SASKATCHEWAN PSYCHIATRIC OCCUPATIONAL THERAPY DRIVING SCREEN (SPOT-DS)
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Overview

Occupational Therapy (OT) is a profession well suited to screen for and assess a person’s ability to drive. The OT focus on function and knowledge of cognitive, perceptual, social, physical, and environmental domains provide an ideal basis for these assessments. Over the last number of years, attention has been paid to aging drivers, yet the challenge of screening driving ability of clients of all ages, especially in the area of mental health remains. While occupational therapists (OTs) aim to maximize independence and community mobility, as well as balance the need for safety, there has been limited guidance as to how to proceed when asked to screen and comment on an individual’s ability to drive.

It is for this reason, that the Saskatchewan Psychiatric Occupational Therapy Driving Screen (SPOT-DS) was created. For this population, psychosocial factors, cognitive and perceptual ability, as well as physical factors and medications must be taken into account when determining fitness to drive. These areas are all represented on the screening tool.

Although originally developed for the acute mental health population, the SPOT-DS can be used to screen the driving abilities of any mental health client. This tool provides a screening structure, to be used along with clinical judgment, to improve the standardization of driving screening and resultant recommendations, for the mental health population. However, the SPOT-DS is not meant to replace the use of sound clinical judgment and reasoning.

Research Project

The SPOT-DS (formerly the Occupational Therapy Mental Health Driving Screen) was initially developed by mental health OTs in Saskatoon, Saskatchewan, Canada, who were routinely consulted to assess and comment on an individual’s ability to drive. They were seeking guidance and consistency in the process of screening mental health clients in acute care.

In May 2012, the Traffic Safety Act in Saskatchewan was amended to include OTs as mandatory reporters of concern regarding a client’s driving abilities to licensing authorities. The inclusion of OTs in this legislation increased OT responsibility and highlighted the need for a more standardized approach to screening driving abilities for this population.

The process of surveying the country to see how other OTs were approaching this task began in 2012. Consultation with OT driving specialists, pharmacists and psychiatrists ensued. A literature search to guide best practice yielded very little, highlighting the need to develop a screening tool for this purpose.

The Canadian Medical Association Driver’s Guide suggestions pertaining to assessing fitness to drive for those with psychiatric illness are as follows:

In general, drivers with a psychiatric illness are fit to drive if:

- the psychiatric condition is stable (not in the acute phase)
- functional cognitive impairment is assessed as minimal (adequate alertness, memory, attention and executive function abilities)
- the patient is compliant with treatment recommendations and consistently takes prescribed psychotropic medication
- the maintenance dose of medication does not cause noticeable sedation
- the patient has the insight to self-limit driving at times of symptom relapse and to seek assessment promptly
- the patient’s family is supportive of his or her driving.

Consider further assessment if:

- a family member reports a concern
- an at-fault crash occurs
- there is uncertainty about the degree of cognitive impairment.
Further, the Canadian Medical Association Driver’s Guide outlines the following alerts:

A patient seen or reported to have any of these problems should be advised not to drive until the condition has been evaluated and treated.

Immediate contraindications to driving:

- acute psychosis
- condition relapses sufficient to impair perceptions, mood or thinking
- medication with potentially sedating effects initiated or dose increased
- lack of insight or lack of cooperation with treatment
- lack of compliance with any conditional licensing limitations imposed by motor vehicle licensing authority
- suicidal plan involving crashing a vehicle
- an intent to use a vehicle to harm others

Based on research, collaboration with colleagues, and clinical experience, the first version of the SPOT-DS was created in 2014. Areas that had potential significance of impacting driving were included in the tool: cognitive and perceptual factors such as insight, planning, judgment, mental flexibility; physical and sensory factors such as vision, hearing, psychomotor retardation; psychosocial factors such as driving habits and history, collateral/family/friend reports, substance use; medications; as well as other factors such as ECT, compliance to treatment, or suicidal or homicidal ideation. Because medications can have a profound impact on a person’s functional abilities, it was very important to incorporate this into the tool. Pharmacy support was enlisted to develop a medication reference guide (Reference Tool for Medications Category).

The tool was examined using a series of surveys, through a modified Delphi data collection technique. OTs across Canada, with a minimum of 3 years working with the mental health population were invited to participate. Three rounds inspected all components of the screening tool, including the screening categories and content, scoring, results, recommendations, as well as the additional resources (Scoring Parameters and Samples 1-6). The process of survey distribution and subsequent tool amendment continued until consensus was reached in early 2016.

