who have a primary diagnosis of dementia (see Figure 6).

### Figure 5: Assessment outcomes for patients diagnosed with dementia in 2005–2006.

<table>
<thead>
<tr>
<th>Assessment outcome</th>
<th>Number of patients in 2005–2006</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable to drive</td>
<td>26</td>
<td>29%</td>
</tr>
<tr>
<td>May be suitable</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>Review recommended</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Should not drive</td>
<td>42</td>
<td>47%</td>
</tr>
<tr>
<td>Legally excluded</td>
<td>6</td>
<td>7%</td>
</tr>
</tbody>
</table>

Thus, more than two-thirds of the total number of patients assessed by SDAS in 2005–2006 were advised to continue driving. However, when specific diagnostic groups are identified the outcomes differ. When considering the group of 90 patients whose primary diagnosis was dementia, the age ranges of the patients seen changes to a range of 47 to 94 years, with the majority being older than 66 years. The assessment outcomes also change, as below (see Figure 5).

The assessment outcomes can also be quantified for patients in specific diagnostic groups. Outcomes for patients with diagnoses that may include cognitive impairment, such as cerebrovascular disease and multiple sclerosis can be compared to the outcomes of patients who have a primary diagnosis of dementia (see Figure 6).

### Figure 6: Comparison of assessment outcomes for patients in diagnostic groups 2005–2006.

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>Cerebrovascular Disease</th>
<th>Multiple Sclerosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable to drive</td>
<td>10 (19%)</td>
<td>2 (5%)</td>
<td>0</td>
</tr>
<tr>
<td>May be suitable</td>
<td>7 (13%)</td>
<td>3 (8%)</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>Review recommended</td>
<td>0</td>
<td>7 (18%)</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>Should not drive</td>
<td>34 (64%)</td>
<td>26 (65%)</td>
<td>3 (43%)</td>
</tr>
<tr>
<td>Legally excluded</td>
<td>2 (4%)</td>
<td>2 (5%)</td>
<td>0</td>
</tr>
</tbody>
</table>

However, some patients attend SDAS without a formal diagnosis of dementia, but with identifiable cognitive impairments. All patients seen have their cognitive abilities coded as one of:
- Satisfactory;
- Impaired, probably satisfactory;
- Impaired, probably unsatisfactory;
- Unsatisfactory.

Of the 863 patients assessed by SDAS in 2005–2006, 136 patients (16 per cent) were coded as having cognitive abilities that were unsatisfactory or impaired, probably unsatisfactory. The primary diagnosis of the patients who have cognitive impairments are as below (see Figure 7).

The assessment outcomes for this group of 136 patients are as below (see Figure 8).
Thus, patients with cognitive impairment identified during the assessment are more likely to be advised that they should not drive than the assessment population as a whole. This is not surprising given the fact that it is recognised that driving does require a variety of cognitive skills. On a more positive note, the figures also demonstrate very clearly that not all patients with a diagnosis of dementia, or cognitive impairment identified during the assessment, lose the ability to drive safely. Thus it cannot be justified to impose an automatic driving ban when a diagnosis of dementia, or cognitive impairment, is made. However, given the number of people who could not drive safely, and the current lack of predictive cognitive tests, it is important that people with identified cognitive impairments have access to driving assessment to ensure their and other road users’ safety.

### Common driving difficulties for people with dementia

When patients with dementia are assessed a variety of driving difficulties are identified. Occasionally the patients, but more often their families, report difficulties with route finding. Losing the vehicle when parked is also described regularly. There are very rarely difficulties with physical control of the vehicle; the difficulties are seen with ‘reading the road’. There appears to be a tendency to drive towards the central white line and then over it. Road positioning at junctions and roundabouts also deteriorates, with a failure to stop in appropriate positions, poor lane discipline and poor decision making (e.g. when to enter a roundabout, when to turn at traffic light controlled junctions). There can also be an assumption of priority on the road and a failure to recognise potential difficulties ahead (e.g. bus...

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**Figure 7: Diagnostic groups for patients coded as having cognitive impairment (probably unsatisfactory or unsatisfactory) in 2005–2006.**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of patients with cognitive impairment in 2005–2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>53</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>40</td>
</tr>
<tr>
<td>Frail elderly</td>
<td>9</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>7</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>6</td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td>3</td>
</tr>
<tr>
<td>Others</td>
<td>18</td>
</tr>
</tbody>
</table>

**Figure 8: Assessment outcomes for patients with cognitive impairment in 2005–2006.**

<table>
<thead>
<tr>
<th>Assessment outcome</th>
<th>Number of patients in 2005–2006</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable to drive</td>
<td>12</td>
<td>9%</td>
</tr>
<tr>
<td>May be suitable</td>
<td>16</td>
<td>12%</td>
</tr>
<tr>
<td>Review recommended</td>
<td>10</td>
<td>7%</td>
</tr>
<tr>
<td>Should not drive</td>
<td>92</td>
<td>68%</td>
</tr>
<tr>
<td>Legally excluded</td>
<td>6</td>
<td>4%</td>
</tr>
</tbody>
</table>
pulling out, pedestrians crossing). On occasion, concentration lapses can be seen during the drive.

DVLA guidelines for patients with dementia
An At-A-Glance Guide to the Current Medical Standards of Fitness to Drive is issued every six months by the Drivers Medical Group, DVLA, Swansea. It provides guidance to all doctors when assessing patients’ medical fitness to drive. The advice for patients with dementia is that ‘It is extremely difficult to assess driving ability in those with dementia. Those who have poor short-term memory, disorientation, lack of insight and judgement are almost certainly not fit to drive.’ The document acknowledges the variable presentations and rates of progression within the disease. It is recognised that a decision regarding fitness to drive is usually based on medical reports, that licences may be subject to annual review and that a formal driving assessment may be necessary.

Thus, there are no diagnostic criteria or cognitive testing recognised by DVLA that predict the ability of people with dementia to drive. The Medical Advisors at DVLA have recognised the variability in people with dementia, and their ability to drive safely, and are increasingly relying on driving assessment as an objective assessment of an individual’s ability to drive.

General Medical Council guidelines if patient drives against advice
Being advised not to drive can be very difficult to accept, particularly if there is limited insight into the driving difficulties and the underlying disease process of dementia. If a patient fails to follow advice regarding stopping driving then it is recognised that, for public safety, there may be the need to break patient/doctor confidentiality. The General Medical Council (GMC) provides advice to doctors which suggests that doctors should:

1. Ensure the patient is aware of the condition that is impairing their ability to drive. If the patient is unable to understand this then the doctor should inform DVLA immediately;
2. Explain to the patient that they have a legal duty to inform DVLA of the condition that is impairing their ability to drive;
3. If the patient refuses to accept the diagnosis, or advice not to drive a second opinion can be offered, but the patient must not drive whilst awaiting a second opinion;
4. If the patient continues to drive the doctor should ‘make every reasonable effort to persuade them to stop’. This may include discussing the situation with relatives/carers;
5. If the patient continues to drive the doctor should disclose medical information immediately to a Medical Advisor at DVLA, having told the patient that they intend to do so, and writing to the patient to confirm that they have done so.

Conclusion
The diagnosis of dementia or cognitive impairment should be reported by the licence holder to DVLA. The licence holder must also inform their insurance company. The diagnosis does not and, based upon SDAS statistics, should not lead to an automatic loss of a driving licence. If there are any concerns regarding a person’s ability to drive then the Scottish Driving Assessment Service (or a Forum Mobility Centre in England, Wales or Northern Ireland) can provide an objective assessment of medical fitness and ability to drive.

Correspondence
Dr Lynne Hutton
Consultant in Rehabilitation Medicine, Scottish Driving Assessment Service, Astley Ainslie Hospital, Edinburgh.
Driving with dementia – to what extent is risk of accident really increased?

Carol Holland

Dementia clearly affects many abilities, e.g. memory, reaction time, visuo-spatial skills, attention and problem solving, that would be expected to be central in maintaining safe driving; although in the early stages only one or two symptoms may be noticeable. Many people with dementia, especially in the early stages, continue to drive, and it is assumed that many of these may be posing a considerable threat to themselves and to the general population. However, not all studies find an increase in accident risk amongst those with a diagnosis of dementia, and those which do often find that the increase in accident risk is no greater than the level posed by healthy, inexperienced younger drivers. Reasons for the lower than expected accident risk, and implications of this data, will be examined: (i) The studies may be largely examining early stage patients, who may not yet have impairments that seriously affect their driving; (ii) Actual, specific functional measures of driving relevant capabilities, rather than general diagnosis, are more likely accurately to predict accident risk; (iii) Some patients, even those with more serious impairments, are greatly reducing or restricting their driving, either on their own initiative or under advice from medical practitioners or friends and family, significantly reducing their risk, thus driving only in situations in which they are within their capabilities. Most patients with more severe impairments do give up driving and it is generally agreed that these patients would present serious risk to themselves and the public as drivers if they were to continue.

