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 in the screening framework.

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 framework provides a screening structure, to assist with complex clinical reasoning, to guide driving screening and recommendations, for the mental health population.

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 guidance to screen 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 framework 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: 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.2,8,22,27,36,39,40,41 Because medications can have a profound impact on a person’s functional abilities, pharmacy support was enlisted to develop a medication reference guide (Reference for Medications Category).22,23,24,35,40

The framework 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 guide, including the screening categories and content, rating, results, recommendations, as well as the additional resources (Rating Parameters and Samples 1-6). The process of survey distribution and subsequent 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 framework:

1. COGNERITION/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 may be indicated here.

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 for Medications Category has been provided for reference. The medication reference 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.

Rating

Each category is rated with either “green” (G), “amber” (A), or “red” (R). Green 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 guide.

A total tally is obtained by adding the number of greens, ambers, and reds for the combined categories.

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

The 6 Samples may be of assistance when determining rating in 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 number of greens, ambers or reds 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 only 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.
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 utilize the guide, including rating 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.

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

- Consent/assent obtained

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<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSESSMENT</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. COGNITION/PERCEPTION</strong>&lt;br&gt;Insight, attention, decision making, mental flexibility, memory, judgment, problem solving, planning, initiation, visual perception</td>
<td>Screen Completion Guidelines: Comment only on relevant considerations in each category. Rate each category based on clinical judgment.</td>
<td>SAR</td>
</tr>
<tr>
<td><strong>2. PHYSICAL/SENSATION</strong>&lt;br&gt;Vision, hearing, ROM, strength, coordination, endurance, psychomotor retardation</td>
<td>Include observations, informal assessments and/or standardized assessments.</td>
<td>SAR</td>
</tr>
<tr>
<td><strong>3. PSYCHOSOCIAL</strong>&lt;br&gt;Driving habits/history, collateral/family/friend report, substance use, aggressive behaviours</td>
<td></td>
<td>SAR</td>
</tr>
<tr>
<td><strong>4. MEDICATIONS</strong>&lt;br&gt;*See reverse for recommendations. For guideline use only.</td>
<td>Impact of medications discussed with pharmacist or psychiatrist</td>
<td>SAR</td>
</tr>
<tr>
<td><strong>5. OTHER</strong>&lt;br&gt;ECT, acute psychosis, undue preoccupations, compliance to medications, hallucinations, fluctuating mood, suicidal/homicidal ideation</td>
<td></td>
<td>SAR</td>
</tr>
</tbody>
</table>

**COMMENTS**

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**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**

- Results/recommendations discussed with client

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Occupational Therapist: __________________________ Date: __________________________
**REFERENCE FOR MEDICATIONS CATEGORY**