This project was approved on ethical grounds by the University of Saskatchewan Research Ethics Board initially in January 2015, and with each subsequent survey.

**Saskatchewan Psychiatric Occupational Therapy Driving Screen (SPOT-DS)**

**Identifying Information**

Name, health services number (HSN), and date of birth (DOB) are listed as client identifiers.

**History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan**

This section is meant to include any pertinent information pertaining to the client’s diagnosis, reason for referral and driving screen, as well as the current treatment plan.

**Consent/Assent**

A checkbox is provided to ensure that a consent conversation has been conducted. Circle the appropriate term to reflect the understanding of the client. If informed consent (permission) has not been achieved, comment on the assent (agreement) conversation instead.

Consent is necessary to proceed with the screen in most locations. Assent may or may not be an option, and depends on local or regional regulations. It is important for the assessing OT to become familiar with local legislation pertaining to client participation in the driving screening process.
Considerations

There are a number of considerations listed for each category. These considerations are suggestions for potential content for assessment or comment. These descriptors are meant for consideration only, to be determined by the OT as to their relevance for each client.

The SPOT-DS is meant to be used as a screen, which refers to “short, easy-to-administer tests that allow the quick identification of drivers who are clearly without impairment and those who need a more in-depth assessment to determine fitness to drive.” Therefore, a thorough assessment of each consideration for each category is not necessary and would be beyond the requirements of a screen.

Categories

Five categories for screening are included in the tool:

1. COGNITION/PERCEPTION
This category is for comments on the client’s insight, attention, decision making, mental flexibility, memory, judgment, problem solving, planning, initiation, and visual perception. These comments can be based on observations, informal assessments and/or standardized assessments. A variety of standardized cognitive or perceptual assessments can be used to inform the cognitive and perceptual status of the client, such as Trail Making Test A/B, MoCA, MVPT-III, or EXIT-25. Other useful tools may be the clock drawing/CLOX, ACE-R, or Bell’s Test. These standardized assessments are not necessarily required to be completed in order to comment on the client’s cognitive or perceptual status.

2. PHYSICAL/SENSATION
This category is for comments regarding the client’s vision, hearing, range of motion, strength, coordination, endurance, or psychomotor retardation. Other physical or sensory factors that may be relevant to the client’s driving can be included.

3. PSYCHOSOCIAL
This category is for comments related to the client’s driving habits and history, collateral/family/friend reports, substance use, or aggressive behaviors that have an impact on driving.

4. MEDICATIONS
“Accident rates are higher among sub-groups of individuals including those having the most severe degree of mental illness and those using specific psychotropic medications such as benzodiazepines.”

This category is for comments pertaining to the client’s medications and their impact on functional abilities. The Reference Tool for Medications Category has been provided for reference. The medication reference tool is meant for guideline use only. The implication of medications on a person’s driving abilities is what is relevant in this category. A checkbox is included to encourage discussion about the impact of medications with a medication expert, such as a pharmacist or psychiatrist.

5. OTHER
This category is for comments pertaining to other factors that may impact a client’s abilities to drive, such as electroconvulsive therapy (ECT), acute psychosis, undue preoccupations, compliance to medications, hallucinations, fluctuating mood, or suicidal/homicidal ideation. Other factors pertinent to the client’s driving abilities not included in previous categories may be included in this category.
Comments

A summary of the major factors impacting a client’s ability to drive (as indicated in the categories), and in turn those that are most significantly impacting the scoring are to be included here. This section is to be used to highlight the major strengths or areas for improvement relating to the client’s abilities, his/her occupations, or his/her environment.

Scoring

Each category is scored with either “green” (G), “amber” (A), or “red” (R). A green score indicates “no concern”, amber indicates “mild to moderate concern”, and red indicates “significant concern” in each category. These degrees of concern are listed on the tool.

A total score is obtained by adding the number of green, amber, and red scores for each category.

The Scoring Parameters are provided as a guide in order to assist with obtaining a score in each category.

The Samples 1-6 may be of assistance when determining scoring of each category.

Results

The possible results include “no concern present” (total=5/5 green), “mild concern present” (total=1-2 amber), “moderate concern present” (total=3-5 amber), and “significant concern present” (total=1-5 red). The specific numbers of green, amber or red scores are delineated for each, which serve to guide the results and the subsequent degree of concern.

Each result has a letter associated with it (A,B,C,D). These letters can be used to assist with determining potentially appropriate recommendations (see below).