Background: The older driving population and their accident risk

The UK driving population has changed in significant ways over the last 30 years, with older people in general now being much more likely to be active drivers. The difference between numbers of older men and women who drive continues to diminish. Clinical practitioners can now rarely assume that any adult patient is not a driver. Table 1 illustrates that between the late 1990s and projected data for the 2020s (projections made in 2000), the percentage of the over 60s population who hold driving licences will have increased by 10 per cent for men in their 60s, 14 per cent for men over 70, but by 35 and 36 per cent for older women in their 60s and 70s respectively. Licence holding amongst all those over 70 is currently 51 per cent (National Transport Statistics, 2006).

As well as this proportional increase in older people who are drivers, as the number of older people in the population increases, so the absolute number of older drivers will increase. Population trends show that the biggest increase in recent years has been for the older old population. For example, there was a 27 per cent increase in numbers of people over the age of 85 between 1991 and 2004 (National Statistics, 2006). Combining this with data that suggests that between 29 per cent (Lobo et al., 2000) and 47 per cent of people aged over 85 (Evans et al., 1989) have a dementing disorder, this means that the driving issue will be affecting not only a greater proportion of dementia patients, but also there will be a greater number of them as well.

In addition, older people drive more than previous generations of older drivers (increasing mileage, increasing number of trips out by car, DLTR, 2001; DfT 2005a) and make life decisions based on the ability to drive, such as where they live in relation to amenities or family and friends. For example, women aged 60 to 69 increased annual distance driven by over 187 per cent between 1985/86 and 1998/2000 (men by...
Driving with dementia – to what extent is risk of accident really increased?

Table 1: Percentage of the population who are driving licence holders, by age and gender: Real (1999, 2005) and Projected (2020).

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>60–69</td>
<td>84</td>
<td>51</td>
<td>88</td>
</tr>
<tr>
<td>70+</td>
<td>64</td>
<td>22</td>
<td>73</td>
</tr>
<tr>
<td>All adults</td>
<td>68</td>
<td>72</td>
<td>70</td>
</tr>
</tbody>
</table>

Adapted from Holland et al. (2003), Sources: National Transport Statistics (2006), and Maycock, 2000).

Table 2: Number of car drivers killed or seriously injured for drivers aged over 60: 1981–85 and 1994–98 averages, and 2004 figures.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60–69</td>
<td>908</td>
<td>613</td>
<td>418</td>
<td>−54.0%</td>
</tr>
<tr>
<td>70+</td>
<td>641</td>
<td>708</td>
<td>548</td>
<td>−14.5%</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60–69</td>
<td>299</td>
<td>299</td>
<td>244</td>
<td>−18.0%</td>
</tr>
<tr>
<td>70+</td>
<td>221</td>
<td>323</td>
<td>271</td>
<td>+22.0%</td>
</tr>
</tbody>
</table>

Figures from Road Casualties Great Britain, 2004 (DfT, 2005b), updated from Holland et al. (2003).

Table 3: Killed or serious casualty involvement of older women drivers as a percentage of all such casualties.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>60–69</td>
<td>1.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>70–79</td>
<td>1.0%</td>
<td>1.7%</td>
</tr>
<tr>
<td>80+</td>
<td>0.2%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Figures from DfT (2005b) and DTLR (2000).
However, we commonly hear it reported that it is a fact that older people have increased risk as drivers. This seems counter to the above statistics. Such reports are commonly comparing older people to those in the safest group, the 30- to 59-year-olds, and are based on numbers of drivers killed or seriously injured. When statistics based on all severities are examined, there is no age-related increase in total number of accidents for the over 60s (DTLR, 2000). As may be expected, older people have substantially fewer accidents than drivers under the age of 30. For example, in 2004, 4091 drivers aged under 30 but only 1481 drivers aged over 60 were killed or seriously injured on British roads, and the rate per 100,000 population of all severities accidents as drivers for the 60 to 69 age group was 118, whereas for the 20 to 29 age group it was 464. (DfT, 2005b). Older drivers (over 60) make up a smaller proportion of seriously injured or killed drivers (14 per cent total) than would be expected from the population (over 60s make up 18.6 per cent of the UK population).

Although older people may not be having a greatly increased number of accidents, they are at higher risk of serious injury or dying as a result of any accident in which they are involved. Mitchell (2000) calculated a fragility index, based on percentage of accidents that are fatal for 20- to 50-year-olds. He found an increasing fragility index for car drivers, passengers and pedestrians of 1.75 at age 60, 2.6 at age 70 and 5.9 for the over 80s. In another study, Eberhard (1996) reported that an 80-year-old is four times more likely to die in a crash of similar intensity than a 20-year-old.

**Dementia patients – what proportion continue to drive?**

Dementia is defined as a progressive decline in cognition generally, but specifically affecting memory, reaction time, visuo-spatial skills, attention and problem solving, all abilities that would be expected to be central in maintaining safe driving. Many older people with dementia, especially in the early stages, only manifest one or two of these symptoms, and they commonly continue to drive. It is generally assumed that many of these drivers pose a considerable threat to themselves and to the general population, but this is an assumption that may not be general – some may be posing a risk, whilst others are probably not, and evidence on accident rates and driving abilities needs to be examined. Estimates of frequency of dementia (all types) vary from five to 15 per cent in those aged over 65, but from 29 to 47 per cent in those aged over 85.

Earlier studies found that 50 per cent of Alzheimer’s disease (AD) patients had stopped driving by three years post-diagnosis (Friedland et al., 1988; Drachman & Swearer, 1993), implying that 50 per cent continued, and Friedland et al. found that for a group of AD patients who had had a car crash as drivers, the mean duration of their illness was four years (± 1.8 years). However, more recent studies indicate that this may have changed (although a variety of countries and US States were the subjects of these studies), with Trobe et al., 1996, finding that 87 per cent of dementia patients had stopped driving within 2.5 years of diagnosis, implying only 13 per cent continued. Studies that have assessed a group of dementia patients (e.g. those attending a certain clinic) to determine percentage still driving, give percentages varying between 22 per cent and 31 per cent (Talbot et al., 2005; Carr et al., 1990; Waller, 1967). With more recent studies giving lower numbers of people still driving. Such data implies more discouragement from driving in current times than there has been in the past for this group. Considering this, in combination with earlier diagnosis and with the more recent availability of medications that ameliorate problems, especially in the early stages, this implies that there may be people who could safely continue to drive, for a time, who are giving up, or being forced to give up. The survey by Christie et al. (2001) suggested that 51 per cent of psychologists are not confident about the recommendations they give.
about fitness to drive, with McAffee and Atkins (2007) finding the same for 53 per cent of a more general group of health professionals who dealt with dementia patients at least weekly (including psychologists). McAffee and Atkins also found that only 53 per cent of respondents would not prefer people with a dementia to give up driving immediately upon diagnosis, with only 67 per cent of respondents believing people with dementia should be allowed to continue to drive following appropriate driving assessment. Other documents in this volume suggest that many clinicians are using only self-assessments or relatives’ opinions to make recommendations, rather than objective, validated neuropsychological or driving tests; although all seem aware of the need to increase clinicians’ confidence in discussing the issue with patients. This strengthens the argument for standardised and objective testing to determine actual fitness to drive that is available to everybody, on diagnosis.

**Accident rates of drivers with dementia**
A key question to consider is whether people with dementia actually have more accidents as drivers. The data are somewhat surprising, with there being less agreement in the literature than may be expected. The first reliable result seems to be that risk of road accident generally increases with time since diagnosis. For example, Duchek et al. (2003) provide a careful longitudinal study demonstrating that re-evaluation every six months usefully shows a gradual reduction in numbers of patients still being assessed as safe to drive, although some with mild or very mild dementia remained safe throughout the duration of the study.

Cross-sectional studies are more common, with individuals with dementia having from 2.5 to 4.7 times the likelihood of being involved in a driving accident of age matched controls (Friedland et al., 1988; Tuokko et al., 1995). Although this is a substantial increase in accident likelihood, Waller et al. (1993) suggests that their crash risk is similar to that of normal healthy drivers under the age of 24 and is still substantially less than the crash risk of drivers who have been drinking alcohol (e.g. data from the first two to three years after diagnosis, Drachman & Swearer, 1993).

An important issue is how crash risk compares with that associated with other illnesses that become more common with increasing age. Koepsell et al. (1994) conducted a study in which they compared people over the age of 65 who had received medical care within seven days for injuries sustained in a motor vehicle collision in which they were driving, with controls who were age, gender, and county of residence matched people who had had no such injury during that year. Odds ratios were used to illustrate relative risk. Relative risks were greatest for individuals with diabetes and coronary heart disease, not for dementia.