**Effects of Psychotropics on Fitness to Drive**

Prepared by: Paige Pinay, BSP Candidate SPEG 580 - Feb, 2013
Reviewed by: Dr. A.J. Remillard, 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>Response</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>Fluoxetine (Prozac), fluvoxamine (Luvox), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Cipralex)</td>
<td>If used in combination with other medication, especially psychotropic medication, impairment may occur.</td>
</tr>
<tr>
<td>Serotonin Non-precipitate Reuptake Inhibitors (SNRIs)</td>
<td>Steady state: 5 days after titration.</td>
</tr>
<tr>
<td>Venlafaxine (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta)</td>
<td>Steady state: 5 days after titration.</td>
</tr>
<tr>
<td>Stimulants</td>
<td>Low dose benzodiazepines may not impair cognitive function, but high doses can cause significant sedation and impaired psychomotor performance.</td>
</tr>
<tr>
<td>METHYLPHENIDATE (Ritalin, Concerta, Vyvanse), dexmethylphenidate (Adderall, Dexedrine)</td>
<td>If used in evening, driving after administration not recommended. Assess for daytime sedation.</td>
</tr>
<tr>
<td>Atomoxetine (Strattera)</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness.</td>
</tr>
<tr>
<td>Flupirizole (Buspar)</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness.</td>
</tr>
<tr>
<td>Buproprion (Wellbutrin)</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness.</td>
</tr>
<tr>
<td>Methylphenidate (Ritalin, Concerta, Vyvanse), dexmethylphenidate (Adderall, Dexedrine)</td>
<td>Evidence suggests moderate to severe impairment. Assess for daytime sedation.</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>Evidence suggests moderate to severe impairment. Assess for daytime sedation.</td>
</tr>
<tr>
<td>Presynaptic</td>
<td>Evidence suggests mild impairment during initiation of therapy, but minimal impairment seen once tolerance is achieved.</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Evidence indicates that mirtazapine 30 – 45 mg may impair alertness and driving ability on initiation. Tolerance may develop after titration, so re-assess at steady state.</td>
</tr>
<tr>
<td>Venlafaxine (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta)</td>
<td>Steady state: 5 days after titration.</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>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>Evidence indicates that mirtazapine 30 – 45 mg may impair alertness and driving ability on initiation. Tolerance may develop after titration, so re-assess at steady state.</td>
</tr>
<tr>
<td>Tricyclic Antidepressants (TCAs)</td>
<td>Steady state: 5 days after titration.</td>
</tr>
<tr>
<td>Tertiary: amitriptyline (Elavil), clomipramine (Anafranil), doxepine (Sinequan, Silenor), imipramine (Tofrane)</td>
<td>Steady state: 5 days after titration.</td>
</tr>
<tr>
<td>Secondary: desipramine (Norpramin), nortriptyline (Aventyl)</td>
<td>Steady state: 5 days after titration.</td>
</tr>
<tr>
<td>Lithium</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness.</td>
</tr>
<tr>
<td>Hydroxyzine (Atarax)</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness.</td>
</tr>
<tr>
<td>Clonidine</td>
<td>Potential to cause CNS depression, which may affect physical and mental abilities, as well as alertness.</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Evidence suggests markedly reduced psychomotor performance during initiation and once stabilized. Ongoing evaluation of psychomotor function indicated.</td>
</tr>
<tr>
<td>First-generation antipsychotics</td>
<td>Evidence suggests remarkably reduced psychomotor performance during initiation and once stabilized. Ongoing evaluation of psychomotor function indicated.</td>
</tr>
<tr>
<td>Second-generation antipsychotics</td>
<td>Evidence suggests remarkably reduced psychomotor performance during initiation and once stabilized. Ongoing evaluation of psychomotor function indicated.</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Low dose benzodiazepines may not impair cognitive function, but high doses can cause significant sedation and impaired psychomotor performance.</td>
</tr>
<tr>
<td>Pasteloids (Klonopin), lurasidone (Latuda), olanzapine (Zyprexa), risperidone (Risperdal, Consta), quetiapine (Seroquel),</td>
<td>As-needed dosing may have a more pronounced effect on driving impairment, as tolerance has not developed. Ongoing evaluation may be indicated for as-needed benzodiazepine dosing.</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>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trazodone</td>
<td>Often used as a hypnotic/sedative, so sedation is expected. If used in evening, driving after administration not recommended. Assess for daytime sedation.</td>
</tr>
<tr>
<td>Phenobarbital</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-DS, please contact Alicia Carey, Occupational Therapy, Saskatoon Health Region. www.saskatoonhealthregion.ca

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<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><em>See Medication Reference Guide</em></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>
**Saskatchewan Psychiatric Occupational Therapy Driving Screen**

**Name:** SAMPLE 1 Al Green  
**HSN:** 987 654 321  
**DOB:** December 4, 1982

**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**

### CATEGORY  
**Considerations**

<table>
<thead>
<tr>
<th><strong>ASSESSMENT</strong></th>
<th><strong>RATING</strong></th>
</tr>
</thead>
<tbody>
<tr>
<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.</td>
<td></td>
</tr>
<tr>
<td>Include observations, informal assessments and/or standardized assessments.</td>
<td></td>
</tr>
<tr>
<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>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>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.</td>
<td></td>
</tr>
<tr>
<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>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>✓ Impact of medications discussed with pharmacist or psychiatrist</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  
  
### RECOMMENDATION

- ✓ A. Continue driving

### 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

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSESSMENT</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. COGNITION/PERCEPTION</strong></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. Include observations, informal assessments and/or standardized assessments.</td>
<td>G A R</td>
</tr>
<tr>
<td><strong>2. PHYSICAL/SENSATION</strong></td>
<td>Ms. Screen demonstrates functional physical and sensory skills. No concerns.</td>
<td>A R</td>
</tr>
<tr>
<td><strong>3. PSYCHOSOCIAL</strong></td>
<td>Ms. Screen drives her own vehicle regularly. She has no family or friend support. She reports occasional alcohol use. She has no history of collisions.</td>
<td>A R</td>
</tr>
<tr>
<td><strong>4. MEDICATIONS</strong></td>
<td>She has been restarted on Lithium during her admission. The length of time she has not been on medication is unknown. Impact of medications discussed with pharmacist or psychiatrist</td>
<td>G R</td>
</tr>
<tr>
<td><strong>5. OTHER</strong></td>
<td>Ms. Screen has a history of poor compliance to medications, which was a contributing factor to this admission.</td>
<td>G R</td>
</tr>
</tbody>
</table>

**COMMENTS**

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

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

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.