Recommendations

The options for recommendation are listed as “continue driving”, “rescreen after further stabilization”, “refer for specialized driving assessment”, “unsafe to drive”, and “other”. Each recommendation has a letter associated with it (A,B,C,D). These letters can be used to assist a clinician to derive potentially appropriate recommendations from the associated results. More than one recommendation may be appropriate in some situations.

Experienced clinicians are encouraged to determine recommendations based on their clinical reasoning and judgment, and may not be directly related to the letters. The letters are not meant to be prescriptive in nature, but instead serve as a guide.

The “other” recommendation may be used to articulate a specific recommendation for your area, location, or client.

Notes

Comments pertaining to the resultant recommendations of the screen, as well as the plan for future assessment or intervention can be included here. Further, comments regarding the client/families’ understanding and dis/agreement with the recommendation may be included. Additional education provided to the client/family pertaining to driving safety, insurance implications, or driving cessation may be included.

A checkbox is included in order to encourage respectful disclosure to the client pertaining to the results.
and recommendations of the driving screen.

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**Samples**

There are 6 example screens included for reference. The content of these examples is hypothetical and based on clinical experience. They are not reflective of any one client. The samples are to be used as guides as to how to properly complete the tool, including scoring each category, obtaining total scores, and resultant recommendations. These are not meant to be prescriptive in nature, nor are they meant to replace the clinical judgment and reasoning of the OT.

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**Use with Caution**

“Occupational Therapists are experts in the relationship between occupation, health, and well-being.”

Internationally, Occupational Therapists have been identified as being the ideal health professional to screen and assess driving ability. The SPOT-DS was developed by Occupational Therapists for Occupational Therapists. The clinical judgment of an OT is important to be able to accurately score and comment on the functional abilities of an individual in each category. These are guidelines, however, and the clinical reasoning of the assessing therapist is imperative.

The SPOT-DS has been developed to be administered by an OT driving generalist. A thorough driving assessment (by an OT driving advanced specialist) needs to follow if there are identified areas of functional concern on the screen.

Bédard & Dickerson (2014) have outlined a number of consensus statements about the use of screening tools when determining driving fitness. The following are of particular relevance to the use of the SPOT-DS:

- In the hands of a general practice occupational therapist, results from screening/assessment tools serve as criteria for referral and action. In the hands of the driver rehabilitation specialist, the same tools can contribute to a decision for fitness-to-drive.
- Processes should be followed for occupational therapy generalists to start the driving discussions with sufficient clinically related evidence.
- Occupational therapy generalists should consider the multi-factorial nature of someone's condition and potential for improvement.

The SPOT-DS has been developed for use with the mental health population, including clients with psychotic, affective, anxiety, and/or personality disorders.
### SASKATCHEWAN PSYCHIATRIC OCCUPATIONAL THERAPY DRIVING SCREEN (SPOT-DS)

**Name:**

**HSN:**

**DOB:**

### History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan:

- Consent/assent obtained

### CATEGORY

<table>
<thead>
<tr>
<th>Considerations</th>
<th>ASSESSMENT</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. COGNITION/PERCEPTION</td>
<td>Insight, attention, decision making, mental flexibility, memory, judgment, problem solving, planning, initiation, visual perception</td>
<td>Include observations, informal assessments and/or standardized assessments.</td>
</tr>
<tr>
<td>2. PHYSICAL/SENSATION</td>
<td>Vision, hearing, ROM, strength, coordination, endurance, psychomotor retardation</td>
<td></td>
</tr>
<tr>
<td>3. PSYCHOSOCIAL</td>
<td>Driving habits/history, collateral/family/friend report, substance use, aggressive behaviours</td>
<td></td>
</tr>
<tr>
<td>4. MEDICATIONS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. OTHER</td>
<td>ECT, acute psychosis, undue preoccupations, compliance to medications, hallucinations, fluctuating mood, suicidal/homicidal ideation</td>
<td></td>
</tr>
</tbody>
</table>

### COMMENTS

#### RESULTS

- A. No concern present (5/5 GREEN)
- B. Mild concern present (1-2 AMBER)
- C. Moderate concern present (3-5 AMBER)
- D. Significant concern present (1-5 RED)

#### RECOMMENDATION

- A. Continue driving
- B. Re-screen after further stabilization
- C. Refer for specialized driving assessment
- D. Unsafe to drive
- Other _______________________________

#### KEY

**G** = GREEN = NONE  
**A** = AMBER = MODERATE  
**R** = RED = SIGNIFICANT

### NOTES

- Results/recommendations discussed with client

Occasional Therapist: _______________________________  Date: ____________________
## Reference Tool for Medications Category