Some well-controlled studies have found no increase in crash incidence for drivers with dementia (Trobe et al., 1996) or no significant increase in the early stages of this progressive disease (Drachman & Swearer, 1993), and some authors suggest that many patients in the early stages of the disease should be safe to drive provided they are regularly re-evaluated (Fox et al., 1997).

**The role of compensation and strategies**
The results of Trobe et al. are surprising, since they did not separate out early AD patients from those who had received their diagnosis some time ago. Importantly, they found that patients with poorer scores on neuropsychological tests actually had lower crash risk than more mildly impaired AD drivers, and suggested that this may be due to reduced mileage and greater restrictions amongst the more severely impaired drivers. The reduced mileage of participants with a diagnosis of dementia suggested that such adaptations to driving were successful in reducing risk. It seems that people make adaptations to their driving to compensate for changes in abilities or for increased
anxiety in the driving situation. There is compelling evidence that people who report various illnesses and symptoms do reduce their driving (Rabbitt et al., 2002). These authors reported that older drivers with high scores on a self-rated measure of health, indicating a greater number and severity of symptoms and illnesses (assessed with the Cornell Medical Inventory, CMI), reported significantly lower annual mileage than older drivers with lower CMI scores. Importantly, this relationship was also found longitudinally, such that increases in CMI scores over a three-year period reliably predicted reductions in mileage and reductions predicted increases in mileage, in a manner unrelated to increasing chronological age.

One striking piece of evidence for the usefulness of one adaptation comes from Bédard, Molloy and Lever (1996 – cited in O’Neill, 1996) who found that drivers with dementia who usually drove alone had a higher crash risk than those who drove accompanied, and Shua-Haim et al., (1999) actually suggest that patients with early AD who drive with a ‘co-pilot’ would be safe to drive.

Table 4: How does dementia compare with other diseases?

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>0.8</td>
</tr>
<tr>
<td>Transient ischemia</td>
<td>1.6</td>
</tr>
<tr>
<td>Head Injury</td>
<td>4.0</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>2.1</td>
</tr>
<tr>
<td>COPD</td>
<td>0.9</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>1.1</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>1.6</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.6</td>
</tr>
<tr>
<td>Diabetics treated with insulin</td>
<td>5.8</td>
</tr>
<tr>
<td>Diabetes and Coronary heart disease</td>
<td>8.0</td>
</tr>
<tr>
<td>Depression</td>
<td>1.7</td>
</tr>
<tr>
<td>Dementia</td>
<td>2.8</td>
</tr>
</tbody>
</table>

From Koepsell et al. (1994) (comparing with age matched drivers).

Approaches to determine who is fit to drive
1. A ‘severity of combined effects’ approach
What is a useful way to approach this issue of distinguishing who can compensate for dementia related difficulties and who cannot, who may be safe on the roads and who may not? The first issue is to consider the individual, rather than the diagnosis, and take a “severity of all combined effects” approach. The diagnosis of dementia is not the only factor that may be affecting driving with a large number of older people. For example, it is necessary to take into account any obvious evidence of normal age-related changes, such as changes in eyesight, speed and strength of movement, slowing of reaction times, in combination with the possible effects of other diseases and associated medications. Most older people have at least one chronic disease process, often more (e.g. see the increase in risk seen in Table 4 related to the combination of Coronary heart disease and diabetes). These other illnesses and medications can all interact to have additional effects on driving (for a review, see Holland, Handley & Feetham, 2003). The key point to consider is whether
individuals are capable of functioning safely in the road environment, taking into account the combined effects of ageing and other illnesses, not just the effects of the dementia. That is, the ‘end point, rather than the source of functional loss is of concern’ (Waller, 1992, p.5). Net driving function should be considered, and factors that may reduce an individual’s reserve capacity for compensating for minor difficulties should be considered. Dementia is a prime example of a disease process where other factors can seriously exacerbate the functional implications of the illness, e.g. depression or effects of sleeping tablets are two such common factors.

2. Which data do we use?

(a) Actual driving performance

Another important issue is which data we use to make policy decisions about people with dementia as drivers. Rather than using crash risk as an end measure of competence, as in the above epidemiological studies, some studies have taken a prospective, experimental approach and examined actual functions, e.g. driving performance on the road or in simulators. These have shown that AD patients generally perform worse than age matched controls (e.g. Bylsma et al., 1990), even when only mildly demented patients are selected for study (Fitten et al., 1995). However, Hunt et al. (1997) report that even so, 55 per cent of patients with mild or very mild dementia still showed safe driving skills on their particular on-road driving test (cf 78 per cent in healthy age-matched controls). Such data illustrate that the reduction in the mean performance of a group of dementia patients as compared with age matched controls does not necessarily mean that everyone in the group is showing poor performance – as with any ageing study, the most striking thing about such data is the increase in variability, not reduction in the mean.

On-road driving tests are a vital part of screening for fitness to drive, especially where retraining is required or medical decisions based on diagnosis of dementia are being disputed. They give important face and ecological validity to the process, a factor that is particularly important for accuracy of assessment, but also to assure any patient advised to discontinue driving that the test procedure is objective and accurate. However, many authors suggest that they should be used in combination with other measures (simulator assessments, neuropsychological measures) because of the difficulty in standardising the situations a driver may face in real traffic.

The kinds of errors a driving assessor uses to make a judgement need careful examination. Dobbs (1997) compared errors made by cognitively impaired drivers with those made by healthy, experienced drivers (age matched and younger experienced control drivers). The analysis produced three categories of errors: the first, labelled ‘Hazardous or potentially catastrophic’ was made almost exclusively by the participants with dementia; the second category ‘positioning and observational errors’, was made by all three driver groups, although AD drivers made more than normal older drivers, who made more than younger experienced drivers; the final set of errors could all have resulted in a fail on a driving test, but were not necessarily indicative of impairment in driving, such as speed errors or ‘rolled stops’. These errors were made equally by all three groups, and the author suggested that they would not be useful to discriminate fitness to drive in older, experienced drivers. Such research suggests that assessors may need to be specifically trained for this type of assessment.

(b) Neuropsychological measures

Another approach is to examine neuropsychological measures in terms of their accuracy in predicting driving performance prospectively, or crash risk retrospectively (see Withaar et al., 2000; Reger et al., 2004; Adler et al., 2005 for reviews and meta-analyses). In the early stages of the disease, performance on specific functional measures may be more likely to identify driving risk
than the general diagnosis. Measures that can be conducted in a clinic that can reliably predict which patients are not fit to drive are a useful first screening device. One test that is widely used as a brief cognitive screen is the Mini-Mental State Examination (MMSE – Folstein et al., 1975). Reports vary as to whether this test discriminates those who demonstrate adequate driving ability from those who do not. Importantly, it was not designed for this purpose. Fitten et al. (1995), found that it is a usefully predictive screening device, more so when scores are particularly low, but Reger et al. (2004) found a relationship between MMSE and on road driving only when healthy controls were included (that is, it did not discriminate amongst dementia patients). Results generally suggest that a high score on the test does not mean that a person is necessarily fit to drive, but a low score on the test (e.g. below 25 – Johansson et al., 1996; or below 22 – Shua-Haim & Gross, 1996) would indicate that the person is probably not fit to drive.

Measures of visual selective attention have shown promising results in terms of distinguishing between early/mild AD patients who drive safely in tests, and those who do not (e.g. Duchek et al., 1998). Ball et al. (1993) showed that a measure of visual ‘pre-attention’, the useful field of view (UFOV) predicted crash frequency for participants independently of mental status, and that individuals with poor mental status who did not have impaired UFOV did not have increased crash risk relative to individuals with good mental status and unimpaired UFOV. Although not all Ball et al.’s poor mental status group had a diagnosis of dementia, this study illustrates that variability in the functions that relate to driving within any group of mild AD patients needs always to be borne in mind.

Studies that find significant differences in driving ability or visual attention between groups of mild dementia patients and controls may be missing the important point that some patients within the dementia group may have good visual attention or be fit to drive whilst others most certainly are not. A study that examines relationships within the dementia group (Reger et al., 2004) found that visuo-spatial skills and attention-concentration tasks show significant relationships with on-road performance. Such relationships suggest that these measures, in particular, may be useful in discriminating those who may be safe to drive at present from amongst a group of dementia patients, although clearly, prospective studies examining the relationship of such measures to actual accident occurrence are needed.

**Overview**

There are many studies that demonstrate that people with dementia, as a group, have increased crash rate or poorer driving abilities compared with age matched controls. However, epidemiological evidence suggests that in actual cases, risk is reduced by use of restrictive driving practices such as reduced mileage or driving with a ‘co-pilot’. In the later stages of dementia, impairment is more global and severe and such adaptive restrictions may not be used as carefully, and there is little disagreement that driving is a serious risk (Lundberg et al., 1997), the majority of patients giving up driving once impairment is severe.