- Results/recommendations discussed with client

**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

### Categorization and Assessment

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSESSMENT</th>
<th>RATING</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></td>
</tr>
<tr>
<td>2. PHYSICAL/SENSATION</td>
<td>Mr. Prokop demonstrates functional mobility. No concerns on screen.</td>
<td></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></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. Impact of medications discussed with pharmacist or psychiatrist.</td>
<td>G A R</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 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 _______________________________

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

### Consent/assent obtained

### CATEGORY

#### 1. COGNITION/PERCEPTION

- **Insight, attention, decision making, mental flexibility, memory, judgment, problem solving, planning, initiation, visual perception**

  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

- **Vision, hearing, ROM, strength, coordination, endurance, psychomotor retardation**

  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

- **Driving habits/history, collateral/family/friend report, substance use, aggressive behaviours**

  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

- **Temporarily withhold medications as per guideline use only.**

  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

- **ECT, acute psychosis, undue preoccupations, compliance to medications, hallucinations, fluctuating mood, suicidal/homicidal ideation**

  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 _______________________________

### TOTALS

2  0  3

### NOTES

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

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**Occupational Therapist:** [Occupational Therapist Signature Sample 4]  
**Date:** January 1, 2016
History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan: Mr. Astor is a pleasant 75 year old with a long standing history of delusional disorder. He is a retired farmer who lives alone on his farm. His GP referred him to OT for an assessment due to concerns regarding his functioning at home and recent isolation. There is a family history of dementia.

Consent/assent obtained

<table>
<thead>
<tr>
<th>CATEGORY</th>
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<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. COGNITION/PERCEPTION</td>
<td>Mild memory impairment noted functionally but demonstrates fair judgment and problem solving on screen. (ie: Mr. Astor reports forgetting information he previously knew such as his children’s phone numbers, but knows how to locate them in the phone book). Some difficulty with instructions, planning, and organizational abilities noticed in Trails B. Family reports he manages better in familiar surroundings compared with novel situations. Include observations, informal assessments and/or standardized assessments.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mr. Astor is hard of hearing, but was able to manage in assessment with minimal modification. He refuses to wear hearing aids, even at insistence of family. Family report increased difficulty with hearing in social settings, with distractions and background noise. Poor sitting tolerance due to remote back injury. Mr. Astor wears glasses for reading.</td>
<td></td>
</tr>
<tr>
<td>2. PHYSICAL/SENSATION</td>
<td>Mr. Astor has had 1 car accident within the last year (fault/circumstances unknown). Previously active and involved with his family and friends, he now has limited contact with his family and has become isolated from his friends. He has very little social contact at present. He admits to some alcohol use. Family has some concerns about his current functional abilities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mr. Astor reports taking a daily multivitamin. He reports taking over the counter pain medications sparingly for back pain. He reports taking no other medications.Ł  Impact of medications discussed with pharmacist or psychiatrist</td>
<td></td>
</tr>
<tr>
<td>3. PSYCHOSOCIAL</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS

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 (1-5 GREEN)
- ❑ B. Mild concern present (3-5 AMBER)
- ❑ C. Moderate concern present (2-5 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 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.

Results/recommendations discussed with client

Occupational Therapist: Sample 5 David Astor

Date: January 1, 2016
History of Presenting Illness, Past Psychiatric/Medical History, Current Treatment Plan: 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

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CONSIDERATIONS</th>
<th>ASSESSMENT</th>
<th>RATING</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>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. Include observations, informal assessments and/or standardized assessments.</td>
<td>A R</td>
</tr>
<tr>
<td>2. PHYSICAL/SENSATION</td>
<td>Vision, hearing, ROM, strength, coordination, endurance, psychomotor retardation</td>
<td>Mrs. Lamb has functional strength, range of motion, and sensation. She reports having an active lifestyle when her mood is stable.</td>
<td>A R</td>
</tr>
<tr>
<td>3. PSYCHOSOCIAL</td>
<td>Driving habits/history, collateral/family/friend report, substance use, aggressive behaviours</td>
<td>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.</td>
<td>A R</td>
</tr>
<tr>
<td>4. MEDICATIONS</td>
<td>*See reverse for recommendations. For guideline use only.</td>
<td>Mrs. Lamb is taking Effexor for her depressive symptoms. Clonidine has been started on admission to address anxiety symptoms. ✓ Impact of medications discussed with pharmacist or psychiatrist</td>
<td>G R</td>
</tr>
<tr>
<td>5. OTHER</td>
<td>ECT, acute psychosis, undue preoccupations, compliance to medications, hallucinations, fluctuating mood, suicidal/homicidal ideation</td>
<td>Mrs. Lamb has a remote history of ECT with good success. She does not have suicidal or homicidal ideation.</td>
<td>A R</td>
</tr>
</tbody>
</table>

**COMMENTS**
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

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References


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<tr>
<th>Name</th>
<th>Position</th>
<th>Contribution</th>
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<tbody>
<tr>
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<td>Clinical Consultation &amp; Collaboration</td>
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<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>
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<td>Literature Search &amp; Retrieval</td>
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