**Effects of Psychotropics on Fitness to Drive**

Prepared by: Paige Pinay, BSc Candidate SPEP S80 - Feb, 2013
Reviewed by Dr. A.J. Romillard, College of Pharmacy and Nutrition, University of Saskatchewan, 2013

### Green - Medication Listed Below Should Have Little/no Effect on Driving Ability. Assess Individual Response Before Driving.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selective Serotonin Reuptake Inhibitors (SSRIs)</td>
<td>No significant impairment as monotherapy expected. Evidence suggests minimal to no effect on cognition or sedation.</td>
</tr>
<tr>
<td>Venlafaxine (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta)</td>
<td>If used in combination with other medication, especially psychotrophic medication, impairment may occur.</td>
</tr>
</tbody>
</table>

### Amber - Medication Listed Below May Have Moderate Effect on Driving Ability. Caution is Recommended.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mitrazapine (Remeron)</td>
<td>Evidence indicates that mitrazapine 30 – 45 mg may impair alertness and driving ability on initiation. Tolerance may develop after initiation, so re-evaluate at steady state. Steady state: 7 days after initiation</td>
</tr>
<tr>
<td>Tycotic Antidepressants (TCAs)</td>
<td>Similar to mitrazapine. Evidence suggests that initial therapy especially with the belladonna (some which are used as hypnics) may produce sedation, dizziness and blurred vision. Minimal impairment may be seen after one week due to tolerance.</td>
</tr>
<tr>
<td>Lithium</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness. Impairment is serum-level dependent, so check serum levels if high CNS depression suspected and re-assess at steady state. Steady state: 5 days after dose adjustment</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness. Caution is advised until patient is stable, then re-assess.</td>
</tr>
<tr>
<td>Hydroxyzine (Atarax)</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness. Tolerance may develop after initiation, so re-assess after steady state. Steady state: 5 days after initiation</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness. Tolerance may develop after initiation, so re-assess at steady state. Steady state: 5 days after initiation</td>
</tr>
</tbody>
</table>

### Red - Medication Listed Below May Have Significant Effect on Driving Ability. Driving is Not Recommended.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-generation antipsychotics</td>
<td>Evidence suggests remarkably reduced psychomotor performance during initiation and once stabilized. Ongoing evaluation of psychometor function indicated.</td>
</tr>
<tr>
<td>Haloperidol (Haldol), chlorpromazine (Largactil), methotrimeprazine (Nozmac), perphenazine (Pipmask), trifluoperazine (Trilafon), thioridazine (Mellaril), thiothixene (Promerine), zuclopenthixol (Floropent)</td>
<td>Low dose benzodiazepines may not impact cognitive function; but high doses can cause significant sedation and impaired psychomotor performance. As-needed dosing may have a more pronounced effect on driving impairment, as tolerance has not developed. Ongoing evaluation may be indicated for co-prescribed benzodiazepine dosing. If regular dosing, re-evaluate for tolerance once steady state is obtained. Steady state varies greatly among benzodiazepines. Contact pharmacy if concerns arise.</td>
</tr>
<tr>
<td>Second-generation antipsychotics</td>
<td>Evidence suggests remarkably reduced psychomotor performance during initiation and once stabilized. Ongoing evaluation of psychometor function indicated.</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa), risperidone (Risporal, Consta), quetiapine (Seroquel, Seroquel XR), ziprazadone (Zeldox), aripiprazole (Abilify, Minalta), Ziprasidon (Saphris), lurasidone (Latuda)</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Low dose benzodiazepines may not impact cognitive function; but high doses can cause significant sedation and impaired psychomotor performance. As-needed dosing may have a more pronounced effect on driving impairment, as tolerance has not developed. Ongoing evaluation may be indicated for co-prescribed benzodiazepine dosing. If regular dosing, re-evaluate for tolerance once steady state is obtained. Steady state varies greatly among benzodiazepines. Contact pharmacy if concerns arise.</td>
</tr>
<tr>
<td>Trazadone</td>
<td>Often used as a hypnotic/sedative, so sedation is expected. If used in eveniing, driving after administration not recommended. Assess for daytime sedation.</td>
</tr>
<tr>
<td>pheasantalbarial</td>
<td></td>
</tr>
<tr>
<td>Non-benzodiazepines hypnotics</td>
<td></td>
</tr>
<tr>
<td>chloral hydrate (Notec), zopiclone (Imovane), zolpidem (Sublimaze), melatonin</td>
<td></td>
</tr>
</tbody>
</table>