Most studies which examine variability find that many patients with very mild or mild dementia still drive safely, and specific screening devices which may help distinguish safe from unsafe drivers within this group are needed. Measures of visuo-spatial skills and visual selective attention seem the most promising potential tests, based on evidence of relationships with driving performance and crash risk. It is also suggested that planning and strategy skills (executive function) are needed to enable effective compensation where needed, and may make the difference between someone who can continue to drive safely and someone who cannot, despite other similarities in functional declines. Further research to examine ability to compensate for minor difficulties is needed.
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Relationship between performance on neuropsychological tests and on-road test

Janice Rees

The Rookwood Driving Assessment Battery: Normative Older Adult Performance.
J. Rees, P. McKenna, V. Bell, E. Skucek, E. Nichols & P. Fisher.

ONE-HUNDRED-AND-EIGHTY-FOUR volunteer older people were assessed on the Rookwood Driving Assessment Battery, to provide normative data on the battery for clinical use. The sample was screened for intact cognition, and 12.5 per cent of the group fell below a cut-off typically used in epidemiological studies to identify age-related cognitive decline. Of the 161 cognitively intact volunteers, performance was marked by poorer battery scores than those observed in an earlier normative study where volunteers up to 70 years of age were assessed. The poorer performance of older people was observed to be closely related to general cognitive integrity, even in the group of cognitively intact volunteers. Among the smaller group of cognitively impaired volunteers, performance on the battery was significantly poorer than for cognitively intact volunteers, closely approaching the mean score of clients assessed at Rookwood Driving Assessment Centre with a diagnosis of dementia. The implications of this age-related battery performance for identifying a suitable cut-off point for adults across the lifespan are discussed.

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OTHERWELL MEMORY CLINIC was set up in 2003, with the aim of providing an effective and efficient assessment, diagnosis and treatment service for older people with memory problems. From the very beginning, the Memory Clinic worked towards two key principles. The first of these was that it should be a multi-disciplinary venture. Currently the Memory Clinic staff includes nursing, psychiatry, psychology, occupational therapy, pharmacy and Alzheimer’s Scotland. Secondly, while the initial emphasis of the clinic was on diagnosis and medication, the intention was always that this would broaden out to address non-pharmacological issues. In addition to the assessment, diagnosis and pharmacological treatment of memory problems, the Clinic now provides pre- and post-diagnostic counselling where required, a Coping with Memory Problems group, a carers support group, occupational therapy home assessments and an ongoing monitoring and support service for older people with dementia and their families, whether or not they are prescribed a cognitive enhancer.

As part of our ongoing work on these and other principles, multi-disciplinary service development meetings are held regularly. At one of these meetings the issue of driving and dementia was raised. A recent referral to the Clinic had highlighted the fact that we did not have a clear protocol for how we should deal with the issue of people presenting at the Clinic with memory problems who were active drivers. We therefore decided that as a team we needed to look at the issues involved in detail.

The first thing we did was to have a team training session on driving and dementia. We reviewed the literature in this area, looked at legal and professional guidelines and discussed how to help people adjust if they did have to stop driving because of memory problems. We then asked the Scottish Driving Assessment Service (SDAS – for more information on the SDAS see elsewhere in this issue of the Newsletter) if they would talk to us about their service, and they gave us an excellent presentation on their role and the type of person we could refer to them. After this, we decided as a team that we needed improved screening procedures clearly to identify people with issues related to driving, and we thought that the best way to do this was to develop a screening questionnaire.

In devising our questionnaire, we took several things into account. The first was that the questionnaire had to be brief, quick and easy to use. The intention was to use the questionnaire with all new patients at their first appointment at the Memory Clinic. As this appointment already involves a lot of assessments, we did not want to add too much to this. Secondly, we considered the role of insight. Hunt et al. (1993) found that all the people with Alzheimer’s disease who failed a road test in their study thought that they were capable drivers, and concluded that self-assessment on driving ability does not consistently predict driving performance. We, therefore, thought that we should ask a relative of the patient how they viewed their driving. However, this is not necessarily a reliable predictor of driving ability either (Hunt et al., 1993). Unfortunately, relatives may have a vested interest in keeping the patient driving, particularly if the relative is reliant on the patient for transport, and we were aware that this was by no means a perfect method of eliciting an accurate
picture of the patient’s driving safety. Nevertheless, we felt that it was worth asking both the patient and their relative about their driving, as long as we were cautious in our interpretation of this information.

Finally, we had to consider what specific questions we should ask. We consulted the available literature, which suggested particular areas of driving that people with memory problems were likely to find problematic (Hunt, 2003; Carr et al., 1991). The questionnaire we devised is shown in Table 1.

Our first protocol, therefore, was that each new patient who attended the Memory Clinic had a driving questionnaire put in their notes, the ‘do you drive?’ question was completed, and if they answered ‘yes’ the rest of the questionnaire was completed. This was then discussed at the weekly MDT meeting, where it was decided what, if any, further action was required. After several months this protocol was audited, with somewhat disappointing results. Despite the introduction of the new protocol, only 25 per cent of patients had their driving status recorded in their notes. Not surprisingly, we concluded that our protocol was not working very well, and that we needed to change it.

As the problem appeared to be staff forgetting either to ask new patients about their driving status, or to record this information if they did ask for it, we decided to incorporate a ‘prompt’ question into the existing Memory Clinic assessment. Each new patient who attends the Memory Clinic has a basic data sheet completed by a member of staff as part of their initial interview with the patient. It includes information such as name, address, date of birth, GP, next of kin and so on. We added a section to this sheet for driving status, which the nurse doing the assessment filled in at the same time as the other basic information. The driving questionnaire would then be completed if it was established that the patient was currently driving.

We then audited this second protocol, with much more encouraging results. Of the 21 new patients seen in the month since the introduction of our second protocol, 20 had their driving status recorded in their notes. Of these, four were active drivers, of whom three had a completed driving questionnaire in their file. So while our recording was still not perfect it had improved dramatically, from 25 per cent of new patients’ driving status being recorded to around 95 per cent.

Table 1: Driving Questionnaire.

<table>
<thead>
<tr>
<th>Question</th>
<th>Detailed Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you still drive? IF NO, STOP HERE.</td>
<td></td>
</tr>
<tr>
<td>2. Have you experienced any problems when driving?</td>
<td></td>
</tr>
<tr>
<td>3. Have you found yourself lost on familiar routes?</td>
<td></td>
</tr>
<tr>
<td>4. Have you mixed up the accelerator and brake pedals?</td>
<td></td>
</tr>
<tr>
<td>5. Have you found yourself not giving way at junctions?</td>
<td></td>
</tr>
<tr>
<td>6. How do passengers respond to your driving?</td>
<td></td>
</tr>
<tr>
<td>7. If a relative is present: What do you think about the patient's driving?</td>
<td>Are the answers you receive giving cause for concern? If so, the following steps could be taken (please tick and date as appropriate).</td>
</tr>
<tr>
<td></td>
<td>Pass information to the patient's GP.</td>
</tr>
<tr>
<td></td>
<td>Advise patient to inform DVLA.</td>
</tr>
<tr>
<td></td>
<td>With patient's consent, refer them to SDAS.</td>
</tr>
<tr>
<td></td>
<td>Advise patient that failure to inform appropriate authorities may invalidate insurance.</td>
</tr>
</tbody>
</table>
We then collated and reviewed the information from the completed driving questionnaires which totalled eight, three since the introduction of the second protocol and five from prior to this. These results are presented in Table 2.

One of the first things that struck us about the completed questionnaires was the three cases where action was taken. Of these, patients 4 and 6 had their GPs advised that they may be having problems driving, while patient 1 had a letter sent to their GP, and were advised to contact the DVLA, their insurers and to stop driving. However, when we looked more closely at this it became apparent that there was no consistency in terms of when action was being taken and what form that action took. For example, patient 2’s relative had noted a deterioration in their driving, and patient 3 had had a recent accident, and no action was taken in either case. Compare this with patient 4, where no concerns were noted, and yet the patient’s GP was written to. So, having dramatically improved our recording of patient’s driving status, it appeared that the next thing we had to do was look at how we were responding to this information.

In fact, this is the stage that our service is at now. We are looking at what we have learned from this process, and trying to implement further improvements. The first thing we plan to arrange is another team training session for Memory Clinic staff. Although our rates of recording for driving status and, where appropriate, completion of the driving questionnaire are significantly improved, they are still not 100 per cent. We are planning further training to ensure that everyone is aware of the importance of ascertaining and accurately recording driving status, and that they know when the full driving questionnaire should be used. We are also reconsidering the list of possible action points on the driving questionnaire (see Table 1). Every new patient at the Memory Clinic is discussed at the weekly MDT meeting, and driving status should be

Table 2: Results of completed driving questionnaires.

<table>
<thead>
<tr>
<th>Pt</th>
<th>Noticed driving problems</th>
<th>Getting lost</th>
<th>Mixing up pedals</th>
<th>Not giving way</th>
<th>Perception of passengers' concerns</th>
<th>Concerns reported by relatives</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Quite happy</td>
<td>V concerned, too fast, too close, several bumps</td>
<td>Y</td>
</tr>
<tr>
<td>2</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>OK</td>
<td>Wife has to navigate, deterioration noted</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td>Recent accident</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Slow and careful</td>
<td>Driving fine and safe</td>
<td>N</td>
</tr>
<tr>
<td>4</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>No problems</td>
<td>No problems</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>OK</td>
<td>Attended alone</td>
<td>N</td>
</tr>
<tr>
<td>6</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>No problems</td>
<td>Multiple tasks difficult, poor concentration, wrong places, no bumps</td>
<td>Y</td>
</tr>
<tr>
<td>7</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>No passengers</td>
<td>OK</td>
<td>N</td>
</tr>
<tr>
<td>8</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>OK</td>
<td>Attended alone</td>
<td>N</td>
</tr>
</tbody>
</table>
part of this discussion. However, there is currently no option to record this on the driving questionnaire. We are considering adding this, partly as a prompt to staff, and partly so that it can be clearly documented that the issue has been raised and discussed appropriately, even if a decision is taken that no further action is required at this time.

Another issue we are reviewing is the consistency of recording of any action taken. For example, one patient had no action noted on their driving questionnaire, but elsewhere in their case notes there was a referral letter to the SDAS, clearly indicating that action had been taken in relation to their driving. We are currently considering where is the best place to record this information. If you are looking specifically for driving information, then certainly the driving questionnaire is the easiest place to look. However, there is a likelihood that information could be missed if it is only recorded on the questionnaire and not in, for example, the MDT meeting notes. We are conscious of not making work for ourselves by duplicating information unnecessarily, and are still working on the devising the optimum recording method.

Similarly, we need to look at improving the consistency of decision-making around any action taken with regards to the patient’s driving, which we hope at least partly to address through further training sessions and increased awareness of driving issues at our weekly MDT meetings.

Finally, we plan to review our driving questionnaire. While the questions we chose to include on the questionnaire were all taken from the available literature, we are beginning to question their validity. Although we obviously only have limited data, so far none of the drivers who have completed the questionnaire have reported confusing the brake and the accelerator or failing to give way. Anecdotally, the staff at the Memory Clinic have often heard relatives talking about patients failing to give way, but no-one is aware of anyone mixing up the pedals. Recent suggestions for other things we could ask about have come out of discussions where this paper has been presented, and include road positioning, and confusing controls such as the headlights and the wind-screen wipers. Our plan is to gather some more data as more questionnaires are completed, then review the literature once again to check for recent research on this topic, and possibly modify our questionnaire in the light of any new information.

Once we have addressed the issues above, we will be ready to draw up our third protocol for driving and dementia, which should, ideally, include clear guidance on where actions are recorded and under what circumstances what form of action would usually be considered. Once we have agreed this, tried it out and audited it, our eventual aim is to roll out our protocol across NHS Lanarkshire old age psychiatry services. There are currently another two memory clinics (one of which is a rural, roving service) as well as nine CMHTs for Older People across Lanarkshire, and we feel that a local version of our protocol could usefully be applied area-wide to ensure greater consistency of care.

Overall, as a multi-disciplinary team, we feel that this has been an extremely worthwhile service development, and a good example of clinical experience driving (excuse the pun!) service improvement. In summary, we have found the most important benefits to be:

- A significant increase in our awareness of the issues around driving and memory impairment;
- That we are moving towards a more consistent approach to working with memory impaired drivers and their families;
- That, in general, staff feel more comfortable having clear guidance with which to work;
- That staff are better equipped to provide patients and relatives with more thorough information at a much earlier stage – this means no ‘nasty surprises’ for people, and hopefully aids subsequent adjustment if they do have to cease driving.
● That more of our patients are able to continue driving when they are safe to do so. It is our impression that since we began to develop our protocol we have become far more likely to refer people to the SDAS for a full assessment, rather than automatically telling patients that they should stop driving;
● That while patients and relatives can still find the issue of driving assessment and/or cessation difficult, staff are more confident in dealing with their fears and distress;
● That it has led to the development of alternative transport information for discussion with patients and relatives who have to stop driving, which looks at establishing what needs driving met and how these needs might be met in other ways.

With thanks to Kathie Ellis and her team at The Memory Clinic, Airbles Road Centre, Motherwell.

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**References**


There have been a limited number of reports in the literature regarding health service clinicians’ knowledge and attitudes towards driving and dementia. These studies have focused on the knowledge and attitudes of medical staff. Gillespie and McMurdo (1999) surveyed the attitudes and knowledge of British geriatricians, using five case studies. Two of the case studies concerned older adults who had dementia: 33 per cent of their sample did not know, or were unsure about, who had responsibility to inform the DVLA if the driver had dementia; 37 per cent of the sample would have suggested giving up driving in the case of mild dementia; and, only 20 per cent would have breached confidentiality in the case of a driver with severe dementia who continued to drive.

In a paper emphasising their view of the danger of continuing to drive when suffering from dementia, Cable et al. (1999) found that 49 per cent of the American geriatricians in their sample did not know the steps to take to report patients with dementia, who continued to drive, to the relevant authorities, although 71 per cent of the sample agreed it was their responsibility to do so; 88 per cent said that they would contact the appropriate authority to ‘take action to recommend that driving privileges of dementia patients be revoked’. In a subsequent study Cable et al. (2000) found that 86 per cent of their sample would contact state authorities despite the objections of the patient, and 73 per cent would despite the objections of the patient’s family.

Byszewski et al. (2003) reported changes in American primary care physicians’ knowledge and confidence after training with their ‘Driving and Dementia Toolkit’. Initial pre-training responses suggested that 66 per cent of their sample did not know what to do if they suspected a significant risk in driving and 72 per cent of their sample felt unable to tell patients they were unsafe to drive. Interestingly, after training, 40 per cent of the sample remained unconfident in discussing this issue with patients.

Marottoli (2000) suggests that there may be a number of reasons why physicians do not take action to report patients whom they believe are at risk while driving because of their cognitive impairments. This may be due to their lack of knowledge of the relevant legal requirements, or it may be due to how they feel about having to report on their patients. He suggests that having a better understanding of why physicians are willing or reluctant to report would facilitate improvements in the reporting processes to maximise their acceptability and effectiveness.

Biernacki (2003) discusses some of the reasons why carers and some professionals continue to find it difficult to disclose a diagnosis of dementia with the person who has the diagnosis, despite a change in NHS policy towards greater involvement of service users in the planning and delivery of their care, and a recognition that carers would want to know the diagnosis if they themselves had dementia. She recognises the anxiety that some people have in giving and discussing a diagnosis, such as a fear that the discussion will distress the patient or even promote suicidal ideation. Not giving a diagnosis, however, makes planning for the future, including considering the advisability of continuing to drive, more difficult. Howe (2000) advises that families and caregivers should discuss quality of life issues (such as driving) with older relatives prior to the onset

Countertransference, driving and dementia
Sandy McAfee & Claire Atkins

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of cognitive impairment, so that in the event
of the development of dementia there is
agreement on the course of action to take –
for example, disclosure to the DVLA or the
American equivalent. Although a reserved-
ness to discuss emotive topics with ones’ rela-
tives may be understandable, for professionals
there is a need to be aware of ones’ own
ageism, motivations (drives, desires, attitudes
and values) and countertransference in
working with people who have dementia
(Kane, 2002); especially where this has the
capacity to affect the quality and the standard
of care that is delivered.

Whyte, Constantopoulos and Bevans
(1982) analysed the countertransference
experiences of nurses working in an
in-patient environment to 10 of their clients,
one of whom had dementia. From their
analysis they identified four characteristic
responses which they categorised as:
● ‘patient-specific responses’ (feelings
towards an individual patient reported by
most of the members of the nursing
staff);
● ‘nurse-specific responses’ (feelings that
distinguished one nurses’ reaction from
those of her colleagues);
● ‘role response’ (five feelings which were
reported more frequently than others
and which were considered to be
identifiable with the nursing role);
● ‘diagnostic response’ (some patients
seemed to stir up a particular feeling or
set of feelings in the staff group – in other
words a reaction in the nurse which was
determined by the patient).

Methodology
A questionnaire survey was undertaken
between February and May, 2006, to shed
some light on these questions. The question-
naire was developed in consultation with
local multidisciplinary colleagues and was
sent to the Scottish Dementia Working
Group (a service user sub-group of
Alzheimer’s Scotland) for their feedback.
Our research governance team advised that
this was a service development audit and so
the project did not need to be submitted to
the local research ethics committee.

Questionnaires were e-mailed to local
multidisciplinary colleagues and PSIGE
members nationally (UK wide) who were
also asked to pass the questionnaire on to
other members of their multidisciplinary
teams so that we could obtain a range of
views from other professions.