Disclaimer: Evaluating fitness to drive is a complex assessment. Other factors may affect level of impairment seen with any psychotropic, including but not limited to: age, body composition, sex, renal/liver function, pharmacokinetic/pharmacodynamic variation, co-morbidities (psychiatric and non-psychiatric), alcohol/substance use, and other medication (prescription, over-the-counter and herbal products). Further, pharmacokinetic/pharmacodynamic variation exists within a population. This variation may cause different responses among individual patients. This is not a comprehensive list of medications or possible effects, but rather an easy access tool for referencing possible levels of impairment due to some psychotropic medication. Each evaluation is based on mono-therapy, but additive effects of these medications must also be evaluated.

*If you have any questions about the SPOT-D, please contact Alicia Carey, Occupational Therapy, Saskatoon Health Region. www.saskatoonhealthregion.ca*

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### Scoring Parameters

<table>
<thead>
<tr>
<th>Category</th>
<th>Considerations</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognition/Perception</td>
<td>insight, attention, decision making, mental flexibility, memory, judgment, problem solving, planning, initiation, visual perception</td>
<td>functional/adequate</td>
<td>limited</td>
<td>dysfunctional/inadequate</td>
</tr>
<tr>
<td>Physical/Sensation</td>
<td>vision, hearing, range of motion, strength, coordination, endurance, psychomotor retardation</td>
<td>functional/adequate</td>
<td>limited</td>
<td>dysfunctional/inadequate</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>driving habits/history, collateral report, substance use, aggressive behaviours</td>
<td>minimally impacts functional abilities</td>
<td>somewhat impacts functional abilities</td>
<td>significantly impacts functional abilities</td>
</tr>
<tr>
<td>Medications</td>
<td>&quot;See Medication Reference Guide&quot;</td>
<td>little to no effect on driving abilities</td>
<td>moderate effect on driving abilities</td>
<td>significant effect on driving abilities</td>
</tr>
<tr>
<td>Other</td>
<td>ECT, acute psychosis, undue preoccupations, compliance to medications, hallucinations, fluctuating mood, suicidal/homicidal ideation</td>
<td>minimally impacts functional abilities</td>
<td>somewhat impacts functional abilities</td>
<td>significantly impacts functional abilities</td>
</tr>
</tbody>
</table>
History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan: Mr. Green presents with a 6 month history of depression. He was admitted to hospital with a suicide attempt by hanging after increased stresses at home. He has a poor support system at present.

- Consent/assent obtained

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSESSMENT</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. COGNITION/PERCEPTION</td>
<td>Planning, mental flexibility, and problem solving are fair. There has been a significant improvement noted by family members since admission. Good insight demonstrated as he voiced concern about potential safety issues pertaining to night driving and poor vision. MoCA and Trails A/B scores are within normal limits. Include observations, informal assessments and/or standardized assessments.</td>
<td></td>
</tr>
<tr>
<td>Physical/Sensation</td>
<td>Mr. Green had laser eye surgery completed approximately 2 years ago, resulting in limited night vision. He already reports a driving restriction after dark. He reports that since the surgery, he has not driven at night. He demonstrates functional strength, range of motion, and sensation.</td>
<td></td>
</tr>
<tr>
<td>Psychosocial</td>
<td>Mr. Green is a life long non drinker. He has no history of aggressive behaviours. He and his family report he has had no accidents.</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>He started Celexa 6 months ago after going to his GP with depressive symptoms. His dose has been increased and adjusted on admission. No other medication changes at this time. Impact of medications discussed with pharmacist or psychiatrist.</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>He has been compliant with his regular medications. He has no history of ECT, no hallucinations or delusions. His suicidal ideation has been minimized since admission with the addition of supports and coping strategies.</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS**

Mr. Green has been working on identification of warning signs and developing coping skills during his admission. His emotional status has improved during the admission.

**RESULTS**

- ✓ A. No concern present (5/5 GREEN)
- ❑ B. Mild concern present (1-2 AMBER)
- ❑ C. Moderate concern present (3-5 AMBER)
- ❑ D. Significant concern present (1-5 RED)

**RECOMMENDATION**

- ✓ A. Continue driving
- ❑ B. Re-screen after further stabilization
- ❑ C. Refer for specialized driving assessment
- ❑ D. Unsafe to drive
- ❑ Other

**NOTES**

The current driving restriction was reviewed with Mr. Green and the need to continue to abide by this restriction for safety purposes was emphasized. Mr. Green demonstrated good insight regarding potential danger to self and others. There are no additional restrictions recommended at this time. Results/recommendations discussed with client.
History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan: Ms. Screen presents with a long history of Bipolar Affective Disorder (BPAD) and is currently in a manic phase. She is undergoing an adjustment of medications during this hospital admission. The plan is to discharge her home at the end of next week.