Results
One-hundred-and-eighty-eight questionnaires
were returned. The majority of the respond-
ents were clinical psychologists (31 per cent)
or nurses (27 per cent), with roughly equal
numbers of care managers, psychiatrists, occu-
pational therapists (7 per cent) and a smaller
number of GPs (5 per cent). The remainder
were made up of other occupational groups or
those who did not specify their occupation.
Most respondents worked daily or weekly with
those who have dementia or their families.
Table 1 shows the extent to which respondents
knew and understood the DVLA guidance on
driving and dementia.

As can be seen, only a minority of each
staff group felt completely certain of the
DVLA guidance. A similar pattern was
reported for knowledge of their own profes-
sion’s guidance. Respondents were asked
how often they discussed the issue of driving
with people who have dementia (Table 2).

The most common response was ‘some
weeks’ although a mean of 25.3 per cent of
respondents never discussed driving with
their clients. A similar pattern was reported
for discussions with the carers or relatives of
patients who had dementia (Table 3).
Table 1: Proportions of respondents who know DVLA guidance (0% certainty – 100% certainty).

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
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<td>3</td>
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<td>12</td>
<td>9</td>
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</tr>
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<td><strong>Nurse</strong></td>
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<td>4</td>
<td>6</td>
<td>8</td>
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<td>10</td>
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<td>0</td>
<td>0</td>
<td>7</td>
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<td>28</td>
<td>14</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Psychiatrist</strong></td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>8</td>
<td>8</td>
<td>38</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td><strong>OT</strong></td>
<td>23</td>
<td>8</td>
<td>15</td>
<td>8</td>
<td>15</td>
<td>23</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>40</td>
<td>20</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Physio</strong></td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
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<td>4</td>
<td>5</td>
<td>8</td>
<td>8</td>
<td>14</td>
<td>10</td>
<td>7</td>
<td>10</td>
<td>6</td>
<td>3</td>
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</table>

Table 2: Proportions of respondents who discuss driving with patients who have dementia.

<table>
<thead>
<tr>
<th></th>
<th>Not at all (%)</th>
<th>Some weeks (%)</th>
<th>Every week (%)</th>
<th>Every other day (%)</th>
<th>Daily (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Psychologist</strong></td>
<td>4</td>
<td>79</td>
<td>18</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Nurse</strong></td>
<td>24</td>
<td>69</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Care Manager</strong></td>
<td>14</td>
<td>86</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>28</td>
<td>50</td>
<td>7</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td><strong>Psychiatrist</strong></td>
<td>0</td>
<td>62</td>
<td>15</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td><strong>OT</strong></td>
<td>23</td>
<td>77</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Left blank</strong></td>
<td>15</td>
<td>69</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>20</td>
<td>70</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Physio</strong></td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>25.3</td>
<td>62.4</td>
<td>7.4</td>
<td>1.3</td>
<td>3.4</td>
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</table>
Table 3: Proportions of respondents who discuss driving with carers of patients who have dementia.

<table>
<thead>
<tr>
<th></th>
<th>Not at all (%)</th>
<th>Some weeks (%)</th>
<th>Every week (%)</th>
<th>Every other day (%)</th>
<th>Daily (%)</th>
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<td>2</td>
<td>84</td>
<td>14</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Nurse</td>
<td>22</td>
<td>69</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Care Manager/ Support Worker</td>
<td>7</td>
<td>86</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>64</td>
<td>0</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>0</td>
<td>62</td>
<td>15</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>OT</td>
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<td>20</td>
<td>70</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physio</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>23.3</td>
<td>64.6</td>
<td>7.0</td>
<td>1.6</td>
<td>3.4</td>
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</table>

Table 4: Awareness of thoughts or feelings which might prevent discussion of driving with patients who have dementia.

<table>
<thead>
<tr>
<th></th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Unsure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>53</td>
<td>38</td>
<td>9</td>
</tr>
<tr>
<td>Nurse</td>
<td>25</td>
<td>61</td>
<td>14</td>
</tr>
<tr>
<td>Care Manager/ Support Worker</td>
<td>21</td>
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</tr>
<tr>
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<td>28</td>
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</tr>
<tr>
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<td>54</td>
<td>15</td>
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<tr>
<td>OT</td>
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<td>62</td>
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<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Physio</td>
<td>50</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Mean</td>
<td>34</td>
<td>50</td>
<td>16</td>
</tr>
</tbody>
</table>
Respondents were asked if they were aware of any thoughts or feelings which might hold them back or prevent them from fully discussing the issue of driving with patients who had dementia. As can be seen from Table 4, a mean of 34 per cent of respondents indicated that they were aware of such thoughts or feelings, with a further 16 per cent saying they were unsure. Clinical psychologists were the occupational group which had the highest percentage of respondents (53 per cent) indicating awareness of such countertransference material.

Respondents were asked if they were ever anxious, worried or concerned about the effect of discussing these issues upon their relationship with the person who has dementia. Table 5 indicates that clinical psychologists were more concerned about this possibility than any other occupational group (78 per cent). Overall there was a majority (48 per cent) of respondents who reported concern about the effects upon their relationship with the person who had dementia, if driving were to be discussed, with a further 11 per cent indicating that they were unsure.

There was a clear majority of respondents (79 per cent) who reported that they were aware of being anxious, worried or concerned that discussing the issue of driving would upset their clients who had dementia (Table 6).

<table>
<thead>
<tr>
<th></th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Unsure (%)</th>
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</thead>
<tbody>
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<td>17</td>
<td>5</td>
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<td>Nurse</td>
<td>41</td>
<td>55</td>
<td>4</td>
</tr>
<tr>
<td>Care Manager/Support Worker</td>
<td>57</td>
<td>36</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>50</td>
<td>7</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>62</td>
<td>38</td>
<td>0</td>
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<tr>
<td>OT</td>
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<td>23</td>
<td>15</td>
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<td>Left blank</td>
<td>38</td>
<td>54</td>
<td>8</td>
</tr>
<tr>
<td>GP</td>
<td>50</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Physio</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Mean</td>
<td>48</td>
<td>41</td>
<td>11</td>
</tr>
</tbody>
</table>
Table 6: Concern regarding upsetting or distressing the person who has dementia.

<table>
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<th></th>
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<th>No (%)</th>
<th>Unsure (%)</th>
</tr>
</thead>
<tbody>
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<td>88</td>
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<tr>
<td>Mean</td>
<td>79</td>
<td>18</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 7: Uncertainty about advice to give regarding driving and dementia.

<table>
<thead>
<tr>
<th></th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Unsure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>52</td>
<td>43</td>
<td>5</td>
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<tr>
<td>Nurse</td>
<td>46</td>
<td>34</td>
<td>20</td>
</tr>
<tr>
<td>Care Manager/Support Worker</td>
<td>50</td>
<td>36</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>54</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
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<td>31</td>
<td>69</td>
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<tr>
<td>OT</td>
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<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Physio</td>
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<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>53</td>
<td>38</td>
<td>10</td>
</tr>
</tbody>
</table>
Respondents were asked if they were ever uncertain, confused or unsure about the advice and information they should be giving to people who have dementia or their families regarding the issue of driving and dementia. Table 7 indicates that the majority of the staff in this survey (53 per cent) were sometimes uncertain or confused about what advice to give, with a further 10 per cent saying they were unsure of their answer.

Respondents were asked if they ever looked back on a session with regret or concern that they had not fully discussed the issue of driving and dementia. The majority (59 per cent) said they had no regrets or concerns, with 29 per cent saying that they did sometimes have such regrets. Respondents were asked if they believed that people who have a diagnosis of dementia should be allowed to continue to drive, if they want to, and if they have undergone an appropriate assessment of driving safety: 67 per cent of the sample indicated that they believed that such people should be allowed to continue to drive. Respondents were also asked how often they believed this assessment should be repeated. The majority were in favour of six-monthly repeat assessments (54 per cent), with 34 per cent in favour of yearly repeat assessments. The others in the sample were in favour of monthly or weekly reassessments.

Regarding the duty of NHS or other staff to inform the DVLA if they become aware of a person who has dementia continuing to drive after they have been assessed as posing a significant risk, a majority (78 per cent) believed it was their duty to inform the DVLA, four per cent believed it was not their duty, and 17 per cent were unsure.

Respondents were asked about how risky they felt it was for a person with dementia to continue to drive. Some respondents answered this question but some (14 per cent) did not, saying it depended upon the extent or severity of the dementia. Clinical psychologists were the occupational group with the highest proportion of respondents who did not feel they could answer this question (34 per cent).

Respondents were also asked if they would prefer a person who has dementia to completely give up driving straight away. Table 8 shows the responses to this question. The majority of respondents (53 per cent) would not prefer a person with dementia to give up driving straight away, but 25 per cent said they would prefer this, with a further 22 per cent of respondents unsure about how they felt. Interestingly, clinical psychologists were the occupational group with the highest proportion of respondents who did not prefer a person with dementia to give up driving straight away (79 per cent).

Conclusions
A national multidisciplinary group of staff, most of whom work at least weekly with people who have dementia or their carers, completed a questionnaire regarding their knowledge, attitudes, feelings and beliefs about driving and dementia. Results indicated that all professions represented in the survey reported large variations in their degree of knowledge of DVLA and professional guidelines, but only a minority in each profession felt completely sure about such guidance. The majority of respondents had anxieties or concerns about discussing the issue of driving with people who have dementia, either about the effect this might have on their relationship with that person, or fears about the distress which this might cause. As far as we are aware no study has yet found that there is in fact any significant distress caused by discussing this issue, despite this widespread belief. Interestingly, the same fear used to be expressed (and sometimes still is) about discussing the diagnosis of dementia with clients and yet changes in professional practice now make this the norm. Other interesting aspects of this finding were that clinical psychologists were the occupational group who reported the greatest concern over relationship ruptures and causing distress, perhaps reflecting the therapeutic bias of this group leading to enhanced insight into counter-transference issues.
The majority of multidisciplinary staff were unsure of the advice to give to people who have dementia or their carers, indicating a significant training need in this area.

Two-thirds of the sample believed that, following an appropriate assessment of driving safety, people with dementia should be allowed to continue to drive, but the majority of respondents believed that this assessment should be repeated at least six-monthly. When asked about their preference, one quarter of respondents indicated that irrespective of driving assessment outcome, they would prefer people who have dementia to give up driving immediately.

Lack of knowledge of professional guidance, solely or in conjunction with countertransference issues, has an adverse effect upon the confidence of staff to discuss the issue of driving with people who have dementia. There is a need to address this issue by offering training to staff who work with this client group. To end on a positive note, it is gratifying that following the PSIGE Scottish Branch conference in June, 2006, on Driving and Dementia we have been hearing from colleagues who attended the conference, saying that they have changed their practice and are now routinely building this issue into their assessment protocol.

**Authors note**
We are grateful to our colleagues across the country who took the time to complete and return the driving and dementia questionnaire, and particularly to those who passed it on to their multidisciplinary colleagues to complete.

**Correspondence**

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E-mail: sandy.mcafee@wlt.scot.nhs.uk

**Claire Atkins**
Assistant Psychologist.

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**Table 8: Those respondents who would prefer a person who has dementia to give up driving straight away.**

<table>
<thead>
<tr>
<th></th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Unsure (%)</th>
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<tbody>
<tr>
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<td>79</td>
<td>12</td>
</tr>
<tr>
<td>Nurse</td>
<td>16</td>
<td>52</td>
<td>32</td>
</tr>
<tr>
<td>Care Manager/Support Worker</td>
<td>21</td>
<td>57</td>
<td>21</td>
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<tr>
<td>Other</td>
<td>21</td>
<td>57</td>
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<tr>
<td>Psychiatrist</td>
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<td>46</td>
<td>46</td>
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<td>OT</td>
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Driver and Vehicle Licensing Agency (2002). For medical practitioners: At a glance guide to the current medical standards of fitness to drive. Swansea: Drivers Medical Group, DVLA.


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Biographies

Liz Baikie
*Consultant Clinical Psychologist, Royal Victoria Hospital, Edinburgh.*
Liz is the Convenor of Scottish PSIGE; a member of BPS Scotland committee and formerly Treasurer then Secretary of the committee. She is also a member of Alzheimer’s Scotland Rights and Legal Protection committee and formerly, a Trustee of the Dementia Services Development Centre, University of Stirling. She has previously been a member of the Edinburgh Association for Mental Health; Scottish Action on Dementia and Alzheimer’s Scotland Action on Dementia (Edinburgh Branch). Liz was a former Chair of the Monitoring Group of Edinburgh Companion Service and has previous experience as a Supervisor for the Edinburgh branch of Cruse Bereavement Care and Trainer with Cruse Bereavement Care, Scotland; Trainer with Scottish Association for Counselling; Trainer for Marriage Guidance, Scotland (now Couple Counselling); and Case Discussion Leader, Marriage Guidance, Glasgow. She was also a Personal Supervisor and Trainer with the Edinburgh Human Sexuality Group. She currently works as a Consultant Clinical Psychologist in general work with older adults; and co-ordinates the modules on working with older people and also human sexuality for the Edinburgh University Doctorate in Clinical Psychology. Liz is also the Chair of Lothian Continued Professional Development committee. Liz has carried out research for PhD on The influence of Dementia on Marital and Sexual relationships.

James McKillop
*Chairman of Scottish Dementia Working Group.*
I am 65 and live in Glasgow. I was diagnosed with vascular dementia in 1999. Since then I have been very active in establishing the Scottish Dementia Working Group, which I chair. I was a speaker at the Alzheimer Disease International conference in the Dominican Republic and at a conference of Middle East Alzheimer Societies in Beirut. I spoke about ‘Advocacy and dementia’ at the Alzheimer Europe conference in Killarney in June, 2005. I have a keen interest in photography and have published a book of my photos entitled *Opening Shutters – Opening Minds.* I was a joint author of the booklet *Don’t make the journey alone.* I was a member of the Citizen’s Jury advising the 21st Century Review Group on Social Work in Scotland. I have spoken to social work students, trainee health visitors, primary school children, various conferences at the Dementia Services Development Centre at Stirling University, Dementia helpline volunteers and many other groups about dementia and have met Scottish Executive ministers as a representative of the Scottish Dementia Working Group.

Alex Scobbie
Alex Scobbie comes from Ashgill in Lanarkshire. He worked as a lorry driver and, for 16 years as a bus driver. He was diagnosed with Alzheimer’s disease in 2002 and initially lost his driving licence, which was restored in 2004.
Dr Heather Major
Senior Medical Adviser, Drivers Medical Development Group, DVLA, Swansea.
Dr Heather Major is the Senior Medical Adviser at the Driver and Vehicle Licensing Agency (DVLA) in Swansea. She has wide experience as a medical adviser in traffic medicine for over a decade following a background in general practice and hospital-based medicine. Drivers Medical Group at the Agency undertakes an important public health role to enhance road safety by restricting licensing only to those able to satisfy the published medical standards. However, there is increasing recognition of the fine balance to be achieved between road safety and personal rights and mobility, against the background of Human Rights and Disability Discrimination legislation. Dr Major shares a lead role in a Department of Transport team undertaking research into the key criteria underpinning current relevant EC and UK licensing regulations and standards.

Dr Lynne Hutton
Consultant in Rehabilitation Medicine, Scottish Driving Assessment Centre, Astley Ainslie Hospital, Edinburgh.
Having attended school in Morpeth, Northumberland I qualified as a doctor from the University of Glasgow in 1995. I did my house jobs at the Western Infirmary, Glasgow and Hairmyres Hospital, East Kilbride, before undertaking the medical rotation in Aberdeen. It was at Woodend Hospital, Aberdeen, that I developed my interest in Rehabilitation Medicine. After obtaining Membership of the Royal College of Physicians (MRCP) I moved to Astley Ainslie Hospital, Edinburgh, in 2000 to complete Specialist Registrar Training. I became a Consultant in Rehabilitation Medicine at Astley Ainslie Hospital in 2005, with responsibilities for amputee rehabilitation and the mobility services, which includes the Scottish Driving Assessment Service.

Dr Carol Holland
Lecturer, School of Life and Health Sciences, Aston University.
Dr Holland is a research psychologist with a special interest in changes in cognition with increasing age. She has been working in the area of University-based road safety research since 1989, first at Manchester, then at Leeds University and now at Aston University. The emphasis of her work has been on adult and older road users. Studies have examined a range of topics, from the relationship of cognitive aspects of ageing, such as limited attentional and processing capacity and slowed processing to other age-related physiological impairments such as poor eyesight and hearing in the applied setting of road safety behaviour, to research on community road safety initiatives. Review work on older drivers, on effects of illnesses and medication on driving and decisions on whether to give up driving, has led to her current work on the combined effects of differential skills and risk taking behaviour in road safety situations.

Janice Rees
Consultant Clinical Psychologist, Caerphilly Borough Older Adult Community Mental Health Team, Gwent Healthcare NHS Trust.
I have been working with older people for 23 years: in Stroke Rehabilitation, a Community Memory Team, and for the past nine years with an older adult Community Mental Health Team. My current work includes close involvement with organic degenerative diseases and with the non-organic mental health problems of later life.

I have had a longstanding interest in issues around advising patients on driving fitness in dementia. Although the ultimate decision is a statutory responsibility of the DVLA, I believe that our clinical work with patients includes a responsibility to deal with the issue of information and advice regarding driving safety, particularly where patients lack insight.

Since 1995, I have used the neuropsychological battery developed by Dr Pat McKenna
at the South Wales Driving Assessment Centre (Rookwood). Pat’s battery has evolved and been refined over the past decade, and she has obtained normative data for healthy volunteers up to the age of the mid-nineties. My involvement in the collection and analysis of the older adult norms has resulted in the data to be presented today.