Consent/assent obtained

### CATEGORY

**ASSESSMENT**

Screen Completion Guidelines: Comment on relevant considerations in each category. Score each category based on clinical judgment.

**SCORE**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSESSMENT</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. COGNITION/PERCEPTION</td>
<td>Ms. Screen demonstrated poor insight, decision making, and judgment prior to admission by spending large amounts of money frivolously while on a very limited income. Erratic and impulsive behaviours have continued while on the unit (ie: buying herself and other patients on the unit elaborate gifts and stuffed animals from the hospital gift shop). Limited attention was noted during the assessment.</td>
<td>G (GREEN)</td>
</tr>
<tr>
<td>2. PHYSICAL/SENSATION</td>
<td>Ms. Screen demonstrates functional physical and sensory skills. No concerns.</td>
<td>A (AMBER)</td>
</tr>
<tr>
<td>3. PSYCHOSOCIAL</td>
<td>Ms. Screen demonstrates functional physical and sensory skills. No concerns.</td>
<td>A (AMBER)</td>
</tr>
<tr>
<td>4. MEDICATIONS</td>
<td>She has been restarted on Lithium during her admission. The length of time she has not been on medication is unknown.</td>
<td>G (GREEN)</td>
</tr>
<tr>
<td>5. OTHER</td>
<td>Ms. Screen has a history of poor compliance to medications, which was a contributing factor to this admission.</td>
<td>G (GREEN)</td>
</tr>
</tbody>
</table>

**COMMENTS**

Ms. Screen is a pleasant, talkative woman. She was agreeable to the assessment.

| TOTALS | 3/3 |

**RESULTS**

- A. No concern present (5/5 GREEN)
- B. Mild concern present (1-2 AMBER)
- C. Moderate concern present (3-5 AMBER)
- D. Significant concern present (1-5 RED)

**RECOMMENDATION**

- A. Continue driving
- B. Re-screen after further stabilization
- C. Refer for specialized driving assessment
- D. Unsafe to drive
- Other

| NOTES | Currently Ms. Screen is unsafe to drive due to significant cognitive and behavioural decline. Re-screening is recommended prior to discharge after her mood stabilizes further. |

**Occupational Therapist**: Occupational Therapist Signature Sample 2  
**Date**: January 1, 2016
History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan: Mr. Prokop is a 40 year old who presents with a 20 year history of schizophrenia. He has a driver’s license but has not driven at all since high school. He lives with his mother, who has been his primary caregiver and support for many years. She has recently sustained a hip fracture; he has decompensated in the community since.

✓ Consent/assent obtained

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSESSMENT</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. COGNITION/PERCEPTION</td>
<td>Mr. Prokop has limited insight into safety concerns and potential outcomes related to him driving now after a 20+ year hiatus. He demonstrates functional cognitive skills based on screen (MoCA and Trails A/B are within normal limits). His mother reports he is independent with his ADLs, such as basic cooking, bathing, dressing, although she reports he requires assistance with some IADLs.</td>
<td>G R</td>
</tr>
<tr>
<td>2. PHYSICAL/SENSATION</td>
<td>Mr. Prokop demonstrates functional mobility. No concerns on screen.</td>
<td>A R</td>
</tr>
<tr>
<td>3. PSYCHOSOCIAL</td>
<td>Mr. Prokop has not driven for 20+ years. Prior to his diagnosis, he had very limited driving experience (less than 2 years). He has maintained his driver’s license for identification purposes. Up until now, his mother has been his primary caregiver. She drove him to appointments and community programming as needed. His mother reports concern regarding her son’s potential ability to drive safely.</td>
<td>G A</td>
</tr>
<tr>
<td>4. MEDICATIONS</td>
<td>He takes Olanzapine and Risperidone for psychotic symptoms. He has suffered recent decompensation due to stress related to his mother’s hip fracture.</td>
<td>A</td>
</tr>
<tr>
<td>5. OTHER</td>
<td>Mr. Prokop relies heavily on his mother for support. He has a history of poor compliance to medications which is why his mother assists with medication management at present. With her help, he takes the medication regularly. He has no active hallucinations.</td>
<td>G R</td>
</tr>
</tbody>
</table>

COMMENTS Due to his mother’s recent hip fracture and subsequent hip surgery, she will be unable to drive, which has precipitated Mr. Prokop’s current interest in driving.