Dr Jennifer Borthwick  
**Consultant Clinical Psychologist, NHS Lanarkshire.**  
Jennifer completed her clinical psychology training at Edinburgh University in 1999. She then took up a post with NHS Lanarkshire working in both adult mental health and old age psychiatry, before transferring to full-time in old age psychiatry in 2002. She worked as lecturer at Edinburgh University for a year, co-ordinating the older people’s teaching module of the clinical psychology training course. In 2005 she took up her current post as the head of service for Psychological Therapies for Older People in NHS Lanarkshire. She has previously served a term of office as the PSIGE representative on the DCP-Scotland committee and is currently PSIGE-Scotland treasurer.

Sandy McAfee  
**Consultant Clinical Psychologist, NHS Lothian.**  
Sandy McAfee is a consultant clinical psychologist working with older people in West Lothian. He trained in Edinburgh in 1987 and has worked with older people for the past six years. Previously he has worked in Glasgow in adult mental health, and in Sheffield in the clinical psychology training course as a clinical tutor, where he developed an interest in supervision training. Most recently Sandy was part of the SIGN 86 guideline group looking at psychosocial interventions in dementia, and he is a member of the NHS Education Scotland steering group developing supervision training for clinical psychologists.
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Please note: if you do not attend on the day or cancel at short notice we will invoice your employing organisation for £30

Register your interest now with Ange Brown at ange_b@virtuosityonline.co.uk or 2, Earnslaw Farm Cottages, Coldstream, Berwickshire, TD12 4JS, Scotland so we can send you an application form. We anticipate this will be a popular event so book early to avoid disappointment. If you would like any further information about this event please contact Carolien Lamers (c.lamers@bangor.ac.uk or 01248 388068) or Tina Lee (tina.lee@canterbury.ac.uk or 01892 507623)

**PSIGE is a Special Interest Group of the Division of Clinical Psychology of the British Psychological Society**
Members’ Updates

DCM course dates for 2007
This year Bradford Dementia Group are running a series of open Learning to use DCM three-day courses that qualify participants at Basic level at the University of Bradford.
The dates are:
12–14 June;
11–13 September;
6–8 November.
There is also one Using DCM for Practice Development (advanced status) course planned at Bradford on 27–29 November. All courses cost £500. Full details can be downloaded at: http://www.brad.ac.uk/acad/health/bdg/dcm/

Many care providers commission BDG to run in-house courses that can be a more cost effective option if you wish to train a larger number of mappers. These courses often offer places to people from other organisations so if the above dates are not suitable, we may be able to fit you in on one of these courses. BDG also offers an advice, training and consultancy service for organisations wishing to implement person centred care and DCM. Full details of this are available from Jean Martin on 01274 235726 or by e-mailing DCM@bradford.ac.uk

Updating to DCM 8
All courses now use DCM 8 which is proving to be a very helpful practice development tool. Many people have updated from DCM seventh edition. If you are trained on an earlier version of DCM you can purchase a self-update pack and new materials. Alternatively, if you want to refresh by re-taking the Basic course BDG can usually arrange this at a reduced rate. There is also an Excel to analyse DCM 8 data.

Postgraduate Modules, Certificate, Diploma and Masters degrees in Dementia Studies and DCM
For those wishing to pursue postgraduate study and development in dementia studies and DCM, a range of modules is available including Becoming a DCM Evaluator; Using DCM in Research; and Becoming a DCM Trainer. Full details are available from Dr Claire Surr on 01274 236455, c.a.surr1@bradford.ac.uk.

Book on person-centred care
BDG is also pleased to announce the publication of Dawn Brooker’s book on person-centred care, published as part of BDG’s Good Practice Guides by Jessica Kingsley Publications. See www.jkp.com for information.

Depression Care Pathway
A key strategic objective for National PSIGE is to influence policy at a national level and also to support the everyday practice of PSIGE members. In order to support this objective, the committee has decided to initiate a programme of developing clearly articulated care pathways for older people with mental health problems. The hope is that these will serve as templates for the highest quality care for older people so that policy makers and commissioners can see the value of psychologically informed care for older people, and that managers, clinicians and service users have clear protocols to guide treatment choice.

For 2006–2007, the committee has decided to focus the development of this care pathway work on depression. This is for a number of reasons:
- National PSIGE has recently put a considerable amount of time into issues affecting people with dementia and we wanted to maintain a concurrent focus on functional services.
At a national level, a great deal of work is already focusing on the treatment of ‘common mental health problems’ in working age adults (i.e. the Increasing Access to Psychological Therapies programme), and the development of a care pathway for older people will complement and enhance this work.

Recent service changes in some areas have led to the amalgamation of functional services across the adult age range without a recognition that general working age adult service delivery models will disadvantage some older adults.

Other services are coming under increasing pressure to articulate their value and this is likely to be more prevalent over time.

National PSIGE would like to facilitate sharing good practice with the membership and outside.

It was decided that it would be helpful to articulate the specialist input along a care pathway that an older person might need over and above that which a generic functional service is able to offer: In other words, What is it that psychologists working with older people have to offer at different stages of the care pathway for an older person with depression that differs from a generic younger adult functional service?

We are looking for any comments, ideas, or examples that would enable us to develop an overarching pathway highlighting the specialist input that an older adult with depression might require. This might include information about commissioning/costings, primary care, assessment, preventative work, delivering therapies, group work, outcome measures, or consultancy. A small group of us have agreed to work on this over the next few months and will make the information available to members as soon as is possible.

Please contact Sarah Dexter-Smith at sarah.dexter-smith@tney.northy.nhs.uk with any ideas or queries.

Understanding Personality Disorder, Launch Conference

The Society has produced a comprehensive document on Personality Disorder (PD) that gives an accurate representation of the current psychological knowledge/opinion regarding PD and a coherent position with regard to treatment/management of people with PD. The Society has had discussions with NIMHE/CSIP and DH and a common interest in promoting the paper has evolved. NIMHE/CSIP are supportive of the paper and its findings, and would like to review the document and have made access to the document available through their national PD website. These joint discussions have resulted in the organising of a conference co-sponsored by the BPS, DCP, NIMHE/CSIP and DH. The conference entitled ‘Understanding Personality Disorder: A psychological analysis of the skills and competencies needed to develop a skilled workforce in Forensic and General Mental Health services’ is scheduled to take place in Manchester in June, 2007.

Understanding Personality Disorder promotes a formulation-based treatment approach for personality disorders, which would require structured assessments, and recognises that individuals with personality disorder have long term mental health problems that affect their ability to integrate into society. Therefore, the knowledge base and skills/competencies discussed in Understanding Personality Disorder are very relevant to the New Ways of Working and Psychological Therapies agendas. Understanding Personality Disorder supports the development of competency based practitioners working in a psychologically
informed service supported and supervised by clinicians with a high degree of psychological knowledge. Understanding Personality Disorder recommends communication between Applied Psychologists in Forensic and General Mental Health Services, in order to promote a cross fertilisation of ideas from these two sectors. This could form a basis for enhancing the appropriate skills needed in Forensic and General Mental Health settings to meet the mental health needs of those in Forensic settings and manage targeted problematic behaviours of those in, or diverted to, General Mental Health settings.

The conference aims to explore these issues through presentations (from the working party who produced the paper and national figures representing the views of DH, New Ways of Working and Psychological Therapies) and workshops (covering therapeutic, organisational and workforce issues).

Please contact Nigel.Atter@bps.org.uk to register an interest in attending.
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FOR APPLIED PSYCHOLOGISTS

LAUNCH CONFERENCE
LOOKING TO THE FUTURE

Issues to be covered:

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- Leadership
- New Roles
- Career Pathways
- Improving Access to Psychological Therapies
- Team Working
- Mental Health Legislation

10.00am – 4.00pm

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Lunch and refreshments included - please apply early as places are limited.
The conference fee will be £65.

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Professor Miles Hewstone

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Notes for Contributors

Articles
Contributions in the form of short articles on any aspect of psychological theory or practice with older people are always welcome. As the Newsletter aims to cover a broad cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication.
Articles should be submitted three months before publication (January, April, July, October).

Research Updates
The Newsletter is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, e.g. ideas for discussion or early stage results, which are not ready for formal publication. Try to keep them below 500 words.
The Editorial Board reserves the right to make minor changes to any submissions.
Where major editing is necessary, the authors will be informed. All contributions must be typed.

Submission Procedure
Please submit articles as a Word file via e-mail to romola.bucks@soton.ac.uk.
Language should be inherently respectful to older people and consistent with the British Psychological Society’s guidelines.

Letters to the Editor
The Editor welcomes correspondence which combines brevity with rational argument. Letters may be edited if more than 250 words in length.

All contributions should be sent to: romola.bucks@soton.ac.uk
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