RESULTS
- ☑ A. No concern present (5/5 GREEN)
- ☑ B. Mild concern present (1-2 AMBER)
- ☑ C. Moderate concern present (3-5 AMBER)
- ☑ D. Significant concern present (1-5 RED)

RECOMMENDATION
- ☑ A. Continue driving
- ☑ B. Re-screen after further stabilization
- ☑ C. Refer for specialized driving assessment
- ☑ D. Unsafe to drive
- ☑ Other

KEY
- G = GREEN = NONE
- A = AMBER = MODERATE
- R = RED = SIGNIFICANT

NOTES Given his limited driving experience, the extended hiatus from driving, as well as the increased stress at home, it is recommended that Mr. Prokop undergo a specialized driving assessment at this time. This has been discussed with Mr. Prokop and his mother and they are amenable to this plan.

☑ Results/recommendations discussed with client
Mr. Unger is a pleasant 45 year old gentleman who presents with a history of depression. He has no history of suicide attempts but was admitted with increasing severity of suicidal ideation involving driving into traffic and off the bridge into the river. He was admitted for stabilization. The admission is planned for 3 weeks.

**ASSESSMENT**

### 1. COGNITION/PERCEPTION

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insight, attention, decision making, mental flexibility, memory, judgment, problem solving, planning, initiation, visual perception</td>
<td>G A ●</td>
</tr>
</tbody>
</table>

Mr. Unger demonstrates poor cognitive abilities at present. MoCA, Trails A/B, and EXIT-25 scores indicate impairment. He is unable to appreciate the potential consequences of his suicide plan. He demonstrates poor reasoning, planning, and organizational skills and questionable judgment at present.

Include observations, informal assessments and/or standardized assessments.

### 2. PHYSICAL/SENSATION

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision, hearing, ROM, strength, coordination, endurance, psychomotor retardation</td>
<td>G A ●</td>
</tr>
</tbody>
</table>

Mr. Unger sustained back and neck injuries at work 2 years ago. He had lumbar and cervical fusions in the last 6 months, which has resulted in significantly reduced trunk and neck range of motion. He suffers from chronic pain and is on long term disability.

### 3. PSYCHOSOCIAL

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driving habits/history, collateral/family/friend report, substance use, aggressive behaviours</td>
<td>A R</td>
</tr>
</tbody>
</table>

Mr. Unger reports social alcohol use. He has a history of aggressive behaviours in young adulthood but has participated in anger management classes since. He has an unremarkable driving history.

### 4. MEDICATIONS

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>For guideline use only.</td>
<td>A R</td>
</tr>
</tbody>
</table>

He has been taking Effexor regularly for 5 years. He reports taking over the counter medications for pain management.

✓ Impact of medications discussed with pharmacist or psychiatrist

### 5. OTHER

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECT, acute psychosis, undue preoccupations, compliance to medications, hallucinations, fluctuating mood, suicidal/homicidal ideation</td>
<td>G A ●</td>
</tr>
</tbody>
</table>

Mr. Unger has undergone 12x ECT with moderate success. Further ECT is planned. His suicide plan involves driving head on into traffic and off the bridge into the river.

**COMMENTS**

Mr. Unger is a pleasant gentleman with significant mood symptoms and a dangerous suicide plan.

**RESULTS**

- A. No concern present (5/5 GREEN)
- B. Mild concern present (1-2 AMBER)
- C. Moderate concern present (3-5 AMBER)
- D. Significant concern present (1-5 RED)

**RECOMMENDATION**

- A. Continue driving
- B. Re-screen after further stabilization
- C. Refer for specialized driving assessment
- D. Unsafe to drive
- Other _______________________________

Given the degree of depressive symptoms, the significant cognitive concerns, multiple ECT, and the significant danger to himself and others that his suicide plan includes, driving cessation is recommended at present. Re-screening may be indicated should his functional abilities improve.

✓ Results/recommendations discussed with client

**DATE:** January 1, 2016
Mr. Astor has long standing delusional disorder. Delusions pertain to government conspiracy and infringement of personal space and identification. He has no suicidal or homicidal ideation. The delusions do not appear to impact his functional abilities at home but may contribute to his isolation.

While his delusional disorder may appear to be impacting his social contact and resultant isolation, it appears his cognitive abilities may have contributed to his functional decline.

### RESULTS

- **A.** No concern present
  - (0-5 GREEN)
  - ✓ Consent/assent obtained

- **B.** Mild concern present
  - (1-2 AMBER)

- **C.** Moderate concern present
  - (3-5 AMBER)

- **D.** Significant concern present
  - (1-5 RED)

### RECOMMENDATION

- **A.** Continue driving
  - Repeat screen may be indicated if functional status changes.

- **B.** Re-screen after further stabilization
  - ✓ Results/recommendations discussed with client

### NOTES

Due to the concerns raised by family regarding questionable functional abilities, apparent cognitive decline, and reduced hearing, a specialized driving assessment is recommended for a road test and more detailed examination of driving skills. Further assessment of ADLs and IADLs is needed to determine Mr. Astor’s ability to manage living independently.

Occasional Therapist: **Occupational Therapist Signature Sample 5**  
Date: January 1, 2016
Mrs. Lamb is a pleasant 56 year old woman presenting to the hospital with long standing depression and a newly diagnosed anxiety disorder. She lives with her spouse and together they are full time caregivers for their young grandson. She is a retired teacher.

Consent/assent obtained

**History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan:**

Mrs. Lamb has functional cognitive abilities. She reports noticing a decline in her organizational abilities recently, but on screen they remain within normal limits. Drowsiness is noted by staff after she started on new anxiety medication. Mrs. Lamb demonstrated good insight and judgment by discussing the safety concerns related to driving in a state of decreased arousal and reports she would currently not drive due to her concerns.

Mrs. Lamb has functional strength, range of motion, and sensation. She reports having an active lifestyle when her mood is stable.

Mrs. Lamb reports being a social drinker. She has no history of car accidents. Along with her spouse, she is currently raising her 2 year old grandson. She reports significant stressors and anxiety relating to her daughter’s drug abuse and lifestyle.

Mrs. Lamb is taking Effexor for her depressive symptoms. Clonidine has been started on admission to address anxiety symptoms.

Mrs. Lamb has a remote history of ECT with good success. She does not have suicidal or homicidal ideation.

Mrs. Lamb has been married for 30 years and reports enjoying travelling with her spouse. While in hospital, she has been working on developing coping strategies and identifying triggers with the goal of reducing her anxiety.

**RESULTS**

- **A. No concern present** (5/5 GREEN)
- **B. Mild concern present** (1-2 AMBER)
- **C. Moderate concern present** (3-5 AMBER)
- **D. Significant concern present** (1-5 RED)

**RECOMMENDATION**

- **A. Continue driving**
- **B. Re-screen after further stabilization**
- **C. Refer for specialized driving assessment**
- **D. Unsafe to drive**
- **Other _______________________________

**NOTES**

Due to concerns regarding drowsiness related to the recent addition of anxiety medication, re-screening in a week is suggested prior to discharge home. This has been discussed with Mrs. Lamb and her spouse and they both agree with this recommendation.

Results/recommendations discussed with client
References


Sincere thanks and gratitude to the following for your assistance with this research project and the development of the Saskatchewan Psychiatric Occupational Therapy–Driving Screen (SPOT-DS). This project would not have been possible without your expertise and support!

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aleksandra Grochulski, BScOT</td>
<td>Senior Occupational Therapist, Irene &amp; Leslie Dubé Centre for Mental Health, Saskatoon Health Region</td>
<td>Clinical Consultation &amp; Collaboration</td>
</tr>
<tr>
<td>Carolyn Burton, MSc</td>
<td>Manager, Data Standards &amp; Reporting, EHealth, Saskatoon Health Region</td>
<td>Data Collection &amp; Analysis</td>
</tr>
<tr>
<td>Paige Pinay, BSP</td>
<td>Pharmacist</td>
<td>Medication Reference Research &amp; Development</td>
</tr>
<tr>
<td>A. J. Remillard, PharmD, BCPP</td>
<td>Associate Dean, Research &amp; Graduate Affairs, Professor of Pharmacy, University of Saskatchewan</td>
<td>Medication Reference Review &amp; Editing</td>
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<td>Suzanne Sheppard, PhD</td>
<td>Director, Interprofessional Practice Education &amp; Research, Saskatoon Health Region</td>
<td>Research Expert &amp; Overall Project Consultation</td>
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<td>Medical Library Staff</td>
<td>Saskatchewan Health Region</td>
<td>Literature Search &amp; Retrieval</td>
</tr>
</tbody>
</table>
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www.saskatoonhealthregion.ca

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